

## Death in the emergency department: a not so absolutely ordinary rainbow

*Don your armour, but beware of the chinks*

I WAS recently showing my two young children around the grounds of my former high school, when I was reminded of our old school sergeant — the onsite caretaker of the school. He was a large man who would often drop unannounced into a classroom, stay for a couple of minutes taking in part of our lesson, and then leave. As pupils we had to stand on his entry and stand on his leaving — a somewhat distracting ritual for the pupils and teacher. The school sergeant would grab just a snapshot of our lives and learning, and leave.

As I reflected on this, I began to think that his somewhat disconnected life with the pupils had similarities with emergency physicians' relationship with death in the emergency department.

Death is unfortunately part of the job of an emergency physician. The death I deal with is usually stark, sudden and shocking. It is often ugly — we are confronted with battered and bruised bodies, which we then further assault with pieces of plastic that protrude from various parts of the person.

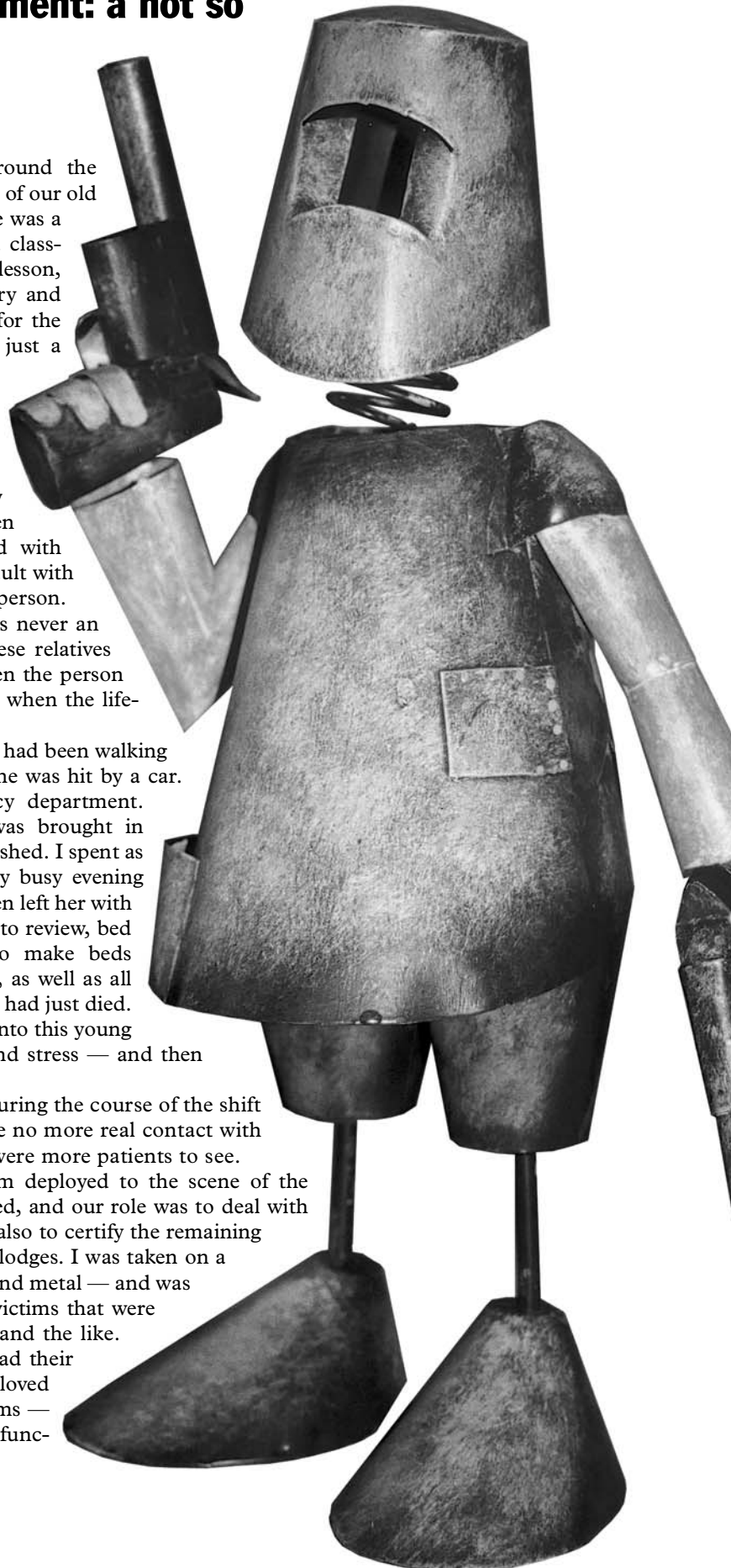
Having to tell relatives that their loved one is dead is never an easy task. Often what makes it even harder is that these relatives were talking to the patient just a few hours before, when the person appeared completely well, or, even worse, were present when the life-shattering event happened.

A recent example was the case of a young woman who had been walking down the road hand in hand with her boyfriend when he was hit by a car. We were unable to resuscitate him in the emergency department. Having to break this news to the girlfriend, who was brought in uninjured a little later by ambulance, was not a task I relished. I spent as much time as I could with her, which on that typically busy evening probably amounted to no more than 10 minutes, and then left her with our social worker. I had a number of other sick patients to review, bed managers pressuring me to clear the department to make beds available for other patients lying on ambulance trolleys, as well as all the paperwork to do for the unfortunate young man who had just died.

I was reminded of my school sergeant: I had popped into this young woman's life — at a time of the most acute anguish and stress — and then rapidly moved on.

I did in fact have to walk past her a few more times during the course of the shift while she was sitting with the social worker, but I made no more real contact with her. Despite feeling for her I had to move on — there were more patients to see.

Back in 1997, I was part of a medical disaster team deployed to the scene of the Thredbo landslide. Our team was the last to be deployed, and our role was to deal with the medical needs of the over 1000 rescue workers and also to certify the remaining victims once they had been extracted from the crushed lodges. I was taken on a tour of the site — a tangled, flattened mess of concrete and metal — and was struck by the number of simple personal items of the victims that were still strewn around: books, photographs, toothbrushes and the like. This really brought home to me that the victims had had their lives so violently and unfairly taken from them and their loved ones. However, when I had to certify the last four victims — all cold, stiff and crushed — I performed this with perfunctory precision.



In order to deal with these aspects of my work, I have developed something like a Ned Kelly suit of armour — an outer hard shell that protects me from the bullets of misery, anguish and stress of people sick and dying; a mask that prevents too much eye contact, and therefore emotional connection, while at the same time preventing the emotion within me from escaping and being seen in the raw. This piece of armour protects me by putting some emotional distance between me and the patients I am dealing with, and allows me to face the onslaught that working in an emergency department often is.

But this Kelly suit concerns me. Does it mean, by definition, that the system and specialty in which I work requires that I don the suit to work effectively, or have I put it on myself because I have become somewhat hardened to the human tragedy I deal with? And, more importantly, whatever the answer to this “chicken or egg” type of question, how is this affecting me elsewhere in my interactions with patients as well as my day-to-day interactions with family and friends?

I think a major reason most people go into medicine is because they like people and want to help them, and for me that drive is still there. However, the increasing workload and demands of the emergency department mean that I often feel unable to spend the appropriate amount of time with patients. At times I have to “cut to the chase” with them, and may therefore appear a little brusque or callous. That is certainly not my nature and was not how I started out as an idealistic intern.

Does this mean I bring this armour and attitude home with me? Having two children under five certainly requires a lot of time, patience and understanding. I hope that I take the armour off when I am with them, but I can never be 100% sure.

Having children has been both a help and a hindrance for my work. I certainly have a lot more understanding of the problems of parents, and I interact more naturally with my paediatric patients than I did before having children. But dealing with the death of a child is a lot harder now.

I recall a 6-month-old boy in cardiorespiratory arrest who was brought in a couple of years ago. We worked on him for some time, but our efforts were ultimately unsuccessful. During the resuscitation I could not help noticing that this boy's fair hair and looks reminded me of my son, who was around the same age at the time. I had to really fight back the tears as I ran the resuscitation, which I knew was going badly. In the past I did not have such an emotional reaction when resuscitating children. So perhaps that shows that the Kelly armour does have some chinks in it.

Death in the emergency department constantly reminds me about the fragility of life, and the need to try to live life to the full and to spend as much time as possible with those who are close to you. The other day, a normally healthy 40-year-old woman was brought in after, as the jargon would say, “a witnessed cardiac arrest at home with bystander CPR”. We were unable to resuscitate her. The bystander attempting resuscitation was her 12-year-old son.

Many of the patients I see now are in their 70s — the same age as my parents. Fortunately, my parents are both still

active and healthy, but when that 70-year-old arrest is called through by the ambulance service on our “bat phone”, I can't help but think sometimes that one day the patient could be one of my parents.

I recently watched the broadcast of the singer Slim Dusty's funeral, and although I didn't know the man, I know his son, who is an emergency physician. The service was a very powerful one — one that had tears washing down my cheeks. They were tears of sadness for my colleague and his family, but also, in a tiny way, tears of joy for me, because it showed me that the Kelly armour was removable. They were tears of true and raw emotion.

I was reminded again of school and some lines of a Les Murray poem I had studied:

*The man we surround, the man no one approaches  
simply weeps, and does not cover it, weeps  
not like a child, not like the wind, like a man  
and does not declaim it, nor beat his breast, nor even  
sob very loudly — yet the dignity of his weeping*

*holds us back from his space, the hollow he makes about him  
in the midday light, in his pentagram of sorrow,  
and uniforms back in the crowd who tried to seize him  
stare out at him, and feel, with amazement, their minds  
longing for tears as children for a rainbow.*

(Les A Murray, *An Absolutely Ordinary Rainbow*.<sup>1</sup>  
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1. Murray LA. *An Absolutely Ordinary Rainbow*: verses 3 and 4. The vernacular republic – poems 1961–1981. Sydney: Angus and Robertson, 1982. □