REFLECTIONS

Dealing with death is part of the work of emergency physicians. In addition to confronting and understanding a patient's death or impending death, the physician must deal with the grief of loved ones and, lastly, the physician must deal with how that death affects him or her. These three essays provide insights and maybe some answers on how we relate to and react to the aura or reality of death in our emergency patients.—**Brian Zink, MD** (bzink@med.umich.edu), *Department of Emergency Medicine, University of Michigan Medical School, Ann Arbor, MI*

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The Hardest Lesson

How do you tell someone her husband is dead? I have been lectured on the subject, seen it done dozens of times, and now I have to do it myself. I know what I am supposed to say, but that is just the beginning, I think. Technically, and in the narrowest sense, my only job in this situation is to be sure the family understands that the patient is dead—you must use that word ''dead''—and to answer any medical questions, if necessary. I know how to convey the information but have never been taught how to deal with the flood of emotion that will be unleashed.

So I walk toward the family conference room at the front of the emergency department (ED) opposite triage, where nurses are even now bringing in new patients who need to be seen. My attending has just informed me that I would be the one to ''tell the family.'' I am still shaking from the strange cocktail of adrenaline and exhaustion that engulfs me after every code. I am going to break the news for the first time in my career. As an intern, I am rarely confident about my work in the ED, but I feel up to this task. I am still learning how to be an emergency physician and I make my fair share of mistakes, but one thing I am sure of is my interactions with my patients. The residents of this elder, eastern European community northwest of Chicago remind me of my grandparents and older relatives. I have spent hours holding hands, comforting, explaining medical workups, and relating to these people; despite some insecurity about my medical knowledge and clinical decision making, I am sure of my interpersonal skills.

The room is small, with a window looking out to the ambulance bay. As I enter, I see the paramedics who brought this patient in. Having finished restocking their rig, they are taking a smoke break, talking, and flirting with the nurses. The room is too small. There are three family members, a nurse, a nun, and myself and my attending. I check my coat to make sure it is buttoned. There are not enough chairs for me to sit down. A nurse is perched on an end table next to the patient's wife. We do not even have enough room to close the door from the noises of the ED. This is all wrong. I need to sit down so that the family feels I am on their level; I am going to seem like some sort of mercenary, delivering horrible news without taking the time to relate to these people, and then striding out to take care of more important matters. I falter, trying to adjust to this change. Why can't I sit down? I have always hated to see my attendings stand imperiously above our patients, doling out life and death as if it were the day's weather forecast. I will never do that. The room is silent. The patient's wife, an 80-ish thin Hungarian woman, is looking at me imploringly. ''I'm Dr. Albinson, and this is Dr. _,'' I start off, motioning to my attending. I know what to do but I can't just come out and say it. I can't. This case was too complicated, too many things went wrong, and I can't just admit that we could not save him. These people have to know that we tried; we tried so hard to save this man who had been anoxic for 30 minutes before he even got to the ED, who had virtually no chance of survival. I want them to know that we did everything possible, that we coded him for longer than we usually do for 87-year-old patients with Alzheimer's disease and congestive heart failure. After this man choked on pierogi dough and he had been without oxygen for enough time to kill his brain five times over, we breathed for him. I reinserted the endotracheal tube that the paramedics had accidentally put in the esophagus instead of into the lungs. We gave him all the drugs we had to try and restart his heart. But there isn't time to explain all that now. ''We tried to breathe for him but he had been without oxygen for almost half an hour, and we gave him medicines to try to start the heart, but, well, he's dead.''

It was out. The imploring looks turned to despair. The wife began wailing, screaming, and hitting herself. ''Why did I do it? Why? I killed him! This happened before, but why? Why? Why! He choked a couple of times before, but I could get it out, then today we make pierogies and I go to get something from the basement and I come back and he is choking! Why? Why did I do it? I should never leave him alone! I should stay with him every second, but then we never eat nothing! I try to force it out, but I can't; oh my God, I killed him and my daughter is coming and she is going to say 'you killed him' and I killed him!'' She is screaming, sobbing, and wailing, the sound drifting out into the hallway and mingling with the clamor of the ED.

I can't speak. All my compassionate gestures and reassurances that have worked so well in the ED are drowned by a wave of sadness. I struggle to hold back tears, knowing that it is selfish for me to cry about the death of someone I don't know while his wife is going to pieces. The nurse and nun try to comfort her, saying ''it's not your fault.'' That is all they say. They are doing a terrible job of comforting this woman. They seem so distant and impersonal. I try to think of something to say, but I know if I