

# The 'Immediate Shock' of Bereavement

As I have pointed out <http://www.bmj.com/content/347/bmj.f4085/rr/654490>

The reason is probably the grossly inappropriate and hugely insensitive behaviour of police for EoL community deaths, when the death is not 'expected'. In this context, expected has an obvious logical meaning: an 'expected death' is one which occurs after the GP has 'promised to certify even if I cannot attend post mortem' (with the safety provided by that promise, the coroner can hugely relax the investigative aspect of post mortem behaviour, effectively instructing suitably trained nurses/etc that 'unless the death was obviously unnatural, just arrange for the body to be removed, try to keep the police out of it, and do not pester grieving relatives').

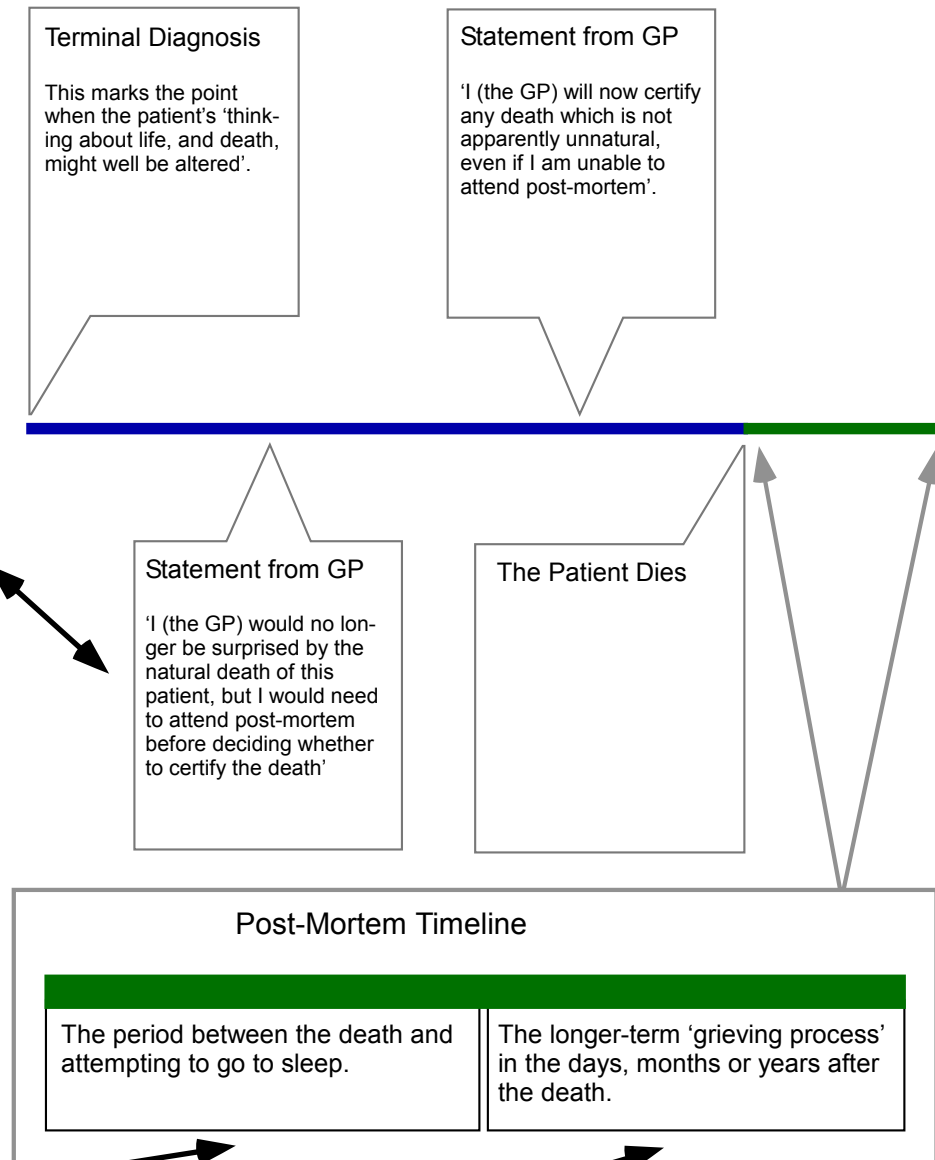
There is no guidance within current community policies, which properly addresses 'I would not be surprised if the patient dies, but I would need to attend post mortem before deciding whether to certify' – currently police behaviour tends to treat 'early EoL death' as very much akin to the sudden death of a believed-to-be-healthy 25 yr old. This is absurd, to put it mildly, when you are in the position of a person who is living with the patient. The transition from considerate treatment by nurses and the GP, to 'being treated by the police like a suspect when my loved one finally died', is a huge shock to the just-bereaved, and very 'disturbing'. I also think such police behaviour reinforces long-term memories of the death itself, which is a bad thing, and is being ignored by policy creators.

So the death of an elderly patient who 'might die any time, but I (GP) cannot say whether tomorrow or in a year's time' is treated as a 'sudden death' unless the GP attends post mortem and decides to certify: and even an 'expected death' will become, from the perspective of the care home, 'a death we, and the police, are not certain will be certified' if the GP has not visited within the previous 14 days. The police have a strong tendency to 'seek to investigate in depth' any death until certification is effectively a certainty – this damages bereaved relatives, and is neither 'balanced' nor rational, if a patient is known to be 'very elderly, final-year-of-life or has a condition which involves an ongoing but small probability of 'dying at any time'".

And the care home, or a relative in the patient's own home, cannot be certain that the GP will be able to attend promptly, when the death occurs.

See also my analysis at:

[http://www.dignityincare.org.uk/Discuss\\_and\\_debate/Discussion\\_forum/?obj=viewThread&threadID=785&forumID=45](http://www.dignityincare.org.uk/Discuss_and_debate/Discussion_forum/?obj=viewThread&threadID=785&forumID=45)



The answer is the presence of this statement from the GP - and **the presence of that statement must be known to the family carers.**

This happening here has the consequence of making this 'subsequent grieving' worse.

**'Psychological Assault'**

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In situations of traumatic bereavement — for example, in accidents or criminal attacks, first responders and disaster relief workers can provide "psychological first aid." These individuals can establish contact, promote safety and comfort, gather information regarding current needs and concerns, provide practical assistance, and encourage connection with medical and social support resources. **Psychological first aid** was developed from expert consensus, and is an important area for future research.

This is the **opposite of**

From Boelen and Smid (BMJ 2017;357:j2016 doi: 10.1136/bmj.j2016)

## **A Personal Reflection about my own dubious healthcare decisions**

I have been briefly discussing some 'grief disorders' with a doctor, and during this discussion I pointed out that I had not sought any treatment for my own depression.

The doctor didn't seem to be entirely 'happy with' that: he argued that we seek treatment for physical problems, heart conditions, etc, so it follows that we should also treat mental health issues. I am on thin ice here – there is logic to his position, and probably less logic to mine – but I'll explain 'my feelings'.

Basically, I knew perfectly well that a series of events which had, in essence, been imposed on me, had definitely led to my depression. But I wasn't keen to then try to further alter 'my mind' deliberately – I just wasn't 'up for that'. I accept that this is a position which is 'self-neglectful' but it was my position – I don't like 'messing about with my mind'.

There are many things, which as a society would improve health, but which we do not do. We have only moved towards discouraging smoking – we have not made smoking illegal. We have not made exercise sessions compulsory, despite the known benefits of exercise.

I suppose, this is the question I would put to the doctor:

**'Is your position, that people should do things which would make them 'mentally happier' ?'**

Because, I pose this. I am secular. I am aware of research that seems to prove that people with a religious faith, are happier in life than secular people. But I simply cannot rationalise why we need to postulate a God, in order to make sense of the universe (and, it seems to me that accepting the existence of a universe which was not created by a God, is less of a challenge than working out how God came into existence if you believe that God created the universe).

**Am I supposed to somehow deliberately alter my mind, so that I can become religious: doing so might [if it were successful] very well 'make me more content mentally' but it would also be 'completely against my nature'.**

My other issue with this 'improving mindsets' thing, is that I see it 'sort of creeping in' to the writings of some clinicians in connection with end-of-life patients. And in my view you definitely should NOT be trying to modify the 'beliefs and attitudes' of dying people, because that is likely to lead to arguments with the dying – **and clinicians should definitely not be setting out to argue with people who are dying** [totally unhelpful !].

## **Complex Nuance is reduced to False Binary Choice – and True Binary Choice is falsely blurred**

I was listening to Radio 4 recently, and during ‘thought for the day’ the speaker said ‘complex nuance is reduced to false binary choice’.

Nuance is not quite the same things as complexity, in my opinion: I think ‘nuance’ has something to do with ‘blending and gradation’ whereas ‘complexity’ is about something different. But, the phrase caught my attention, in connection with my end-of-life ‘stuff’.

When you read the Mental Capacity Act, you will not find much ‘nuance’ - you will find descriptions of binary separations (either/or) and ‘areas of enormous complexity’. When you read what people write about the MCA, you will find people trying to complicate the binary things, and to over-simplify the complex things.

For example, according to the MCA: for any given decision at a particular time, the legal ‘rule’ is either Informed Consent if the person is mentally-capable, or best-interests decision-making if the person is not mentally capable – completely ‘binary’; when best-interests decision-making is required, there either is a person given legal authority over that decision-making by section 6(6), or else there is no such person with legal authority – completely ‘binary’ until we throw in a sort of ‘very complex pseudo legal authority that could arise from section 42, which is in fact a somewhat different issue.

Best-interests decision-making itself, is a process to which I would attach the word ‘complexity’ whereas some people might describe best-interests as ‘nuanced’: it is not ‘nuanced’ so much as ‘mysterious and lacking-in-definition’. What is ‘nuanced’ is the reason why best-interests is so ‘lacking in clarity’ within the MCA.

In one of my BMJ pieces <http://www.bmj.com/content/350/bmj.h2883/rr-2> I wrote:

‘But whichever way you go, law or ethics, there is a ‘sticky wicket’ lurking somewhere.’

To an extent – and I only say to an extent – for some things, it is possible to frame the issues in different ways, and by doing so you ‘move the complexity around’. It is rather like squeezing a balloon: you can squeeze ‘the balloon containing the tricky bits’ and the shape of the balloon changes – you apparently reduce complexity in one place, but it pops out stronger somewhere else.

Which part of the balloon you try to squeeze, will depend on which of the ‘complexities’ are the more problematic for you and your own objectives; that – different people seeing different problems, and therefore ‘squeezing the balloon of complexity into very different shapes – is a serious problem and impediment to the achievement of consensus.