Death in the Clinic

By Dr Julian Lim Lee Kiang

Death is never just a bio-medical event and neither does it only affect one person. As a family physician, I have to manage not just life but also death in the family.

"This should be interesting," I told the MOH Family Medicine (FM) Trainee posted to my clinic as we looked through the death certificates that I have issued since I started practice. The "Address where death occurred" was that of my clinic!

BODY AND SPIRIT

I still remember the commotion outside my consultation room after the parents left my room carrying the still infant wrapped in a towel. The ruckus was not from the crowd of patients who had to patiently wait while I tried to resuscitate the child in the consultation room and then meet the face of death after. It was created by the child's mother screaming hysterically at someone through her mobile phone. I quickly ushered them back into the privacy of my room.

"She is screaming at my mother as my mother does not want my son's dead body to be brought back to our house," the father of the child confessed. I left them at an adjacent treatment room to sort out the impasse. I know that many elderly Chinese consider it bad fortune that a death should occur, more so if it occurred to an infant. This bad fortune should never be brought back to the house of a senior member of the family, so they believed.

THE UMBRELLA

My mind raced to recall if there were any other traditional, cultural or religious issues that I might further need to address to avert a family meltdown. Strangely, it flashed back to my army days when I was told the reason why a certain barrack was haunted – the pallbearers did not use an umbrella to shield the corpse from the sky while moving it from the barracks onto a waiting vehicle. Superstition had it that the spirit would then leave the body and wander away. On returning back later to find the physical body gone, it would take abode to haunt that place forever.

I offered them an umbrella, which they accepted with gratitude. It was not because I was afraid to practise in a haunted clinic. Honestly, I was more concerned that I might later have to turn down a request for a "saikong" (priest) to perform some rites in my clinic to appease the spirit allegedly squatting here. I did not probe into where they decided to take the body to. They must have sorted that out by then as they seemed composed. They left the clinic, the mother forlornly carrying the body wrapped in a towel - the umbrella over all three heads.

CONGENITAL HEART MALFORMATIONS

"So the cause of death was congenital heart disease, eight months," commented the trainee, "Was he brought in dead?" "Yes and no," I replied with a straight face, trying hard not to sound stupid.

The baby was born with "double inlet single ventricle complex. Pulmonary atresia. Patent ductus arteriosus. Hypoplastic pulmonary artery etc" according to the cardiologist. As their family physician, I had shepherded the entire family through this difficult time, the mother in particular. I first saw the infant when he was 3 months old.

I still remember the futile optimism the mother had when she repeatedly told me that she would get the best heart surgeon in USA to operate on her son. "For this ever to happen, he would still require his vaccinations," I would counsel, being very careful not to burst her balloon of hope prematurely. I used the windows afforded by the scheduled visits for the child to counsel the family. By the time he was 6 months old, she had gradually accepted that there was nothing much that surgery could offer. However, I could see that the love of the mother for her son grew even stronger.

DEAD OR ALIVE?

He was a cyanotic infant to begin with but on that day that he was brought into the clinic, he was bluer than ever. My clinic assistants rushed him into my consultation room. There was already no pulse and no spontaneous respiration. Was he clinically dead?

The mother claimed that her son was still breathing when she brought him out of the flat. She slumped down on a chair and recounting the history in self-admonishment, "He developed some cough and fever yesterday. I thought I could wait until today before bringing him to see you. He suddenly became unconscious and turned blue so I rushed him down. He must have stopped breathing somewhere along the way here." "I should have brought him to the hospital yesterday," she mechanically repeated again and again. Her husband stood silently in one corner.

The ball was in my court. I could respond clinically and say, "Yes, you should have brought him to see a doctor yesterday. Now that you have brought him here in this condition, it is already too late for me to do anything." Or I could be more consoling and say, "It is better this way. The doctors would not have been able to do much even if you had brought him to the hospital yesterday."

The deafening silence in the face of death was punctuated only by her subdued sobbing. I could see this poor

Page 10 ►

◄ *Page 9 – Death in the Clinic*

woman still sobbing in that chair months from now, wrongly admonishing herself for causing the death of her child by neglecting to bring him earlier for medical attention. An advent of a major depression - can I prevent that?

A DOCTOR'S FAILURE

I decided that I should be the one that "failed". My clinic assistant and I immediately strapped on the ECG leads, popped in an airway and took out the air viva. The woman stopped sobbing immediately. On that cue, I decided against calling for the ambulance but proceeded with cardio-pulmonary resuscitation (CPR).

Five minutes into the resuscitation, I could feel the uncomfortable father shuffling his feet. What was he thinking? "Doc, please try as hard as you can" or was it "Doc, I think he is dead. Don't revive him only to die in the ICU a few days later".

Remembering that I was to be the "fall guy", I said my lines, "I don't think I can revive him but I'll try a while longer." The father however interjected, "But I think he is already dead." I had to agree with him. However I had decided that the child was not dead and had commenced CPR. I could not stop. I had to now show the parents that the child was indeed dead.

The idioventricular twitching of the ECG pattern came into the way. It would be too difficult, I thought, to explain those movements in the recording. "How could someone be dead if the heart is still moving?" I thought hard and decided to use the ultrasound instead. So I placed the probe on the chest and showed the parents the absence of any heart movement. I finally pronounced the infant dead.

LEARNING POINTS

"Okay, learning points," I reminded the FM trainee, "Remember the umbrella and other cultural, traditional and religious issues when handling the body." My conduct of the resuscitation in the face of death was not so cut and dry. Should I have called the ambulance immediately? Should I on hindsight have at least demonstrated a sense of urgency and hoped that the ambulance would arrive after I have pronounced the infant dead and not during the resuscitation?

The other decision to shift the mother's failure to bring the infant to see a doctor earlier, to my failure to resuscitate the infant had potential medico-legal and other implications for me. What if the parents alleged negligence on my part in the resuscitating process in the anger of their grief reaction? I know of a colleague who had been maligned and the injections given in CPR had been blamed for causing death. This unfortunate GP had the dubious honour of having the hearse routed to stop by his clinic in recrimination after an angry relative found empty injection vials marked 'Poison' around the body of the deceased.

"Treating the family as a whole" is an easy maxim to exposé. However, death is never just a bio-medical event and neither does it only affect one person. As a family physician, I have to manage not just life but also death in the family. The young trainee beginning his journey in Family Medicine, I hope, has learnt valuable lessons from this case. ■

Editor's Note:

Dr Julian Lim, MBBS (1988) was in the first batch of private practitioners who successfully completed their Master of Medicine in Family Medicine in 1995. He exited as a Fellow of the College of Family Physician last year and is now practising as a Consultant Family Physician in the private sector. He presently supervises a group of GPs in the NUS Graduate School's Master of Medicine (FM) private practitioner's stream.