Sudden Death: Nurses' Reactions and Relatives' Opinions

by

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Those who work in Emergency and Accident Departments and in Intensive Care Units meet death daily and in circumstances which are often very traumatic to the bereaved family. Sudden, unexpected and untimely deaths, particularly if they are caused by violence or accident, can have lasting effects on mental health. Nurses, doctors and others who are in attendance can do much to reduce that risk.

In this issue of *Bereavement Care* we publish papers by two people who work in these difficult areas. In the first paper Bob Wright reports the opinions of nurses and patients' relatives regarding their difficulties and the help which they received at the time of a sudden death. He concludes that the most important component is the 'personal touch'.

Editor

In a study conducted from our emergency department, we looked at 100 sudden deaths and carefully recorded the circumstances of the death.

About 60 per cent died from medical emergencies. Most of these arrived in cardiac arrest, with the full resuscitation team standing by for them.

In many cases the relatives had travelled in the ambulance. The other deaths were from road traffic accidents and industrial accidents, suicides, cot deaths and two on the sports field.

Each nurse who cared for the family involved was asked to evaluate the relatives' response to the loss and describe aspects that she herself had difficulty with.

We wrote to the families, half after six months and half 10 months later, asking them to describe what happened to them at the hospital. They were simply told that we were attempting to improve our care of relatives at the hospital in this very difficult situation. Some of the families were able to recall at this later date what they felt the carer had difficulty with.

The study was initiated as much for the benefit of the carer, in this case the nurse, as for the client. In the nurses' evaluation we were able to read a clear statement: "If we are to go into this situation and work effectively, you tell us about the value of what we are doing and what people's needs are at this time." They were recognising some of the stresses of the work, but saying, in effect: "If we are aware of our effectiveness, it will be worth it".

There are many stressful aspects in caring for relatives when a sudden death has occurred. Not least is the nurse's role when bad news is broken to relatives.

In the study nine common emotional responses were witnessed when news of death was broken: denial; acceptance; anger; bargaining; isolation; withdrawal; guilt; inappropriate response and crying, sobbing, weeping.

There was clearly not just one reaction, and some people experienced opposite extremes of the spectrum of feelings.

Some of the discomfort for the nurse was produced by these extremes of feelings and the resulting ambivalence. Indeed, some responses had the effect of almost incapacitating the nurse. Some work on role conflict and personal communication skills will usually deal with this.

Table I shows the form used to identify these feelings. Table II identifies the responses found difficult to cope with. The number in brackets is the position, on a scale of nine, at which the nurses placed that response in relation to the other eight, number one being the most difficult to cope with and so on. This shows that withdrawal, denial and anger in the relatives produced the most difficulty for the nurse. Crying, sobbing and weeping were the most acceptable. Another struggle for the carer was the need for the suddenly bereaved to have an advocate. We have some insights into what is useful in this immediate situation and will try to facilitate these.

But other relatives or friends may question their value and be resistant. In turn, this will frustrate and incapacitate the nurse. Sometimes the effects can go deeper than this, making the nurse feel bad about what she is doing, about what she has on offer.

Deaths in institutions, or dealt with in institutions, present particular problems. As soon as the relatives step through the doors they are disadvantaged. They do not know how to behave or what they can ask for.

We must know their needs and make sure we have the means to meet them.

These people lose some of their autonomy just because they are in the confines of the organisation. They are even more obviously debilitated by the threat and subsequent loss of a loved one. They become powerless and they need an advocate.

For example, they are not even sure what requests they can make. One elderly lady (and she was not alone) told how she was pleased when the nurse said she may have things to say to her dead husband, even if it was only goodbye. She was not sure how it would appear, being seen talking to somebody dead, or whether she would have been overheard.

Body Contact

Another said: "It was nice that the nurse touched his hand and said I could do the same. When you have laid them out (is that what you call it?) you are not sure if you are allowed to touch them."

Table I — The questionnaire used in the study

You are involved with a family where news has been given of a *sudden* death. How difficult would you rate having to cope with the following emotional responses? Please tick appropriate column.

Number of years trained.....

Response		Difficult to cope with	Manageable	Never a problem
Denial	eg, of fact, feeling, reality			
Acceptance	totally — "one of those things"			
Anger	directed at you, patient, doctor, self, etc			
Isolation	feelings of aloneness			
Bargaining	"I'll pay anything not to have . . ." "Give up something if only . . ."			
Withdrawal	Inaccessible, mute, refuses to listen			
Inappropriate responses	eg, feelings, behaviour			
Guilt				
Crying, sobbing, weeping				

Table II — Nurses' reactions to relatives' responses

Response	Number of nurses
Denial	28 (2)
Acceptance	3 (9)
Anger	27 (3)
Isolation	24 (4)
Bargaining	23 (5)
Withdrawal	30 (1)
Inappropriate responses	13 (6)
Guilt	12 (7)
Crying, sobbing, weeping	11 (8)

The relative may have lived with the deceased for 50 years but still, within this setting, may not be sure if it is all right to touch the dead person's hand. The person is not theirs any more. At this time we must support and facilitate those experiences which will comfort and will usefully begin that process we call grief.

The whole question of contact with the body produced difficulty for the nurse. We are fortunate in Leeds in that we know the value of this contact.

This knowledge helps to alleviate some of the stresses of working with it.

Not one person in our follow-up had negative feelings about spending time with the body. In fact, the feelings of the bereaved were clearly the opposite.

The initial care of the relatives who were not present when the emergency occurred will concern the identity of the patient. This may involve finding a suitable moment during the resuscitation to take the relatives to look at the patient in the resuscitation room.

If the patient is going to the operating theatre quickly it is important to establish positive identification before this. This will prevent relatives having to sit with uncertainty for a long period. Even if you positively know the identity, relatives may remain with unreality until they personally have set eyes on the patient.

This uncertainty, if a factor, will produce more difficult behaviour for the carers to cope with, as they will witness relatives expressing opposite ideas about the reality. Questions about injustice and guilt, and other profound and difficult issues, may be raised.

"It cannot be him. We are so happy. Everything is going so well for us now."

"Please tell me this is not true. He was due to be somewhere else at that time."

"I know it is him. It is not fair. Bad people live. Why is this happening to us?"

"Do you believe in God when this happens?"

"Do not say any more. You are making a terrible mistake."

The issues raised may produce a very real discomfort in carers, confronting them with issues they have previously avoided.

It is difficult to be in the role of carer and supporter and not to have the answers.

The nature of the injuries or illness may mean a prolonged period with the relatives before a patient dies or is pronounced dead. Serious head injuries, for example, may mean brain scans are required or insertion of intracranial pressure measuring devices and neurosurgery.

At some time during the process of care, the patient may die. News of procedures to be performed may give hope that is seized on with unrealistic expectations.

For instance, the patient going for insertion of a pacemaker may not survive and all hopes are suddenly dashed. This produces feelings that are very obviously opposites.

The time spent with relatives while many resuscitation procedures were being carried out was measured for the 100 deaths in our study. The result showed that this time spent with the relatives on many occasions exceeded two hours. Two hours is a long time to witness and share another person's extremes of anguish and distress.

The task of encouraging someone to spend time with the deceased person is also fraught with problems. As has been said, relatives or friends may question the value of a bereaved person's interventions. For example, Mrs. Jones sat rigid in the relatives' room awaiting news of her son's condition. Paul was eight years old and her only child.

He was hit by a bus when he was crossing the road on his way home from school. His friend ran home in panic to give the news of Paul's accident. A neighbour confirmed that it was Paul, and that an ambulance had taken him to the emergency department.

The nurse told Mrs. Jones that Paul's condition was critical and asked if she would want anyone to join her at the hospital. Her husband was away working and she asked for her mother and mother-in-law. Her words were almost inaudible. Now and again, she fearfully asked if there was any news.

When her mother and mother-in-law arrived the nurse went to the resuscitation room for an update on Paul's condition. The team was talking of abandoning further efforts, as there were no signs of



life. The nurse was grateful that Paul did not look too bad as she returned to the relatives' room.

Paul's mum looked so fragile and the nurse was tormented that her further information would cause Mrs. Jones to break. Told there was no improvement, she just whispered: "Thank you".

It was an hour after her arrival before the doctor joined the nurse, Mrs. Jones and her family. Everyone knew the gravity of what he was going to say and hoped he would not: "Your son Paul has just died. I am very sorry."

The grandmothers wept openly and held Mrs. Jones. They were distressed that their comfort evoked little or no response.

The doctor carefully explained what measures had been taken to restore life and how it was all to no avail.

They thanked the doctor for his efforts and Mrs. Jones flatly asked him if Paul had suffered. She was confidently assured that he had not.

When the doctor left the room, there was silence for a while before Paul's mum asked: "Can I see him?" The nurse's relief at this reaction was tempered by anxiety at the distress she would feel. "Yes, of course you can," she replied.

But Mrs. Jones' mother quickly became very agitated: "You must not do that. It is best to remember him as he was." The mother-in-law confirmed this: "It won't do you any good. Let us just go home."

"I would like to see him," Paul's mum whispered. The words did not convey the longing in her heart just to have another glimpse of his face.

"Take it from me," her mother said: "You must not. You don't know about these things." Her voice *was desperate. She just wanted to* get away. "Why prolong the agony? We'll take her home," she told the nurse.

The calm and sadness was rudely interrupted by a voice not previously heard. It was strong and determined: "I want to see my little boy. Take me to him."

When Mrs. Jones returned to her mother and mother-in-law she was weeping and could not be consoled. Her cry was one of torment and questions: "Why? Why?". "We told you not to," they said.

"It was nice that the nurse touched his hand and said I could do the same. When they have been laid out, you are not sure if you are allowed to touch them."

When Mrs. Jones was seen 10 months later she clearly remembered the struggle to see her son. She described how she nearly lost the battle and how she had always believed in her mother's authority. The memory of her struggle to speak, and wondering if she was being heard, was crystal clear to her. She was powerless and at the mercy of all around her and her fate was to lose.

She was not clear where she found the strength to state clearly what she wanted. What is clear is that the nurse quickly used the opportunity to take her to her son. For this, she was very grateful. She wanted to be with him — and quickly. And she was glad he was just where he was when he had died. Her memory is of him lying on the resuscitation table draped in a white sheet, and seeing the shape of his genitals under the sheet. When she saw this, and his washed white face, she just knew it was her little boy. She held his hand and wept and said goodbye to him.

Now, 10 months later, she clearly knows the value of this time and how it was nearly denied to her. Her loss she bears alone, as Paul's death is a taboo subject with her husband. Her comfort comes from her joys with Paul and her goodbye.

Her secret of the value of her goodbye is simple to her. Since her childhood she had believed that anyone injured in this way would be squashed flat.

To carry this image around with her would have been torment and misery. She knows that, for most people, reality is far more acceptable than fantasy.

Fantasies are bizarre and cruel, and can be uncontrollable. Reality gave her comfort. Reality confronted her with the starkness of death, but it was preferable to her long held childhood belief of flattened people.

For me, this was the beginning of confirmation that the truth will set people free from some of the pain. Yet, for the nurse, the process of taking people to touch and talk with the deceased is painful and time consuming.

There were obviously many other difficulties and factors for distress in this immediate care. To identify, confront and prepare staff for this will remove some of their fears, increase their effectiveness and consequently reduce their stress.

One other factor that became apparent was that the person was more valued than the person's role. It is our own personal touch, our own humanity, that is experienced by relatives in these situations. They remember many personal details about us.

If your role, experience or expertise appears to have little to offer, or if you feel ineffective or impotent, do not be afraid to fall back on your own personal skills, your own humanity. People remember with warmth, and are grateful for, the person they meet on that awful day.

MEMORIAL SERVICE
SUSAN LE POIDEVIN

A Memorial Service for Susan Le Poidevin will be held in Southwark Cathedral, London Bridge, S.E.1, on Wednesday, 28th June at 6.30 p.m. All are welcome but it would be helpful if those planning to attend would, if possible, let Dr. Colin Murray Parkes know in advance at the Academic Unit of Psychiatry, Alexandra Wing, The London Hospital Medical College, Turner Street, London E1 2AD (Tel. 01-377 7344).