Care of the suddenly bereaved

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The hospice movement was established over 20 years ago to care for and support the dying and their relatives and now makes an important contribution to the management of patients with terminal illnesses. Over one third of people who die in hospital, however, do so within a few hours of arrival, often in the accident and emergency department and usually after a brief illness or an accident. Many of them are young, and most die outside normal working hours.

Medical staff are not trained to manage the suddenly bereaved. Nursing staff, who usually have more experience in this, are often working under considerable pressure. The first contact relatives have with hospital staff is just before or at the time of the patient's death, and there is rarely any subsequent support of the type recommended by the hospice movement. Yet the impact of a sudden death on relatives is often more pronounced than that of a death after a prolonged illness, during which the relatives have had time to prepare themselves.

We describe some of the problems encountered by the suddenly bereaved and present the experience of a counselling support service that has been developed in this accident and emergency department over six years.

Evolution of the service

Interest in providing support for distressed relatives within this department was stimulated by the experiences of Lapwood,¹ and in 1983 a bereavement counsellor was temporarily appointed. The appointment was generally welcomed, but problems were encountered: one nurse was lost from the resuscitation team, and the service was available only when the counsellor was on duty. The work was restricted to the department, but follow up in the community was clearly needed.

In 1986 this temporary post was established as a formal part of the nursing service. When not counselling or teaching the counsellor worked as a nurse in the department. Visits were made to relatives' homes on one day a week, and a network of community support was developed. Close liaison with the hospital's social work department was established so that the new service complemented and extended the work already being done by the social worker in the accident and emergency department.

All medical and nursing staff working in the accident and emergency department now receive training from the counsellor in the initial support of suddenly bereaved relatives when they are appointed. The working hours of a group of senior nurses have been coordinated so that the service is available at all times. This has allowed the counsellor more time to develop community support. The demands on the service, however, continue to outstrip the available resources, and conflict continues between the need to support isolated relatives in the community and the need to be present in the accident and emergency department.

The counsellor must spend time working alongside the resuscitation team so that she can understand the stresses of the full time nurses.

The emotional demands on those providing support are considerable. The counsellor helps the staff of the accident and emergency department but also needs support herself; this is achieved by monthly informal discussions with a professional counsellor based in an adjacent (non-medical) postgraduate institution.

Support in the accident and emergency department

On arrival in the department friends and relatives of critically ill or injured patients are taken to a specially furnished relatives' room by a nurse, who stays with them and provides an honest interpretation of the patients' progress. All staff are taught the importance of continuous support and communication with non-technical language. The relatives' room is adjacent to the resuscitation area but opens on to a quiet corridor with toilets nearby. It contains sofas and easy chairs, facilities for making tea, a mirror, a box of tissues, and a direct dial telephone. Carpet, wallpaper, curtains, and a table lamp create a warm, domestic environment. Some relatives ask to witness the resuscitation, and this is encouraged after explanation by the nurse. Frequent reports of developments are essential. News of deterioration or death is given by the most senior members of staff managing the patient. Repeated, simple explanations and listening and sharing are important. Spiritual support is immediately available, but a priest is not approached without the relatives agreeing.

If the patient dies the body is moved into a private room. Relatives and friends, including children, are encouraged to visit and stay in the room for as long as they wish. If the patient was a child or baby the relatives are encouraged to hold the body. Subsequent communication with the coroner's officer, general practitioner, health visitor, social services, and clergy follows standard practice.

When the patient's relatives and friends have left the medical and nursing staff are given support. They are encouraged to take a few minutes for quiet discussion and to share feelings, and this time is considered invaluable.

Support in the community

The bereavement counsellor is told about all deaths and decides, in consultation with staff present at the time of death, whether she needs to give community support. The risk factors listed in the box are considered. Occasionally staff may think that a particular family is in need of support despite none of the risk factors being evident. Whenever possible the first visit is made without an appointment within 72 hours of the death. The extended family is usually together at this time, and a spontaneous conversation is considered to be more valuable than a prearranged formal consulta-

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Factors that may complicate bereavement

Loss of practical and emotional support and companionship
Loss of or anxiety about financial provision
Loss of or anxiety about the family home
Children or adolescents in the immediate family
Dependent family members (handicapped, elderly, or sick)
A parent surviving his or her child
Inability to share feelings with the family
Reluctance to acknowledge the death
Marital or family discord
Difficulty in dealing with previous losses
Lack of spiritual support
Lack of community support
History of mental illness

tion. The visit usually lasts about one hour, a non-directive counselling technique being used. The need for and the timing of further visits are then decided.

Results

Records of all deaths in the department over 12 months and the support provided for relatives were reviewed. A total of 338 patients died, of whom six were infants and seven were children under the age of 16. The support provided in the department seemed to be welcomed. Comments were made about the value of the relatives' room and the constant availability of the support nurse.

The success of the community work was more difficult to determine. The counsellor visited 109 families living within 100 km of the hospital. Follow up visits were arranged in 98 cases; a mean of five visits were made to each household. In 85 cases some of the family were at home when the unannounced visit was made. Sixty eight families requested information and explanation about the cause of death, certification, and funeral arrangements. Although the next of kin in 74 cases stated that they had good support from extended family, neighbours, or the church, in five cases they were totally alone and admitted that the visiting counsellor was their first contact since they had been bereaved. Twenty one people displayed grief reactions such as denial and anger, and one person rejected help.

The typical problems encountered by the suddenly bereaved and the value of continued support from this department in the community may be judged from the following case reports.

Case 1—A 5 year old boy had been given 20p by the tooth fairy and on the way to school dashed across the road to the sweet shop. He was knocked down by a car and sustained multiple injuries to the head and trunk. His parents quickly followed him to hospital and were present during the unsuccessful attempt to resuscitate him. Subsequently they found it helpful to talk to an outsider about their feelings of guilt and anger.

Case 2—A woman was called to a hospital 80 km from her home after her husband had had a myocardial infarction and died on a motorway. Her initial reaction was complete denial, anger, and agitation. Follow up telephone conversations indicated that she had not adjusted to her loss, felt isolated and suicidal, and had little local support. After a visit from the counsellor and discussions with her general practitioner she received support from the community psychiatric nurse and the local branch of the Samaritans.

Case 3—Before going out to play squash a mother had encouraged her 15 year old only son to join his friends for a game of football. He was knocked down

while crossing the road to the field. She arrived in the accident and emergency department to find her son dying in the resuscitation room. The bereavement counsellor drove home with her and maintained contact over many weeks. The mother had an overwhelming feeling of guilt and was keen to talk about her actions and her relationship with her son.

Case 4—A 59 year old widow whose pregnant daughter and 7 year old grandchild died in a house fire had no surviving relatives. A bunch of flowers (paid for by the hospital's social work department) was a useful introduction to the first home visit. Further visits followed. She said that the knowledge that someone at the hospital cared had given her renewed determination to come to terms with her grief. She particularly appreciated the opportunity to talk over the events surrounding the deaths.

Discussion

A wide range of grief reactions and features may be associated with abnormal responses.² These features, some of which are listed in the box, can be used to determine how limited resources can be most efficiently used.

Raphael suggested that 30% of those who are bereaved may develop maladaptive grief.³ The value of counselling and support for such people is unknown, although it is generally assumed that a combination of lay and professional services is beneficial.⁴ Those with delayed and chronic grief reactions eventually make considerable demands on medical and paramedical resources, and mitigation by early intervention is desirable from both the bereaved people's and the services' viewpoint. Morbidity can be reduced in high risk groups by early counselling.³

A person's personality and social circumstances will influence his or her response to the sudden death of a relative. It is therefore generally acknowledged that non-directive counselling is most appropriate.⁵ We used this person centred approach and tried to help by listening and empathising as advocated by Egan.⁶ This approach can take many months.

Woodward *et al* suggested that early skilled counselling after the sudden death of an infant was particularly valuable when initiated in the accident and emergency department.⁷ Support offered in the hospital, however, is of limited value if it is not continued and developed in the community over the following weeks. This is time consuming, and it would be impossible and inappropriate for counselling to be undertaken solely by a bereavement counsellor based in the accident and emergency department. The counsellor is more effective when showing the bereaved how to use the available resources than when trying to solve every problem personally. Integration with the work of the hospital's social work department and the bereaved relative's general practitioner is essential, and self help groups are invaluable. The Compassionate Friends, CRUSE (for the widowed and their children), the Samaritans, and the Foundation for the Study of Sudden Infant Death have extensive local networks.

The bereavement counsellor trained a group of senior nurses, one of whom was available to support relatives and friends of critically ill patients at all times. We found that there were usually enough nurses available at the time of the resuscitation for one of them to be spared to support the relatives. Indeed, this was considered as important as many of the other aspects of resuscitation and is now an integral part of the resuscitation team's work.

Teaching medical, nursing, and administrative staff in this department to care for the suddenly bereaved has been successful. The work has assumed a high profile, and there was no difficulty in establishing

liaison with other professional groups, both within the hospital and within the community. Indeed, the enthusiasm to develop such liaison brings an increasing workload.

The counsellor was employed as a clinical nurse specialist (grade H), which was considered to be the minimum for the responsibilities entailed. This, together with the use of a hospital car, clearly has important cost implications for the health authority. Only a quarter of the counsellor's time is spent supporting her clinical colleagues in the department. The cost must be set against the long term expense of supporting relatives in the community who have no initial support and subsequently present with major psychiatric problems and unresolved grief reactions.

A few courses are now available for those wishing to study bereavement counselling, but they are usually designed by and intended for people with a specific interest in the hospice movement. An exception is the six week training session run by CRUSE for voluntary bereavement counsellors.

Conclusion

Sudden death robs the relatives of preparatory grief,

is more common in young people, and usually occurs either in the clinical environment of the resuscitation room or in an unfamiliar high dependency or intensive care unit. People who are suddenly bereaved may require more support and counselling than those who have known for some time that their relative is dying, yet they usually receive less. All accident and emergency departments should review their arrangements for providing help for the bereaved and integrate their services with those available in the community. A similar system should be developed in intensive care, coronary care, and neurosurgical units, where many patients die shortly after admission. If such support were widely available it might reduce the number of people presenting with unresolved grief reactions.

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4 Murray-Parkes C. Bereavement counselling—does it work? *Br Med J* 1980;281:3-6.

5 Rogers C. *Client centred therapy*. Boston: Houghton and Mifflin, 1951.

6 Egan G. *The skilled helper*. 2nd ed. California: Brooks and Cole, 1986.

7 Woodward S, Pope A, Robson WJ, Hagan O. Bereavement counselling after sudden infant death. *Br Med J* 1985;290:363-5.

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Letter from . . . Chicago

Ten opinions

George Dunea

I woke up that morning with a painful elbow. In the mirror I could see a slightly raised swelling, some 8 cm in diameter, red, and tender on palpation. I asked my wife to help me put on an ice bandage, but it only made things worse, so I took it off again. Then I began to rummage through a drawer that contained various medicine bottles, expired eye drops, disposable razors, a neck collar for long aeroplane trips, a bottle of aftershave lotion, some old Australian coins, and an engraved knife bought in Toledo during the long summer of 1959.

"You should show this to a doctor," she said. "I wasn't planning to do so," I replied, struggling to open a bottle that disappointingly turned out to contain dicyclomine—the blue tablet that cures all distress below the diaphragm—unlike chlorpheniramine, the yellow pill that eliminates most symptoms above, including cough, sinus, congestion, itching, restlessness, and an inability to sleep. There were faint suggestions wafting through the air of doctors treating themselves and fears of losing control. By that time I had found the orange pain pills, so distinct in their action from the blues and yellows.

At the hospital drug and formulary that morning we talked about the rising cost of drugs. Why use the expensive non-steroidal anti-inflammatory drugs when ibuprofen and indomethacin can be bought for 15 to 25 cents? I agreed, fortified by two orange pills, not thinking it relevant to mention that they were free samples of the expensive alternatives. After more discussion we adjourned and I asked the doctors to look at my elbow. The older surgeon advised hot packs, recommending antibiotics only if I saw red streaks running up the arm. A young internist wanted to aspirate the area, but the surgeon said "you won't get any fluid." The infectious disease specialist said he would agree with the surgeon were it not for a small scab on top of the lump. "Should I take ciprofloxacin?" I asked, ready to use the latest universal nostrum. She

preferred a new oral cephalosporin that I had not heard of, "better for staph," and I picked up 10 tablets from the pharmacy—"would normally run you \$20, doc."

Back at my office, a Letter from Chicago beginning to germinate in my mind, I remembered writing some years ago about the war correspondent thrown into despair because three specialists had each recommended a different treatment for his carcinoma of the prostate. Later, also, a senator had written in a financial newspaper, complaining that there was too much uncertainty in medicine. He was referring to the big dollar items, coronary bypass, carotid endarterectomy, and the like. But what about swellings at the back of the elbow?

At the clinic I asked a physician whose opinion I respected. "Take ciprofloxacin," he said. Another thought I had cellulitis and should take antibiotics. A third, more academic, did not know what was the matter, nor what I should do, but recommended a battery of blood tests. I reflected that his career would have come to an abrupt end at the clinical part of the membership examination.

Is it tennis elbow or gout?

I tried out some of the house officers. "It's a tennis elbow," said one of them. "It's gout," said another, mashing it harder than necessary. I pointed out that the joint was not involved and that my uric acid level had been normal three months earlier. The resident said that he would feel happier if I had it repeated and also offered to tap the joint.

The clinic over, my psychological state restored by orange non-steroidals and expensive cephalosporins, I went to a meeting on tuberculosis. I learnt that there were 16 million sufferers in the world; eight million new cases yearly; two million deaths. One billion (with a B, the lecturer emphasised) have been exposed to Koch's bacillus. In America epidemiologists had

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