



After a patient's unexpected death, First Aid for the emotionally wounded

📌 In those dreadful hours, it's possible to offer survivors lasting comfort and aid, the authors say—but you need to learn necessary skills. To that, add the model of the *citizen volunteer*, a supportive presence when the professionals have left.

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Editor's note: Find more information about TIP in the box, "Want to learn more about TIP? About becoming certified as a TIP citizen volunteer?" on page 52.

2 CASES

Situations that stun

Your postop patient suffers acute chest pain and dyspnea on the second hospital day, becomes moribund, and dies. Her family, agitated and upset, has gathered in her hospital room. The unit nurse telephones you and asks you to come to the hospital.

Your brother calls to tell you that his teenaged daughter has just been killed in an automobile crash. He is at the emergency room of your local hospital and asks you to join him there.

In both cases, how can you prepare yourself for what you will face, and what you will say, when you arrive at the hospital?

Like all ObGyns, you have experience telling parents about an expected, or unexpected, perinatal death, and bringing news to a family when death comes finally to a patient who has metastatic cancer. But how well are you prepared to handle the two hypothetical scenarios above? Granted, they represent infrequent, if not rare, occurrences for most of us, in or outside our practices—but they happen.

In this article, we offer suggestions—based on extensive experience we've gained working with a national organization, the Trauma Intervention Program (TIP)—on how you can provide emotional first aid to family and other loved ones in the hours after your patient has died unexpectedly. We also briefly explain how TIP citizen volunteers can extend the comfort and counsel that you and

IN THIS ARTICLE

5 skills to provide emotional First Aid
page 48

How a trained "citizen volunteer" can help
page 52

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Have you been called upon to provide support in the hours after a sudden death?

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5 basic skills for providing emotional First Aid

Be present in a caring manner. Caregivers often believe that they must do something. But survivors have repeatedly reported that what they appreciated most was just the person's caring presence. This includes reaching out physically and emotionally: positioning one's self at the survivor's physical level of standing or sitting; a gentle touch; use of the person's name; a soft voice; and acknowledging the reality of the experience.

Protect the survivors from unnecessary and inappropriate emotional and physical intrusions and behaviors. This skill includes redirecting survivors from making impulsive and, in particular, major decisions—most of which can wait. It also involves paying attention to the person's physical needs, such as food, water, prescription medicine, and rest. Last, it means helping survivors find a safe place, where they can be protected from being pressured or victimized by others who may not have their best interests in mind.

Provide survivors with timely, clear, valid, and understandable information about what is happening; convey it in an affirming and useful manner. Doing so can be greatly reassuring to loved ones because there is often an urgent need to have answers to questions such as "What happened?" and "Why did this happen?" Preferably, this task falls to medical personnel but, at times, it's necessary for another member of the team to act as the information advocate and to focus on what the survivors specifically want to know. The more accurate the information that survivors have, the less apt they are to blame themselves for the death of the patient or the circumstances of that death.

Help organize a simple plan that will facilitate survivors' regaining a sense of control of the situation. Focusing on what needs to be done now mitigates the paralysis that causes a person to lose the capacity to deal with the novel demands created by tragedy.

Reinforce survivors' source of strength. This is an essential step. Survivors will seek to find something or someone to hold onto in the first hours in an effort to survive emotionally and regain a sense of control. The task of the caregiver is to help them find that source of strength and then support its value once found.

other hospital team members provide immediately after the death.

After a death, a window opens briefly for crucial action and care

When a patient dies, your role is usually limited to the notification of death and whatever comfort you can provide in the short time

you spend with the family and other loved ones (we'll simply call them all "survivors" here). Most of us have not interacted with grieving survivors beyond that—in the several hours after the immediate time of the death.

But what does, or does not, happen during that subsequent interval has the potential to be healing for survivors or to cause them pain (and, it's worth noting, to have a positive or a negative impact on your emotional health). In those hours, many thoughts crowd in for survivors: What happened to their loved one; what they were doing and how they were informed; the attitude, behavior, language, and tone of first responders and health care professionals. And all these thoughts become everlasting memories.

After such a traumatic event, those closest to the person who died often feel helpless and confused. Confronted with circumstances for which they are probably wholly unprepared, they are in emotional shock. Their lives have been irreparably altered and their priorities for the upcoming period have shifted.

Shock and confusion notwithstanding, the hours after a death require decision making by survivors. Being organized and decisive can be emotionally challenging and disruptive, and can bring repetitive stress for both family and health care professionals.

A period of turmoil calls for emotional First Aid

Immediately after a death, the family often finds itself surrounded by people who—to be blunt—soon have a job to return to. You and the other health care professionals on your team have other patients; you must get back on service and concentrate on their care.

The coroner or medical examiner's office may need to determine if an autopsy is mandated.

The survivors have work to do, too: notify extended family and friends; make plans for a service; choose a mortuary for the burial or cremation; and care for young children, to name a few tasks.

Some families call for a personal pastor



Sample “Table of contents” for a hospital’s resource manual

We recommend that a comprehensive manual to inform and counsel grieving families contain these key sections. The manual should also contain a chapter on resources for families who speak any language other than English that is spoken widely in the community.

I. Coping after a tragedy

- a. Dealing with loss
- b. Common reactions after trauma
- c. Dealing with emotions and resolving grief
- d. Helping children grieve
- e. Dealing with suicide

II. Emotional First Aid

- a. Helping the emotionally injured after a tragedy
- b. What should I say? What should I not say?
- c. How you can help, later

III. Sheriff, coroner, police, fire

- a. Police, sheriff, highway patrol
- b. What to do, and what not to do, after a fire

IV. The media

- a. Dealing with the media: Your rights

V. Handling estates

- a. Practical considerations
- b. Papers and certificates
- c. Insurance policies, Social Security
- d. Veterans’ and employee benefits
- e. Wills, probate, taxes, general finances

VI. Memorial services

- a. Cemeteries, memorial parks
- b. Mortuary services
- c. Cremation services

VII. Grief and trauma support groups and services

- a. Government agencies
- b. 24-hour hotlines
- c. Legal services
- d. Pet services
- e. Psychological support
- f. Shelters (for victims of domestic violence)
- g. Shelters (for the homeless and disadvantaged)
- h. Transportation
- i. Victim services

or a hospital chaplain to be present at this time. Well-meaning friends and family members arrive, too, and they often hold strong opinions about what should or shouldn’t be done next.

All of these activities and personalities have the potential to add unwanted emotional turmoil.

5 skills to master. Whether the caregiver who provided the notification of death is a physician, nurse, social worker, chaplain, or trained citizen volunteer, we have determined that **five general skills** form the basis for providing emotional first aid to survivors (see “5 basic skills for providing emotional First Aid,” page 48).

In considering the purpose of those five skills, however, consider this overarching tenet: **A broken heart cannot be “fixed.”** Don’t try! What you can offer to someone who is emotionally devastated is a caring presence. Just being there is powerful and will be experienced by survivors as deeply helpful. It is best, therefore, not to “over-care”—to do too much for them.

Benefits of an expanded team approach. We have found that a hospital crisis response team approach, with an identified role for each team member, can be of great value to survivors. In addition to the deceased patient’s attending physician and primary nurse, the team typically includes a social worker and hospital chaplain.

In many instances, however, these professionals have so many responsibilities that they are precluded from assisting survivors and from being present for more than a short time after the death. Furthermore, shift changes mean team members come and go during the hours crucial for the survivors; and few hospitals employ social workers and chaplains around the clock.

That is why our repeated experience supports **an essential role for a certified, trained citizen volunteer whose only responsibility is to assist and support survivors** at all times of the day, all week. This caregiver serves as a guide and a buffer to enable survivors to act on their wishes, feelings, values, and beliefs—not according to what



Want to learn more about TIP? About becoming certified as a TIP citizen volunteer?

As noted, coauthor **Dr. Chez** is a certified citizen volunteer for the Trauma Intervention Program (TIP), established by coauthor **Mr. Fortin** in 1989 as a nonprofit organization

The national TIP organization, TIPNational, reports that it comprises 18 regional chapters in the United States that serve more than 75 cities, 100 hospitals, 67 police departments, and 55 fire departments. Mr. Fortin describes TIP as the largest operator of emergency services volunteer programs in the nation.

To learn more about TIP, how to become certified as a citizen volunteer, and other ways to participate in the organization's work, visit www.tipnational.org/home1.htm.

others think should be done. The volunteer provides this necessary temporary support until survivors are able to depend reliably on family, friends, neighbors, and others.

This model of a trained volunteer was developed by the Trauma Intervention Program (TIP) with which we work. You can learn about TIP in the box, "Want to learn more about TIP? About becoming certified as a TIP citizen volunteer?" and at www.tipnational.org/home1.htm.

The value of training and a manual

We strongly recommend that you encourage the administration at your hospital to create a response to expected and unanticipated adult death that includes education—for physicians, nurses, social workers, and hospital clergy—in emotional First Aid. The suggested reading list below forms a good basis for that education.

Last, we encourage hospitals to publish

a resource manual for distribution to grieving families as an ongoing source of information. Our recommendations for the contents of such a resource manual appear in "Sample 'Table of contents' for a hospital's resource manual," on page 50.

You can obtain a copy of the resource manual that we have found most useful in our work in Orange County (California) by writing to us in care of the Editors at obg@qhc.com. Please provide your name and mailing address with your request. 📧

Suggested Reading

- Bub B. Strategies for breaking bad news to patients. *OBG Management*. 2008;20(9):21-30.
- Maciejewski PK, Zhang B, Block SD, Prigerson HG. An empirical examination of the stage theory of grief. *JAMA*. 2007;297(7):716-723.
- Gold KJ, Kuznia AL, Hayward RA. How physicians cope with stillbirth or neonatal death: a national survey of obstetricians. *Obstet Gynecol*. 2008;112(1):29-34.
- Iverson KV. *Grave words: notifying survivors about sudden, unexpected deaths*. Tucson, AZ: Galen Press; 1998.
- Resources. Trauma Intervention Programs, Inc. TIPNational Web site. www.tipnational.org/resources.htm.

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Here's how the test result patterns match the diagnoses in the **INSTANT POLL** on page 12

Pattern “A” (CA 125, 9 U/mL; HE4, 41 pM): **CASE 3—healthy woman**

Pattern “B” (CA 125, 1,550 U/mL; HE4, 2,030 pM): **CASE 4—serous ovarian cancer**

Pattern “C” (CA 125, 22 U/mL; HE4, 99 pM): **CASE 2—endometrial cancer**

Pattern “D” (CA 125, 44 U/mL; HE4, 46 pM): **CASE 1—4-cm ovarian endometrioma**