Human Resources

Death, Dying and Grieving

by Alan R. Cowen

It is very difficult to deliver pre-hospital care on a regular basis to patients whose injuries and illnesses are often very critical. Even more difficult than the pre-hospital clinical skills required, is the ability to compassionately, over and over again, deliver health services in a manner which emphasizes empathy and loving support. There is no doubt, when facing this day to day, that some might become callused or otherwise hardened and even contract an attitude of indifference.

The mere fact that a pre-hospital care provider recognizes this as a process is the first step in understanding this tendency and forestalling the unfortunate development of such an attitude.

Of primary importance is that each of us involved in this activity carefully examine our attitudes on a regular basis, so that we don't fall prey. If we allow these feelings to become internalized without benefit of reflection, they become permanent, causing barriers between a patient seeking care and the health care provider.

This information is a common denominator for the subject at question. Something not written about. The death of loved ones of pre-hospital care providers. The emotional impact on emergency medical services (EMS) providers working in the most difficult of circumstances, in the most negative of environments who must face the death of his/her own loved ones.

We must all be on guard not to ignore and not to become callused of others *or our own* emotional and psychological needs. We need to have ongoing regular discussions with each other to maintain our own health and well being.

This personal essay reflects my experience in dealing with death and dying as an EMS fledging from 1963 to 1997, a 34-year period in which many changes occurred within me—culminating in the grieving process as the result of the death of my mother in January, 1993.

My first experiences as a professional EMS provider began on a hot August Sunday in 1963. Her name was Tobey. I met her on the asphalt of the Pacific Coast Highway in Malibu. She was the patient; I was the provider. She was a pretty 16-year old surfer girl and I was an 18-year old with one week on the job—a job while working myself through college. She lay on the highway, a victim of an auto versus pedestrian near the Malibu Pier. She was very critical with multiple fractures, including bilateral compound femurs, massive chest, pelvic and certainly multi-organ, multisystem involvement. In short, she was a mess, a living hell.

I had never before seen anyone so broken apart, so destroyed that even now, I get goose bumps just thinking about her and about me being her care giver.

To make a long story short, like her life, her injuries were not compatible with life, but I offered Tobey all the EMS prehospital care that I possibly could. These included a 16-hour first aid course, first aid supplies, oxygen, splints and a blanket. These, plus an old E and J resuscitator were the tricks of the trade in 1963.

I'll remember all my days, those eyes as she looked at me, as I tried to help her, not cognizant of the fear that I myself contained.

En route to the hospital, I noticed that her eyes became glazed over and dilated, so I remember trying something I had read about in a book —I put my mouth on hers, and blew breath into her mouth. I can still hear the wail of the siren, while continuing down the highway—knowing all the while what would happen.

At the hospital and after she was pronounced dead, I cleaned up the equipment, put a new sheet on the gurney and prepared for the next call, yet all the while wondering if I could have done better. Did I do enough? Those questions haunted me for 20 years, as I watched the EMS system develop, observing incredible technological ad-

vances in equipment, supplies and training. To this day as I sit in my office, I often reflect back on that 1963 day, and wish I had possessed additional skills that may have changed the outcome for Tobey.

Those Stone Age methods *cannot* be compared to the advances and the EMS revolution we have seen in the last 20 years.

Nevertheless, Tobey was the first patient with whom I had contact, and whose care was in my hands, who died. It was on my mind, but I shrugged it off and moved on in my career.

There were to be many more critically injured patients that I would treat in my early career; some would live, some would not. But each time, I would shrug it off and move on. I did not dwell on their death, nor did I deal with it.

In 1967, I began my career with the Los Angeles City Fire Department. I have witnessed and been part of the early development and growth of the Los Angeles EMS experience. There have been incredible advances in EMS that people 25 years ago never dreamed about. EMS has come of age; it has grown strong and become an integral part of the fire service of today.

It was 1974, a Friday night, and I was working out of Fire Station 105—a typical Friday night for a City Paramedic. We responded to a square dance where we found a man in full cardiac arrest on the dance floor. No history could be provided by onlookers, or the pretty young dance partner that had attempted CPR prior to our arrival.

When all was said and done, and the nine defibrillation shocks were completed, our patient was breathing on his own, and was as cyanotic as textbooks paint, and as lucky as any 300+ pounder could be who had the "Big One."

While so many others had not been able to be saved, this one would have another lease on life; the difference was electricity. It would be over a month, and subliminally forgotten when the doorbell at 105's would ring and we would come face to face with our own reality. This man surely would have died without paramedic intervention, and proof existed, right before our eyes, that we can be successful. We hugged, chatted, and said our good-byes and he was gone—but for some unexplained reasons the feelings remained.

My partner, who has since left the fire service, approached me and for a moment we looked at each other silently—it was then that I noticed his tears, and he mine. We had made a difference!

In early 1992, while visiting my parents, my mother complained of a swollen ankle. All of the usual tests proved negative, until the edema became more evident and began travelling proximally. Then the other ankle. More negative tests; finally the diagnosis: Non-Hodgkins Lymphoma. And, of course, the chemotherapy was next, with the vomiting, the hair loss, and medications—only to watch the slow deterioration, and demoralization—an ugly disease!

Pauline knew of her disease and the prognosis. As we neared the end, the world of the wonderful hospice program entered—with those compassionate and understanding nurses.

I often wondered what it meant when my friend and priest, Christian Van Liefde, told me, "You have time to make peace with your mom—use this time wisely."

I sat with her nearly every night and we talked; sometimes it was as though I did all the talking and she did all the listening. There were the times of her mood swings, punctuated with the need for morphine to reduce, but never eradicate, the intractable pain.

While men today are more able to express their feelings, there is still extreme discomfort in our culture when a man openly gives in to painful emotions of loss, hurt, or fear. Being strong for others is frequently reinforced as being an honorable and "strong" quality. Many men do not lend themselves permission to mourn openly. The unfortunate result is that men grieve alone and away from others, or deny their grief through other means.

Men who experience loss and are unable to turn inward, reflect on that loss, and become incapable of beginning the healing process.

Some consequences of the inability to acknowledge loss and pain are: symptoms of chronic depression, withdrawal and low self-esteem; deterioration in relationships with family and friends; headaches, fatigue, restlessness, and chronic anxiety; passive indifference toward others.

Because grief-related feelings are repressed, males frequently live in a state of internal tension; this is designed as a protective mechanism to protect against feeling and expressing pain—the very solution to overcome these negative consequences.

Usually a male will only work to become aware of his grief when he begins to realize how deprived he is of being fully alive and living. The beginning of acknowledging and expressing grief seems to only come with the awareness of what not feeling is doing to his life.

Once accomplished, the male can begin a journey of learning or relearning how to be a feeling person, which is not by any means an easy job!

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