Death Pronouncements: Surviving and Thriving Through Stories

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Death pronouncements are the responsibility of many first-year residents, especially family medicine residents. A number of years ago, after we taught an educational seminar on family conferences, one resident mentioned that she wished there was a seminar on how to communicate with patients during a death pronouncement. She explained that performing death pronouncements is a common occurrence for first-year residents, often on their first night on call. Residents were typically unprepared for this responsibility and often wondered if this was even part of their job description. The difficulty of the task was often compounded by the fact that many residents had never touched a dead person, felt helpless to do anything for the patient, and had difficulty knowing what to say to the gathered family members. Nurses were usually the ones to tell them what to do and then guided them through this difficult task. We also learned that the only resource residents had 9 years ago to guide them was a chapter on doing death pronouncements in the book *On Call: Principles and Protocols.*

We realized that the first few days of residency presented the perfect opportunity to conduct a workshop designed to prepare residents emotionally to deal with patients’ dying, to communicate effectively and compassionately with their families, and to perform the basic steps of a death pronouncement appropriately, which includes confirming that the patient has died, documenting their findings, knowing when a coroner needed to be notified, and knowing when to request an autopsy or organ donation. In other programs, death certificate completion could also be addressed at this time. The workshop we developed also covers Accreditation Council for Graduate Medical Education core competencies in the areas of patient care, professionalism, communication, systems-based learning, and medical knowledge.

The emotional impact of this seminar relies on the humanities, stories, and role-play. Poems and prose at the beginning of the workshop invite the residents to appreciate the many aspects of death pronouncements, both negative and positive. This reflects the range of emotional responses they may have in doing death pronouncements. Elements of the humanities have been added over the years to deepen the emotional experience of the workshop. We are always surprised at how little experience our incoming residents have with death. Most have not lost a parent or close relative or friend, and few have had significant experiences during medical school.
The workshop begins with several pieces of literature that pertain to the emotional aspects of death pronouncements. First is the poem "Late Night Call to 6 West" written by a fellow faculty member, Jon Tente, MD, PhD, set when he was a first-year resident in our residency program. The poem establishes the tone for the tension experienced in doing a death pronouncement. The diagnosis is easy: the patient is dead. Yet, the resident feels the tension between the profoundness of the moment of death and the insignificance of the task. A resident may wonder "What am I doing here?"

Next, we read a piece by Victoria Johnson-Magill, MD. In the course of a busy day as a resident doing "medicine," she is called to do a death pronouncement. The family is there, and the narrator feels helpless; there is nothing she can do for this patient or the family. Because she can give no hope to the family, she concludes that her role as a physician has been rendered impotent. But, what she misses is that she can still be a compassionate presence for them. For the family, this is a momentous event. The hope is, perhaps, that even in death, the person who was this body, and the family, can be honored through the important life-closing ritual of the death pronouncement.

In the last piece of literature, Ruth Lerman, MD, describes a profound moment when a resident, who had been supervised as a medical student by her physician father, is called to pronounce him dead. She realizes that doing death pronouncements pales in comparison to the action of saving lives. Lerman effectively describes the high drama of trying to save lives, compared to the absence of action with dying. A compassionate presence and the honoring of the person who died are important in this context as well. How do we care for families at this time? Lerman muses how she needed to teach herself about this kind of doctoring. Medical school did not teach her the importance of this essential ritual so fundamental to being a doctor.

Following the readings, we present a historical perspective on death pronouncements. A video clip from an interview with a senior internist is shown. He explains that traditionally, prior to having resident physicians conduct death pronouncements, attending physicians were called right before a person died. In the interview, he observes that it was considered a sign of physician competency to attend a dying patient, support the family, and then pronounce the patient dead. A physician would not miss a dying patient, just as a physician strives to be present for a birth. We also read an excerpt from an issue of the 1899 Journal of the American Medical Association that reports on New York State legislation to mandate death pronouncements by a physician exam to prevent premature burials. Through this piece, the fear of mistakenly pronouncing a live person dead is addressed.

The new residents are then asked to discuss their experiences with dying. Generally, they have few personal or professional experiences. We ask them about their fears and concerns. Often, first-year residents have already done a death pronouncement, and we ask them to tell us how it went and their emotional experience of it.

Next, invited senior residents, usually three of them, discuss how their comfort, style, and feelings about death pronouncements evolved over time. They share notable cases and wisdom they have gathered in caring for dying patients. These stories are often poignant. First-year residents learn that all residents struggle emotionally over difficult cases and dying patients and that these cases may be the most meaningful to them in their journey as physicians. The senior residents describe all the components we want to teach: preparing oneself emotionally, getting familiar with the circumstances of the case by reading the chart and talking with the nurse, asking the nurse to accompany them if needed, knowing how to do the actual death pronouncement, and establishing therapeutic presence and communicating empathetically with the family. The senior residents also discuss difficult cases and how they handled them and the development of their own style and emotional development in doing death pronouncements. These stories are the most powerful aspect of the workshop.

A shorter amount of time is spent reviewing the actual procedure of a death pronouncement, and discussion centers on autopsy, organ donation, when to call the coroner, and cultural issues regarding death. Death certificates could be discussed here as well. Our residents don't complete them and receive this educational piece at a separate time. The actual protocol is outlined in a previous article.

The workshop concludes with a final role-play, which has proven to be a powerful experience. Faculty and senior residents role-play a couple who had a baby die unexpectedly from a neurological problem. A CPR baby mannequin wrapped in a blanket is used to increase the reality of the situation. A first-year resident is asked to volunteer to do the death pronouncement. When first-year residents see a colleague doing this well (and all residents have done very well after the seminar), it gives them the confidence to be able to handle similar or less-difficult death pronouncements. Concerns expressed by residents include touching a dead person, how to handle emotion and crying, what to say to the family, and how to be a compassionate presence.

Preparing residents emotionally to deal with death and dying right from the start of residency is a compassionate gift that residency programs can offer their residents. It is
an opportunity to begin the palliative care curriculum. Most importantly, residents learn to appreciate that as physicians we can cure sometimes, but we can comfort always.

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REFERENCES
