Should doctors go to patients' funerals?

PLAINPICTURE/NORMAL

Some years ago I (BA) decided to start attending the funerals of patients. This was in response to having had a positive experience of attending a funeral where the family was appreciative of my presence. Recently I attended the funerals of two patients who died within a few weeks of each other. Again, both funerals afforded me the opportunity to meet the extended family of the deceased and again, in both cases the family appreciated my attendance.

What stood out with the two recent funerals was that in both cases a close relative came to visit me in the clinic within a week. It was obvious these were not visits for any particular pressing medical problem but more of a social nature. The talk revolved around the funeral and, having been a participant, I felt I could make a meaningful contribution to the conversation. I was left with the impression that my attendance at the funeral was contributing to the resolution of grief in those two people. This was particularly rewarding and made the small investment of a few hours of my time worth while.

These recent events piqued our interest in the area of doctors attending their patients' funerals. It is not an area of much discussion (perhaps because doctors view death as a defeat?), but we had expected there to be literature on this topic to offer guidance.

To many, having a doctor attend a loved one's funeral validates and emphasises the worth of that person

A Medline search was fruitless. Searching on Google was more illuminating, offering up anecdotal experiences which highlighted the value of attending patients' funerals, and provided some common themes of the value of doing this—namely, themes of appreciating the human and of ongoing caregiving.

Attending the funeral of a patient is a gesture of respect to the deceased and is generally interpreted as such by the patient's family. It also allows the doctor to gain a complete picture of a patient's life: often services are a real celebration of an individual's life and this is a positive and affirming experience. Long term patients often become fond fixtures in a practice and can even be regarded as good friends. Attending a funeral shows this important connectedness and it also enables a personal expression of grief.

Traditional viewpoints often persist among the community of patients, and, to many, having a doctor attend a loved one's funeral validates and emphasises the worth of that person. As Dame Cicely Saunders, a pioneer in the modern palliative care movement, once said: "How people die remains in the memories of those who live on." This is true regarding the dignity of death that they are afforded, but also the celebration of life that they are given at the funeral service.

To many doctors–particularly those ascribing to the patient centred or family centred approach—a crucial point to emphasise is the recognition that in most cases our responsibility to the departed person extends to caring for their family in the wake of their death. As Elizabeth Kubler-Ross quite rightly emphasises, "Be available. The void and emptiness is felt after the funeral [when the busyness of preparations is over]. It is at this time that the family members may feel most grateful to have someone to talk to, especially if it is someone who had recent contact with the deceased. This may help the relative over the shock and the initial grief and prepare them for gradual acceptance." The doctor's presence at a funeral service can pave the way for the family to have an opportunity to talk about their experiences surrounding the death. They may have questions about what happened in the last days or need reassurance or help with guilt. The family (or attending) doctor is the appropriate person to "be available."

Regular funeral attendance will not fit all doctors. Clearly, those in palliative care and some hospital disciplines may find this burdensome. It may be wise to avoid funerals when the family is unhappy with care, but asking the family for their permission to attend might facilitate reconciliation. Primary care providers usually have long term relationships with patients and their families, and we would argue that it is important to witness the end of the life journey of an individual. This is what we do for friends and family, and longstanding relationships with patients are in a similar category. Our experience indicates that there are personal and family benefits to be gained and little to be lost.

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Competing interests: BA is on the advisory board for the Pharmac educational seminars (Pharmac is the government funded pharmaceutical purchasing agency in New Zealand) and is on the primary care committee of the Future Forum, an educational foundation funded by Astra Zeneca (UK).

"How is it that privileged and educated young people increasingly turn to varied kinds of self harm, as a way of coping and escape?"
p 1325

REVIEW OF THE WEEK

Seeds of discontent

A chronicle of a couple's epic attempt to have children questions whether modern reproductive technology is more trouble than it's worth, finds **Abi Berger**

Caroline Gallup went through almost four years of unsuccessful infertility treatment before finally stopping. It's clear from her book that reaching the decision to stop was a long and painful process and that her persistent hope of becoming a mother has never quite died.

Gallup tells the story of her initial desire to become a mother and the desperate gnawing that grows inside her as achieving her dream seems to slip away. It's a story that makes essential reading for couples hell bent on producing a family and for doctors trying to support them. It's also a useful eye opener for those who are not sure whether they are ready for the robust demands that infertility treatment can make on couples.

The book combines the story of a journey with a lay person's digest of the biological aspects of infertility technology. It would have been hard to do the first without providing the second, although there's a lot of repetition—just in case the reader has forgotten what's involved.

Or perhaps, the sense of this simply reflects the repetitiveness of undergoing seemingly endless cycles of the same thing until someone says enough is enough. Reaching that point is undoubtedly a unique decision for everyone undergoing such treatment, and should be regarded as such.

What's interesting in this couple's story is that Gallup's husband Bruce has been diagnosed with azoospermia, and therefore for him it's apparently an open and shut case. He discovers that he cannot conceive children naturally through any intervention whatsoever. His hope truly dies. But Caroline can still hold out for a genetic child of her own if she is willing to accept a donation of another man's sperm. And while this remains a possibility, the door never quite closes.

While the goal—pregnancy—is the same for both partners, if feels very different, and they become virtually estranged from each other. The book's message is an important one that is often underplayed or even ignored by the medical profession: undergo infertility treatment without thinking through the emotional implications at your peril, or at least recognise that the emotional whirlwind may be far removed from the dream you were pursuing. Fortunately, this couple survived, but it's not always the case.

Apart from addressing the arguably modern cultural assumption that having children is a right, this book provokes other more difficult questions. Is the conception of a non-genetic baby going so against nature's intention that for women to conceive using donor sperm can feel like infidelity? And can couples who embark on such a journey ever truly come through it intact? Is modern technology causing more trouble than it's worth?

Doubtless Gallup would conclude that the availability of the technology and her own personal resources allowed her hope to survive longer than would otherwise have been the case. Without them she may have felt more bereft at the point of the diagnosis, but I suspect she would have come through with more resolution and reached closure more quickly and more succinctly.

The book's message is an important one that is often underplayed or even ignored by the medical profession: undergo infertility treatment without thinking through the emotional implications at your peril

On the other hand, had she not been in this position she may have always wondered with regret about what might have been. It is one thing to simply and rationally close the door right from the beginning, but quite another to close the door after working through the process emotionally. Undertaking the treatment at least helps to ensure that no stone is left unturned, or at least considered.

The only thing really missing in this story is the robust voice of Caroline's husband, Bruce. He is "heard" only sporadically throughout the narrative. There are numerous references to the two of them undertaking different processes to get through the ordeal, but I would have loved to have read about their journeys in equal measure.

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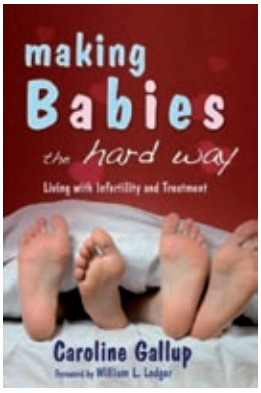

Making Babies the Hard Way: Living with Infertility and Treatment
Caroline Gallup
Jessica Kingsley, £12.99, pp 240
ISBN 978 1 84310 463 6
Rating: ★★★★

Stubbed out

FROM THE FRONTLINE
Des Spence

I went to the launderette fortnightly. It wasn't that I had lots of clothes—I didn't. But a wet sponge and steam iron works wonders. As I ironed, the steam billowed from my PolymixPubJob shirt, carrying the sweet smell of stale beer and cigarettes. The final touch to my shirt was aftershave. In the 1980s this was all produced in Middlesbrough by ICI to a classified cold war formula—a tiny splash of Brut Musk could conceal weeks of unwashed clothes. To this day it still seeps from my pores when I sweat. But the modern bartender will soon be spared the need to wear cheap aftershave, for England is to ban smoking in confined public spaces.

The risks of smoking have been clear for many decades, but when I grew up in the 1970s smoking was common—vast ornamental ash trays and coffee table lighters were the order of the day. People puffed away in sitcoms and in Hollywood's blockbusters, and Formula One cars were cigarette packets on wheels. As an adult in the 1980s I smoked occasionally but regularly in a way that has become known as "social smoking"—on nights out and sometimes during the day. In the conformist sausage factory that is medicine it was my youthful (and stupid) act of defiance to stand outside the exam hall smoking one of those foreign brands that newsagents would sell only to card carrying students. The dire warnings printed on the packets were meaningless to risk obsessed youth. I am lucky, for I was able to resist the terrible pull into the tornado of addiction that smoking is.

But by middle age, life matters—I don't want to die. Half of all smokers die from their addiction, and on average smokers live 10 years less. But quitting is not easy. For me, smoking is bound to the extremes of my life—the good and the bad.

Smoking is pernicious. I have witnessed too many men and women in their 40s die from the many manifestations of vascular disease and seen others consumed by lung cancer. But worse still is the decades spent on an oxygen mask, confined to your home. Smoking has left great wounds slashed into the lives of children, husbands, wives with the needlessly and prematurely death of their loved ones. It is harder still for families to accept the injustice of the loss of a victim of second-hand smoking.

My attitude towards smokers remains passive. If smokers choose to smoke, then so be it. In the cockpit of life the control panel is jammed with self destruct buttons—smoking is merely one among many. Smoking is in terminal decline, and banning smoking in public is long overdue. Whether we do likewise with 1980 aftershaves is another issue.

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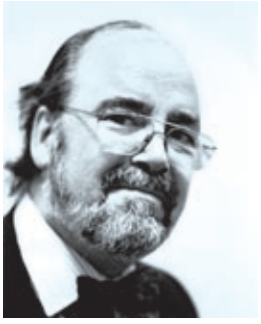
Back from Basra

IN AND OUT OF HOSPITAL
James Owen Drife



When your son joins the Territorial Army it seems no big deal at first. Weekends on Salisbury Plain are healthy exercise for a lawyer. From time to time he helps to fire off a royal salute or invites you to a rather jolly mess dinner.

Then reality bites. Volunteers are wanted for a tour of duty "somewhere overseas." Not you, son, surely? Tell them you're an essential worker. Oh. OK. I suppose it's a matter of honour. That and no loss of salary, he replies. The government is desperate, after all.

The farewell, last September, was a cliché repeated down the centuries but no less affecting for that. Mum holding back tears, handshake from dad, laconic smile and a wave from the young man. Mum now says she thought she'd never see him again.

You keep checking for email. Communication with Iraq is fitful but you begin to notice a pattern. A brief, unexpected phone call just to say hello. Then silence for a few days. Finally, a short item on the evening news. A British soldier has been killed and the next of kin have been informed.

What does "being informed" entail, now that telegrams have been abolished? An army car waiting when you get home from work? Mum sometimes thought she heard the doorbell in the night. Then, thank goodness, another email: "Day off, relaxing. Biggest danger is sunburn."

Here, the biggest danger is losing friends in hospital management. They tell us we can't afford more midwives because there's no money. When I remind the meeting that we can afford £3m (€4.4m; $5.9m) a day for the prime minister's war, everyone looks uncomfortable. Their silence implies: there's nothing we can do, so why mention it?

My silence implies: that's democracy for you.

After six months the veteran returns, suntanned. He seems taller. Photos on his laptop show his comrades with camouflaged Land Rovers. And son in battledress with his number and blood group in big letters on the chest.

I feel smaller. Did I protest against the war? No, I left that to others. My father, wounded in 1944, and my son have done things I'll never achieve. My dad's generation set up the NHS only three years after coming home. My generation, combat free, can't even run it properly.

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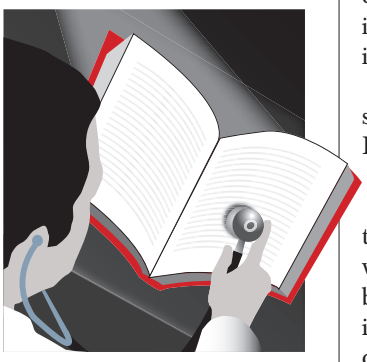
Sheer delight in doing evil

BETWEEN THE LINES
Theodore Dalrymple



In the case in which I was involved the man was not motivated by revenge, but (as far as I could tell) by sheer unadulterated malignity

In Sir Arthur Conan Doyle's *The Resident Patient*, a doctor called Trevelyan comes to see Sherlock Holmes about a little problem. Dr Watson recognises him as the author of "a monograph on obscure nervous lesions." Dr Trevelyan is delighted, naturally enough: "I so seldom hear of the work that I thought it was quite dead. My publishers give me a most discouraging account of its sale."

This, the common lot of all authors, or at least the lot of all the authors known to me in person (though this, I admit, may be a reflection merely on the nature of my literary acquaintance and therefore indirectly on me), is not the problem about which Dr Trevelyan comes to consult Holmes.

Trevelyan is in an unusual situation. He has been set up in practice by a stranger called Blessington, on condition that he, Blessington, continues to live in Trevelyan's house and takes three quarters of his fees. Trevelyan, who has no capital to start a practice of his own, agrees.

This arrangement works until one day Blessington seems to have been agitated by some news and becomes fearful for his safety. A little while later, Trevelyan is consulted by a man who is supposedly a Russian aristocrat, accompanied by his son; the man is suffering from catalepsy, a condition in which Trevelyan is a specialist.

During the visit, the man has one of his attacks, but he and his son disappear from the house while Dr Trevelyan searches for amyl nitrite (the inhalation of which has produced good results in such cases). Later, Holmes replies to Watson's question about the cataleptic attack: "A fraudulent imitation, Watson, though I should hardly dare to hint as much to our specialist. It is a very easy complaint to imitate. I have done it myself."

To cut a short story even shorter, Blessington is not really Blessington, but Sutton, the worst of a gang who committed a bank robbery that, in the words of our current chief constables, "went tragically wrong," and in which the caretaker, Tobin, was killed. Sutton/Blessington subsequently turned Queen's evidence, and one of the gang was hanged. The others (apart from Sutton/Blessington) were sent to prison for 15 years. Sutton/Blessington disguised himself by means of living with Trevelyan. Hearing that the other gang members had been released early (some things never change) he becomes fearful for his life. The Russian aristocrat and his son are really members of the gang, and eventually they manage to get into Sutton/Blessington's room, where they hold a mock trial and then hang him, trying to make it look like suicide. They are never caught.

Oddly enough, I was once involved as a witness in a similar case: a man hanged another and tried to make it look like suicide. Apparently he gave his victim, whom he had intimidated into obedience, a choice: to have his throat cut or be hanged.

The main difference between the cases was this: that in the case in which I was involved the man was not motivated by revenge, but (as far as I could tell) by sheer unadulterated malignity, by sheer delight in doing evil. This delight is one of the great puzzles of human nature.

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MEDICAL CLASSICS

The Bell Jar By Sylvia Plath

First published in 1963

Chiefly celebrated for her "confessional poetry," Sylvia Plath (1932-1963) was also ambitious to break new ground with prose. Poignantly, *The Bell Jar*, published under a pseudonym a month before her death, was her only attempt at the novel form. One of the compelling aspects of this increasingly respected novel is the degree of connection between the troubled life of its heroine, Esther Greenwood, and Plath herself. Inevitably, as we encounter Esther's subtle mental breakdown and successive suicide attempts, we are drawn further into the now almost mythic events of Plath's short life. Despite the inevitable curiosity about the autobiographical content, *The Bell Jar* is of lasting importance for further reasons.

First and foremost is its subject matter, which has increasing relevance 40 years on. The book examines a contemporary concern—how is it that privileged and educated young people (especially young women) increasingly turn to varied kinds of self harm, as a way of coping and escape? Plath was one of the first writers to explore this area, and her description of Esther's escalating suicidality is all the more realistic for being described so matter of factly.

Various themes spin out from this central idea, such as the restricted role of women in 1950s America, an emerging feminist viewpoint, and personal renewal through struggle.

Plath: matter of fact about suicide

CSU ARCHIVE/EVERETT/REX

Esther's development of psychotic depression is Plath's interpretation of the classic "rite of passage" journey. The bell jar of confusion that descends on Esther hampers her personal progress, yet it protects her from being overwhelmed by a highly competitive social world. Plath ushers us into the clinic of the subtly monstrous psychiatrist, Dr Gordon, and exposes us to the stunning brutality of Esther's unanaesthetised electroconvulsive therapy. Psychiatry is redeemed when Esther is renewed under the care of a female consultant, Dr Nolan, who represents what Esther aspires for herself—independence and social respect as a professional woman.

In describing Esther's recovery, Plath covers an aspect of mental illness that is not sufficiently publicised. Esther has undergone a life changing experience. Plath's novel serves as an important reminder that our stigmatised psychiatric wards, sometimes places of misery and tragedy, can also nurture momentous personal change and a new beginning. As we finish the novel, we are drawn again into the author's own life. Esther's overriding concern, as she faces the grand round that will decide for or against her hospital discharge, is whether the bell jar "with its stifling distortions" might descend again. Tragically (for once, this word is not misplaced), Sylvia Plath did not escape the fate that Esther fears.

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