Bereavement China and Edge-Work

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Most hospital wards in the United Kingdom have a special tea set called the "bereavement china" or "bad news china." It is strictly reserved for patients and families who have lost a loved one or received a devastating diagnosis. The physician breaks the bad news, the patients and relatives cry, then someone is assigned to make tea, with the murmured aside: "use the *special* tea set." The logic behind this does not stand up to scrutiny; after hearing the worst news of your life, is your subsequent heartache alleviated one whit by the serving of tea in a nicely patterned china cup and slightly fancy teapot? Probably not, but it is something we do. It makes us feel better.

Breaking bad news is actually a 2-way process. The doctor is always affected somewhat by the encounter, although often in subtle and hidden ways. The "breaker" must enter a shared emotional space with the "breakee," which can feel discomforting and exhausting. Even the thickest-skinned physician often feels an unpleasant flicker of anguish as they watch someone's life fall apart. The heterogenous group of physical reactions is varied and difficult to prepare for. Some patients explode outward, sobbing and keening; some seem to physically diminish in front of you, collapsing in on themselves and becoming suddenly small and frail. Some move textbook-like through the Kübler-Ross model of grief; others merely become dazed and monosyllabic, their unseeing eyes focused on something horrible in the future. Most of us will have faced an actor in our medical school examinations, our clumsy attempts at delivering a cancer or HIV diagnosis prompting a prolonged and rehearsed emotional reaction, while we squirmed with the awkwardness of it all. Perhaps, we should be awarding the top marks to the student who decides to boil the kettle and hunts down some teabags.

These precarious psychosocial situations are part of what I call "edge-work"; the physician is working right on the edge between life and death, and it forms the very soul and center of our profession. Geriatricians, palliative care workers, oncologists, and many others are familiar with edge-work in their daily work, whereas other specialists, such as those working with acute medical admissions (like myself) undertake edge-work on a less frequent basis. One might suppose that our colleagues, the obstetricians, are edge-workers too, working at the very limits of life: albeit from the other end. It is on the edge, however, when our patients need us the most.

We have a responsibility to our patients even after they expire; dealing sensitively with the patient's relatives is part of that responsibility. I try to inculcate this in my medical students, although the average student's interest in a patient understandably dwindles rapidly after the patient dies. Sometimes, I ask them to assist the nurse in preparing the body to be transferred to the morgue, with the half-serious words: "The laying out of the dead is an ancient and sacred duty in nearly every culture in the history of mankind and is often the responsibility of the wise woman of the tribe," to much eye rolling from the students (and nurse). The intent behind these words, however, is to encourage them to see that even after death, the patient is not gone: They have a small physical presence and a massive nonphysical presence in the memories and relationships with the ones they leave behind, who now need our help.

I work in the emergency department, and my colleagues sometimes ask me why I always volunteer to be the one to "break it to the family." My answer is because it is important that it be done well. It sounds paradoxical, but there are good ways and bad ways to hear terrible information, and if you have ever witnessed it done badly—aloof, underexplanatory, overexplanatory—you feel an unwavering desire to ensure you *never* see it again. I volunteer for the unpleasant task because I know I can do right. I don't think my method is very different from most other physicians: a small warning shot ("As you know, your father was desperately unwell when he arrived in hospital"); the nasty truth delivered simply and sympathetically ("Despite our efforts, he passed away; I am very sorry"); and a small physical gesture—my hand briefly on theirs, or a brush of their elbow. The ensuing conversations are often tricky to navigate; the patient may want answers but not be able to process the information. The family may ask things the physician simply does not know.

So, I don't mind being responsible for searching out the bereavement china and serving the hot tea. The ward kitchen provides a small quiet sanctuary, and the few minutes waiting for the water to boil and tea to brew affords me the chance to take a few deep breaths, reorganize my thoughts, and deal with my own feelings and reactions. When you break bad news to people, you take something precious from them: their loved one, their future, their hope. The grieving heart is not a rational one, and they may unconsciously resent you for taking away

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their comfort and their happiness. You may be a sudden stimulus for all the anger and pain stored up quietly inside them hitherto. You may become the villain of the piece through no fault of your own. You must be prepared for all this and accept it without indignation or quarrel. This is a seemingly impossible task, but in a world where we can resuscitate the dead with external defibrillation and perform life-saving organ transplantation, physicians are quite used to the impossible; we see it all the time.

It is certainly a bleak business, but an immensely important one. People *deserve* to have their hearts broken and worlds turned upside down in a calm, sensitive, and professional manner. Edge-work doesn't look very dramatic or exciting; we are not wielding scalpels, administering medication, or pumping someone's chest. Edge-work, however, may be some of the most life-changing work we do; we will be burned into our listeners' memory for rest of their lives.