Managing sudden bereavement

EDITOR,—In their article on managing sudden bereavement in accident and emergency departments M W Cooke and colleagues seem to have overlooked the fact that staff themselves need support in these incidents.¹ While it is essential, as the authors emphasise, that accident and emergency staff receive adequate training in bereavement care to provide the necessary service for relatives in these circumstances, the staff also have their own needs. Casualty staff are subjected to many conflicting demands and pressures during their working day, not least of which is the management of sudden bereavement and its after-effects.

The BMA's board of science and education will shortly be releasing an educational package on dealing with the unexpected death of a patient. The video, entitled *A Stressful Shift*, consists of a 20 minute dramatised account of the work of a casualty house officer during a difficult 24 hour shift, which includes the death of a child. This powerful fictional account is followed by brief discussion among three doctors about ways of managing sudden bereavement, including breaking bad news to relatives and minimising avoidable stress for staff. The board of science and education hopes that this package, together with a report that it will be publishing soon, *Stress and the Medical Profession*, will assist members of the profession in caring for bereaved relatives and will prompt recognition of the needs of doctors and other staff in maintaining the balance of the humane professional—a term that should not be regarded as an oxymoron.

JACK HOWELL

Chairman, BMA Board of Science and Education,
London WC1H 9JP

1 Cooke MW, Cooke HM, Glucksman EE. Management of sudden bereavement in the accident and emergency department. *BMJ* 1992;304:1207-9. (9 May.)

EDITOR,—In their article M W Cooke and colleagues conclude that immediate care of relatives is good.¹ Informed by my own experience when my son died in an accident and emergency department, I gave thought to what would have been helpful both to me and the hospital staff at that time. Although these observations refer to the sudden death of a child, they could equally apply to the death of any relative.

I think the single most helpful thing staff in accident and emergency departments can do is to give back to the relatives the responsibility that the hospital assumed when the dead child was alive. The following simple format could be followed. On arrival at the hospital as much decision making as possible should be given to the parents. Up to this moment all decisions concerning the child have been made by the parents. This will therefore come naturally to them. The first decision should be when they see the child and the first question asked of them, before any other official procedures begin, should be, "Would you like to see her immediately?" followed by a second question, "Would you like to wash her?"

These questions are saying to the parents "She is still your child, you can still care for her, you can touch her." If the answer to these questions is yes, the child's condition can then be explained. The parents should be told that a nurse will help if

dressings, injuries, or drains need attention. The parents should also be allowed to change their minds. If the answer is no the parents should be asked if they would like to wait until the child is washed and reassured that if they change their minds while waiting they only have to say so and they can then see their child.

I would suggest that they should not be asked a question containing alternatives such as "Would you like to see her right away or would you like to wait until we have washed and dressed her?" If the question is asked in this form the parents will try to guess what might be the normal or correct answer. The bereaved parents are in a strange place with unknown etiquette, and almost unbelievably at such a time will be foundering about trying to discover the correct responses. Asking a simple question is much more likely to elicit the response they actually mean and need to give.

Professionals can help parents if they remain mindful that when all the parents' tenderest emotions are centred on the child, that at that very moment, their child is effectively taken into care. Up to this moment no decision has been taken about their child without their consent. In the event of sudden death their child is not only lost to them in life, she is lost to them in responsibility as the officials take over. The parents are doubly bereft.

Both the death and loss of responsibility are matters of fact. But I don't believe an immediate and abrasive ripping away promotes healing. I think we can find a much less traumatic and injurious way of facing the facts.

S AWOONOR-RENNER

Dorchester,
Dorset DT1 2DH

1 Cooke MW, Cooke HM, Glucksman EE. Management of sudden bereavement in the accident and emergency department. *BMJ* 1992;304:1207-9. (9 May.)

Postviral fatigue syndrome

EDITOR,—A M O Bakheit and colleagues suggest that the buspirone challenge test may be useful in distinguishing between a "primary depressive illness" and the postviral fatigue syndrome.¹ It is difficult to assess the truth of this from the data presented in their paper. To know the usefulness of this test the numbers of controls and patients scored above or below an appropriately chosen cut off point of serum prolactin concentration needs to be known. Unfortunately, the authors present the prolactin concentrations as mean values. If the aim of the test is to exclude major depression then a cut off which produces few false negative results should be chosen. Were the high mean values in the postviral fatigue group due to one or two extreme outliers? It is noteworthy that the standard deviations in the patients were much higher in the controls at baseline assessment. Why was this?

SIMON HATCHER

Academic Unit of Psychiatry,
University of Leeds,
Leeds LS2 9LT

1 Bakheit AMO, Behan PO, Dinan TG, Gray CE, O'Keane V. Possible upregulation of hypothalamic 5-hydroxytryptamine receptors in patients with postviral fatigue syndrome. *BMJ* 1992;304:1010-2. (18 April.)

EDITOR,—A M O Bakheit and colleagues report an enhanced prolactin response to buspirone in patients with postviral fatigue syndrome and suggest this may be due to upregulation of hypothalamic 5-hydroxytryptamine receptors.¹ They fail to mention the considerable evidence indicating that the drug is a moderately potent dopamine antagonist, a pharmacological action which suggests an alternative explanation for their data.^{2,4}

They administered a single 60 mg dose of buspirone—in excess of the daily maximum of 45 mg recommended by the *British National Formulary*—so antidopaminergic effects may well have been significant in their studies. The fact that the prolactin releasing effect of buspirone can be blocked by the drug metergoline does not prove 5-hydroxytryptamine receptor specificity. Indeed, metergoline is used commonly as an alternative dopamine agonist to bromocriptine in managing hyperprolactinaemia. Thus enhanced prolactin release after buspirone in postviral fatigue syndrome may reflect, at least in part, inhibition of increased hypothalamic dopaminergic tone on the anterior pituitary. It would be interesting to study the same groups of patients using a specific D2 dopamine antagonist (such as domperidone) to see whether this is the case.

J S BEVAN

Aberdeen Royal Infirmary,
Aberdeen AB9 2XB

- 1 Bakheit AMO, Behan PO, Dinan TG, Gray CE, O'Keane V. Possible upregulation of hypothalamic 5-hydroxytryptamine receptors in patients with postviral fatigue syndrome. *BMJ* 1992;304:1010-2. (18 April.)
- 2 Riblet LA, Taylor DP, Eison MS, Stanton HC. Pharmacology and neurochemistry of buspirone. *J Clin Psychiatry* 1982;43:11-6.
- 3 Meltzer HY, Flemming R, Robertson A. The effect of buspirone on prolactin and growth hormone secretion in man. *Arch Gen Psychiatry* 1983;40:1099-102.
- 4 Meltzer HY, Lee HS, Nash JF. Effect of buspirone on prolactin secretion is not mediated by 5-HT-1a receptor stimulation. *Arch Gen Psychiatry* 1992;49:163.

EDITOR,—A M O Bakheit and colleagues report enhanced release of prolactin after administration of buspirone in patients with the postviral fatigue syndrome compared with controls and patients with depression.¹ Their report would have been improved if they had described more fully the differences between the two groups of patients. As they point out, depression can be difficult to distinguish clinically from the postviral fatigue syndrome.

The authors used the criteria of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* to define depressive illness,² but to qualify for this diagnosis a patient need complain of only four symptoms such as fatigue, hypersomnia, retardation, and loss of concentration in addition to depressed mood. The criteria they used for the postviral fatigue syndrome included depression, fatigue, reversed sleep pattern, and constipation alternating with diarrhoea. It would be surprising if there was not a substantial overlap between the two groups and if one of the main factors affecting diagnosis was not whether the patient presented first to a psychiatrist or a neurologist.

This diagnostic overlap makes it all the more remarkable that a significant difference in response to buspirone was found between the groups, and we would like to know exactly which symptoms or pathological findings account for this difference.