LEADING ARTICLES

Treatment of anaphylactic shock .............................................. 1011
Bladder cancer ........................................................................ 1012
Beta2-microglobulin ................................................................ 1013
Chondromalacia patellae ............................................................. 1014

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Generalised smooth-muscle disease with defective muscarinic-receptor function ROGER BANNISTER, ANTHONY D HOYES ................................................................. 1015
Do colonic bacteria contribute to cholesterol gall-stone formation? Effects of lactulose on bile J R THORNTON, K W HEATON ................................................................. 1018
Diagnosis of deep vein thrombosis using autologous indium-III-labelled platelets ALBERT FENECH, J K HUSSEY, F W SMITH, P P DENDY, B BENNETT, A S DOUGLAS ................. 1020
Familial hypocalciuric hypercalcaemia and acute pancreatitis M DAVIES, P S KLIMIUK, P H ADAMS, G A LUMB, D M LARGE, D C ANDERSON ........................................... 1023
Pain due to lesions of central nervous system removed by sympathetic block L LOH, P W NATHAN, G D SCHOTT ................................................................. 1026
Combined treatment with sustained-release theophylline and beta2-adrenoceptor-stimulating agents in chronic childhood asthma GUDMAR LÖNNERHÖLM, TONY FOUCARD, BJÖRN LINDESTRÖM ......................................................... 1029
Effects of cooking on serum glucose and insulin responses to starch P COLLINGS, C WILLIAMS, I MACDONALD ................................................................. 1032
Compression of oesophagus by tortuous dilated aorta R H PEARSON, E M BESSELL, N R BOWLEY ......................................................... 1032
Multisystem disorder after exposure to paint stripper (Nitromors) N A MEMON, A R DAVIDSON ......................................................................................... 1033
Exaggerated hypokalaemia in acute myeloid leukaemia P C ADAMS, K W WOODHOUSE, M ADELA, A PARNHAM ................................................................. 1034
Brain abscess due to Arachnia propionica T V RILEY, A K OTT ................................................................. 1035
Legionnaires' disease and abscess of appendix PAUL HOLT ................................................................. 1035
Spacing between doses on a thrice-daily regimen LARS S ALFREDSSON, STAFFAN E NORELL ......................................................................................... 1036
Correction: Effect of hyperlipidaemia on haemostatic variables ELKELES ET AL ................................................................. 1028

Practice Research: Do general practitioners have different "referral thresholds"?
RICHARD O CUMMINS, BRIAN JARMAN, PATRICIA M WHITE ........................................................................... 1037

Pitfalls in Practice: Employment law—IV NORMAN ELLIS ........................................................................... 1038

Medicine and Books

English: Bladder cancer

No 6269
BRITISH MEDICAL JOURNAL 1981 VOLUME 282 1011-1094
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

SUPPLEMENT

The Week .................................................................................. 1087
Letter from Westminster WILLIAM RUSSELL ................................................................. 1088
The strategy behind the Jenkin non-strategy RUDOLF KLEIN ........................................................................... 1089
Postgraduate teaching hospitals: future management ................................................................. 1092
GMC Professional Conduct Committee ........................................................................... 1092
Increase in category 'D' fees ........................................................................... 1092
General Medical Services Committee ........................................................................... 1093
ARM: accommodation at Brighton ........................................................................... 1093
Scottish health statistics ........................................................................... 1094
Consultants' contracts: CCHMS warning ........................................................................... 1094
Explaining death to children

Jane Davies

1069

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Explaining death to children

SIR—In one episode of a recent television series on death and bereavement they showed an actual burial and an actual cremation. My 6-year-old daughter happened to be in the room when this was on and she watched with rapt attention. “That was most interesting,” she said at the end. “I have heard of funerals but didn’t know what actually happened. It will also be useful because I’ve never been to a funeral but I expect I’ll come to yours, Mummy.” A few minutes later she suddenly flung herself into my arms and sobbed, “That would mean I would no longer have you with me.”

These two distinct responses to death and bereavement shown vividly by a child would seem true for most of us, children and adults alike—on the one hand the practical facts, on the other the raw emotion that the reality of death arouses. Susan Foster’s recent article “Explaining death to children” (14 February, p 540) attempted to look at how we prepared children for facing death and bereavement with a clinical description of the various stages and possible effects of mourning, but it made no real attempt to look at the emotions that death arouses in a child and in those who care for that child. Indeed, her final sentence—“If these people are actively concerned in child care they will know that the creed and the colour do not matter, for the children are just children, and their needs are the concern of us all”—underlines just how far we are from facing this subject honestly.

“The creed and the colour” do matter, whether we are prepared to acknowledge it or not. We cannot just be clinical and factual about death. In talking about death we are talking about fears, emotions, beliefs, and cultures, not just fact. The only fact about death that is provable is that those we love die and are physically separated from us; but what happens then we do not know. Those who maintain that that is the end can prove their view no more than those who believe in an afterlife. What we believe happens after death inevitably has an effect on how we come to terms with death and how we mourn. Those who would stick to fact—that is, provable fact—are in trouble as we simply cannot ignore the reality of fears and hopes. Can we then explain death to children? Let us look first at the situation when a death has occurred and we are trying to help an individual child. Above all we must remember that children are individuals and will all react differently. The conclusions arrived at by Anthony1 and others can serve only as background information, not as a reliable starting point. Any professional caring for a bereaved child needs to discipline himself to observe and listen with an open mind. Some children will come from homes whose culture and creeds give them background knowledge of death, beliefs handed down from generation to generation. Doctors, nurses, teachers, and other professionals should have the humility and the courage to respect such beliefs, helping the child to draw comfort from them where he can. It is not the time to break beliefs that differ from our own as this can cause great stress within the family. It is also important to know what the various creeds actually teach and not rely on what we think they say, as we all have our prejudices.

Some children will come from families with no beliefs or, at the best, muddled ones. The child may then be confused or anxious, not knowing what has happened to his mother, sister, or whoever. The honest answer is that we do not know, but in my experience this factual, blunt answer is softened by emphasising to the child how important it is to go on loving and approving of the dead person. Few parents object, in this situation, to the statement of personal beliefs, provided that they are genuine personal beliefs, prefaced by “We do not know but I believe”—this is then accepted as a personal and not a religious statement.

Most children can get on with the business of mourning only when they have sorted out what has happened and where the dead person is. It is part of a practical approach to life. There is often real fear at the idea of the deceased being burnt or buried alive. The assurance that it really is just an empty shell and quite dead, not like the person they knew and loved, is often important. Many deeply resent any clumsy suggestion of a substitute. “You’ve still got your brother to play with” or “Granny will come and look after you” can be interpreted as someone taking the place of