
Problems in Family Practice

Dying and Death of a Family Member

John P. Geyman, MD
Seattle, Washington

There are many factors that have mitigated against optimal or even adequate medical care of the dying patient despite recent technological advances in medicine. Major changes are now taking place in terms of public expectations, medical practice, and legislation related to dying and death in this society. The dying patient has five basic requirements that must be met: independence, dignity, acceptance by others of an individual approach to dying, relief of symptoms, and physical care. In many instances the home offers advantages over institutional settings if other family members are able to manage the burdens of care. Regardless of setting, the family physician plays a central role in the care of the dying patient and his or her family during preterminal, terminal, and follow-up stages. This paper presents an approach to comprehensive care whereby the symptoms of incurable terminal illness can be effectively relieved on an individualized basis. Anticipatory guidance and care are important for the effects of terminal illness and death of a family member on the surviving family members, particularly with regard to recognition and treatment of depression.

An excellent case report published several years ago entitled "Dying in a System of 'Good Care'"¹ described the terminal care in a teaching hospital of an elderly woman with incurable end-stage disease. This report, which should be required reading for all physicians, portrayed this care as a "nightmare of depersonalized institutionalization, of rote management presumably related to science, and based on a team approach of subdivision of work." Unfortunately, the many problems identified in this report are all too common throughout the country, and an extensive litera-

ture in recent years has addressed various aspects of death and dying from cultural, ethical, medical, and legal perspectives.

Among the many problems related to death and dying in this country are the following: inadequate preparation of many patients for their own death, institutional barriers to appropriate family involvement in the care of the dying family member, inappropriate physician attitudes and behavior with respect to dying and death, common reliance on "curative" care instead of "carative" care in terminal illness when the underlying disease processes can no longer be altered, high, often iatrogenic, morbidity and costs of terminal care, and failure to prevent, recognize, or appropriately manage depression and other medical problems in surviving family members. Because of these and related problems, major changes are taking place

From the Department of Family Medicine, School of Medicine, University of Washington, Seattle, Washington. Requests for reprints should be addressed to Dr. John P. Geyman, Department of Family Medicine, School of Medicine, RF-30, University of Washington, Seattle, WA 98195.

in public expectations, medical practice, and legislation related to dying and death as part of an overall societal reassessment of past and current practices.

The purpose of this paper is threefold: (1) to summarize some of the more important changing societal trends related to dying and death, (2) to review the impact on the family of the dying and death of a family member, whether an infant, child, or adult, and (3) to present a practical approach to comprehensive care of the dying patient and his or her family during preterminal, terminal, and follow-up care.

Some Changing Societal Trends

In 1900 most Americans died at home surrounded by family, friends, and clergy.² Today, about 80 percent of the terminally ill die in institutional settings, which tend to separate the patient from family and support systems.³ The emphasis on specialization and subspecialization, together with advanced diagnostic and therapeutic technology, has frequently placed "curative" care in fundamental conflict with the care needed by the terminally ill. Keene⁴ points out that "the real terror for the institutionalized dying is not death, but mechanical maintenance without medical purpose, wrists restrained by leather bonds so that tubes cannot be removed, potentially continuous pain, and ultimate indignity of having one's remaining days controlled by strangers." As Kass⁵ has observed, when the dying patient most needs human contact, his ties to a "community of men" are medically replaced by inescapable ties to a "community of machines."

There is a growing wave of popular sentiment for the rehumanization of the dying process. An important outcome of this groundswell has been recent legislation of the rights of the dying in a number of states. The California Natural Death Act, enacted in 1976, was the first "Right to Die" legislation passed in the United States. This act clarifies the right of patients to refuse treatment under various circumstances. Those protected by the act include the comatose patient; the custodial, physically disabled patient; the patient who requests that life-supporting procedures be discontinued; the patient whose physician finds himself confronted with conflicting pressures from family,

hospital policy, or medical colleagues; the patient who finds it difficult to communicate with his physician; and the patient who did not communicate his desires concerning terminal care in advance of an unexpected illness or accident. For the physician, the act clarifies the law concerning the termination of life-supporting procedures in dying patients and affords protection from malpractice claims from families when other family members disagree with the dying patients' requests.⁴

This type of legislation represents an effective means by which individuals may invoke personal autonomy over the process of their own dying through explicit instructions to their physicians. Such legislation has led to a variety of "living wills," such as that proposed by Bok in 1976⁶ and that developed as part of the Washington State Natural Death Act of 1979⁷ (Appendix). With some exceptions (eg, the incompetent patient, children, emergencies) the courts have supported the right of patients, after a process of informed consent, to refuse treatment, even when such treatment may be lifesaving.^{4,8-10} Courts have held that the physician may not substitute his own judgment for that of the patient,¹¹ and the California Natural Death Act requires a physician to withdraw from a case and turn it over to another physician if he disagrees with the patient's instruction to stop treatment.¹²

Although few states have ruled on the legality of "no code blue" orders, there is widespread support for the "no code" concept as a lawful, medical activity under appropriate circumstances. Three criteria should be met in applying the "no code" order: (1) The patient should be irreversibly and terminally ill, so that resuscitation would not change the inevitable outcome (the basis for this judgment should be explicitly documented); (2) the "no code" order should be discussed with the patient and family, and their desires should be documented in the medical record; and (3) the order must be written.¹³

Another significant trend in the care of the dying patient in this and other developed countries is the hospice movement. A classic example that has had considerable influence around the world is the St. Christopher's Hospice, which opened in 1967 in London. This program is contractually linked to the National Health Service and provides terminal hospital care or support services for home care. The hospice movement stresses indi-

vidualized medical and nursing care with the aim to reduce the pain and discomfort of dying patients to a minimum while allowing the families to participate actively in this care.¹³ Hospices have been developed in many communities of this country during the last ten years and today present a real alternative to institutionalized dying for many terminally ill patients.

Impact of Death on the Family

Dying and death of a family member impose intense and disruptive stresses on the family, which adapts to the impending and actual loss by some kind of internal reorganization. In many instances the ongoing sense of family itself is threatened, and the family's structure, function, and identity may be quite different after the death. This is particularly true in a small nuclear family, which is more vulnerable to these stresses and is potentially more dysfunctional than an extended kindred type of family.¹⁴ The outcome of family reorganization after the death of a family member is highly variable and depends on many factors, including the level of family function before the fatal illness or accident and the extent to which the surviving family has been able to cope with adaptive tasks to meet the family members' new needs.

The individual family members involved with the care of a dying family member inevitably undergo role changes as the dying patient becomes increasingly dependent. The dependency of the dying patient may itself often create conflict within the family, especially when the patient has been largely responsible for the economic support of the family. As Barton¹⁴ has pointed out in his excellent chapter on the family of the dying person:

The sometimes unconscious decision that a spouse is to "train" for independence in the anticipated absence of his or her mate can lead to a disruption of long-established patterns of relating. Competitive conflicts are often activated as the freedom, mobility, and control of the emerging independent spouse becomes a source of resentment for the ill person. The lowered self-esteem and anger of the person who must become dependent becomes subtly and sometimes blatantly involved in the relationship within the family.

The pressures of current activities and responsibilities of other family members, their uncertainty

about the future of a changing family, their grief over the impending loss, and their increasing fatigue due to the time requirements of care of the dying patient together represent cumulative stresses for the family. These stresses are often further heightened by a sense of guilt if there is any perception that the dying patient's medical problems were potentially avoidable, and all feelings are sensitized by the various family members' individual past relationships with the dying patient.

The death of a child involves some predictable and potentially preventable problems for the parents and siblings. Guilt is a problem for the parents, since they will inevitably wonder whether they were in any way responsible for their child's illness or accident. Denial of the diagnosis is common, sometimes to the extreme situation of "the isolated wife syndrome," when the father denies the child's illness to the extent that he will not talk to the mother about it at all.¹⁵ The parents may feel by accepting a fatal diagnosis they are condemning their child to death, and may project their anger on the physician who conveys this diagnosis.¹⁶

The death of a newborn causes more stress and grief within the family than is often recognized. Parents, especially mothers, develop strong attachments to their babies during pregnancy and usually experience classic grief reactions after neonatal death.¹⁷ Guilt is a common problem, and some mothers may even fantasize the cause of death in such terms as a fall, not taking iron pills, not keeping prenatal appointments, or coitus during pregnancy.¹⁸ The sudden infant death syndrome, involving about 10,000 babies in the United States each year, may cause especially severe emotional reactions in the parents, aggravated by the sudden, unexpected, and unexplained nature of death. These parents often feel anger, helplessness, loss of the meaning of life, and fear for the safety of their other children.¹⁶ The resultant stress on the parents is often intense, and the divorce rate is high among couples experiencing such a loss.

In addition to the painful stresses on the family during the dying and death of a family member, there are serious implications for morbidity and mortality of the surviving family members during the subsequent grieving process. Various studies in the 1960s showed striking mortality and morbidity rates in surviving spouses compared with

expected rates in the general population, including a 40-percent increase in mortality in the first year of bereavement (usually from coronary thrombosis^{19,20}) and a 2.5 times increased risk of suicide.²¹ In a recent large prospective study of over 4,000 widowed people and an equal number of married people matched for race, sex, age, and geography of residence, it was found that widowed men in all age groups experienced higher mortality than the married man.²² Clayton²³ has observed that compared with nongrieving individuals, grieving individuals during the bereavement period seek more medical attention for anxiety, depression, headaches, insomnia, and related (often somatized) complaints. On an immunological level, some recent studies have shown decreases in several parameters of the immune system after loss of a family member.²⁴

Parkes,²⁵ who has studied the outcomes of grieving for many years, has identified the following risk factors associated with pathologic grief (defined as continued severe grieving beyond 13 months):

1. Unexpected or untimely death
2. Griever who is young
3. Griever with poor reaction to separation in the past or depressive illness
4. Griever who did not grieve openly
5. Griever who had additional stresses such as loss of income or difficulty with the children

With regard to normal grieving, Parkes²⁶ and Lindemann²⁷ have described a range of common symptoms and behaviors, including initial numbness, disbelief, yearning, internal loss of self, restlessness, guilt, anger, anxiety, hallucinations of the deceased, and adopting the deceased's habits or symptoms. In most instances, uncomplicated grief lasts less than six months, is minimally disruptive to normal activities, and rarely requires psychiatric assistance.²⁸

Management

The family physician, who in many cases has a longstanding relationship with the family over a period of years, can and should render invaluable care for the family dealing with a dying patient. Based on knowledge of the family and past relationships with family members, the family physician is in a good position to understand and

anticipate family reactions to this crisis and to facilitate communication and a normal grief process within the family. The family physician can play an active role in care of the family in preterminal, terminal, and follow-up phases, individualized in each case to the unique needs of the dying patient and his or her family.

Preterminal Care

It is often the family physician who must initially talk with the patient about his or her life-threatening disease. For a variety of reasons there may be some pressure not to tell the dying patient the full nature of the illness or the likely prognosis. In one study, for example, 88 percent of physicians tended not to tell their patients of a terminal cancer diagnosis.²⁹ Sometimes family members will want to protect the patient from the diagnosis, in some cases fearing resultant depression and possible suicide. Withholding of such information, however, is not fair to the patient and establishes a dysfunctional "secret" alliance within the family. Moreover, studies have shown that cancer patients almost always want to be told,^{30,31} and most dying patients, even if not told, become aware of their diagnosis. As Veatch points out, ". . . truth-telling and self-determination are simply the inherent right of the patient, independent of whether the consequences are good or bad."³²

It is helpful to talk openly and candidly with the patient and the family about the diagnosis, likely course, and prognosis. At the same time, hope must be preserved for the patient as alternatives of treatment are discussed. One needs to be sensitive to the patient's desires about the extent of detail wanted. Close follow-up with the patient and family is then important, since further questions and anxieties often arise after the initial conversation.

Full discussion and informed consent are essential to selection of further diagnostic or therapeutic interventions so that they match the patient's needs and desires. The family physician can often play a key role in coordinating consultations, clarifying consultants' findings and recommendations, and serving as the patient's advocate should consultants disagree about treatment.

During follow-up visits as care of the terminal illness and other medical problems proceeds, other subjects should be gently raised when the

patient and family seem ready. The most common fears that dying patients express are pain and abandonment.^{33,34} These issues can often be addressed as treatment options are discussed. In this context it is useful to discuss the options for location and type of terminal care (ie, hospital vs home care, with or without hospice support, "curative" vs "carative" care). The advantages and limitations of a living will should be discussed (Appendix). A tactful way of introducing this subject is to say, "There may come a time when you become too ill to communicate with us about your medical care; are there any specific instructions you might want us to follow at such a time?"³⁵ Other subjects that may be discussed during the preterminal phase include the patient's desires concerning autopsy and organ donations as well as plans for family and business affairs, including a will.³⁶ One recent study showed that almost two thirds of patients in one family practice do not have wills and that only one in ten would not be pleased to have the physician inquire about the status of a will.³⁷

It is worth noting that some life-threatening diseases, such as coronary heart disease, often involve sudden death or a relatively short trajectory of dying. Freeman and his colleagues³⁶ found that physicians tend to neglect the above issues in patients with possible short dying trajectories, whereas they discuss these issues with patients with relatively long dying trajectories (eg, those with cancer or other advanced chronic disease). Such an approach will often deny patients with short dying trajectories the benefits of adequate personal and family preparation for the death.

Terminal Care

Perhaps the most important single management decision having a major influence on the nature and process of terminal care is the choice of setting for this care. Several options are available, including hospital, nursing home, and home care; hospice support is available in various forms in a growing number of communities. The desires of the patient and family in this choice should be weighed heavily and balanced with a realistic assessment of what can be done for the patient's illness and relief of symptoms in each setting. Dying patients have five basic requirements: (1) independence, (2) dignity, (3) acceptance by

others of an individual approach to dying, (4) relief of symptoms, and (5) physical care.³⁸ Home care offers many advantages if "carative" instead of "curative" care has been decided upon and if other family members are able to take on the burdens of care. In many instances hospice care, visiting nurse services, or other support services can be mobilized to help provide terminal care at home. In one recent study of the desires of patients with cancer, one half of the patients and one half of their family members selected the home as the location of terminal care.³⁹ Home care allows active participation by the family in personal and individualized terminal care of the dying patient, facilitates early grief work with the possibility of decreased morbidity of surviving family members later, and avoids the discomfort and costs of more technologic hospital care. One recent study of the billed charges for the last two weeks of care of terminally ill patients with cancer showed that the cost of such care was more than ten times greater for patients in a hospital than at home, and that diagnostic and therapeutic interventions were continued until the day of death for almost all inpatients.⁴⁰

Control of pain is usually the highest priority expressed by dying patients and their families regardless of where their care takes place. Some patients with severe intractable pain may be candidates for radiation therapy or a nerve block procedure. In most instances, however, a well-designed program of pain medication is effective. With careful attention to the details of analgesia, excellent pain relief can be provided regardless of setting. The most common error leading to inadequate analgesia is the failure to use high enough doses of the appropriate analgesic with sufficient frequency. It should be possible to provide a full night's sleep without pain and to also provide complete pain relief at rest in bed or in a chair during the day. If pain relief cannot be obtained with nonnarcotic or weak narcotic drugs such as codeine, oral morphine or methadone in aqueous solution is the next logical step. Using similar dosages morphine and methadone are equivalent in potency, but methadone has the advantages of improved absorption orally and longer duration of action (a half-life of 10 to 18 hours compared with 5 hours for morphine).⁴¹ If the patient complains of continuous pain, analgesia should be given on a regular basis (every four hours for morphine or

every six hours for methadone) and the first dose (usually 5 to 10 mg initially) should be increased by 50 percent at each subsequent dose until the pain is controlled. The bedtime dose may be increased up to double the usual dose and combined with a sedative as well, if necessary. Most patients with severe continuous pain become pain-free with doses of between 10 and 30 mg of morphine or methadone every four to six hours, respectively, although some will require more. Drowsiness may be experienced with early doses but clears for many patients when the dose has stabilized.⁴²

Some kinds of pain may require adjuvant medication in addition to a narcotic analgesic. A non-steroidal anti-inflammatory drug is often helpful for bone pain; a corticosteroid may be useful for nerve compression pain or soft-tissue swelling or infiltration, and a muscle relaxant such as diazepam (Valium) may be used for muscle spasm. Hydroxyzine (Vistaril) or promethazine (Phenergan) may also be helpful to relieve anxiety associated with pain. Either may potentiate the effects of narcotics and may be used with morphine or methadone in a "pain cocktail" (eg, methadone and hydroxyzine in 1/4-strength cherry syrup, 10 mL every six hours). The dosage of each should be individualized to provide adequate analgesia without undue drowsiness.

Nausea, which may result from the use of morphine and methadone or from the underlying disease, may be treated with an antiemetic such as prochlorperazine (Compazine). Most patients requiring regular doses of morphine become constipated. This may be treated with a stool softener (eg, docusate sodium—Colace), and if necessary bisacodyl (Dulcolax) suppositories may be used in addition two or three times per week.⁴² If the patient is unable to clear secretions and appears to be within 48 hours of death, 0.4 mg of atropine every 8 hours is effective in drying secretions.⁴³

One needs to be alert to the possibility of depression complicating terminal illness. The incidence of depression in patients with cancer, for example, was found to be 37 percent in one study of randomly selected patients seen in radiotherapy,⁴⁴ whereas 75 percent of patients admitted to an oncology research unit in another study were depressed.⁴⁵ An underlying organic basis for symptoms of depression should be considered (eg, hypokalemia, hypercalcemia, hypoglycemia, hypothyroidism, hypoxia, drug-induced mental sta-

tus changes) and consideration should also be given to contributing psychosocial factors (eg, isolation, alienation from family or friends). Severe depression that cannot be resolved by correction of underlying medical or psychosocial problems may be treated with an antidepressant. Considerable success has been reported, for example, with the use of tricyclic antidepressants for depression associated with advanced cancer, especially in reducing such symptoms as sleeplessness, crying spells, and withdrawal while helping the patient to relate more easily with other family members and friends.⁴⁶

Regular visits by the physician are important in supporting the patient and family and in assuring that symptom control is maximally effective. It has often been shown that physicians tend to shorten their visits and increasingly avoid the dying patient the closer the patient gets to death.² Instead, unhurried visits are essential, involving physical closeness (ie, sitting on the patient's bed, touching), empathy, active listening, and genuine concern expressed through such open-ended questions as "Well, Mrs. Smith, what's on your mind today?"⁴⁷ The physician needs to support as best he can the dignity and autonomy of the dying patient in a setting in which death may be as individual in character as in life itself.⁴⁸ Near and at the end, farewells are of therapeutic value, whether explicit or nonverbal and implicit.⁴⁹

There is growing evidence that, in many cases, the funeral may serve as a positive experience for the surviving family members. The funeral ceremony provides the bereaved with some comfort that others are also involved in mourning, facilitates the grieving process, and recognizes the integral worth and dignity of the life that has been lived.^{50,51}

Follow-Up Care

In view of the known increased prevalence of morbidity and even mortality in surviving family members after the death of an individual, it is essential to see the spouse or other appropriate family members at periodic intervals thereafter. Freeman and his colleagues consider that post-death care requires a minimum of two contacts with the deceased patient's family, the first between 1 and 3 months and the second at 6 to 24

Table 1. Symptoms and Behaviors of Unresolved Grief*

1. A depressive syndrome of varying degree of severity beginning with the death
2. A history of delayed or prolonged grief
3. Symptoms of guilt, self-reproach, panic attacks, and somatic expressions of fear such as choking sensations and breathing attacks
4. Somatic symptoms representing identification with the dead person, often the symptoms of the terminal illness
5. Physical distress under the upper half of the sternum accompanied by expressions such as "There is something stuck inside," or "I feel there is a demon inside of me"
6. Searching behavior
7. Recurrence of depressive symptoms and searching behavior on specific dates, such as anniversaries of the death, birthdays of the deceased, and holidays, especially Christmas
8. A feeling that the death occurred yesterday, even though the loss took place months or years ago
9. Unwillingness to move the material possessions of the deceased
10. Change in relationships following the death
11. Diminished participation in religious and ritual activities
12. The inability to discuss the deceased without crying or the voice cracking, particularly when the death occurred over one year before the interview
13. Themes of loss

*From Lazare²⁸

months.³⁶ At the first follow-up visit the family support system and grieving should be discussed, including clarification of any questions that may have come up since the death. At the second visit discussion areas may include the impact of the death on other family members, sex, and remarriage. The status of grieving should be carefully assessed and consideration given to the possibility of clinical depression.

The differential diagnosis between normal grieving and depression is a challenging one, since the symptoms are quite similar. In both instances, these symptoms include feelings of sadness, crying, narrowed interests, illusionary experiences and dreams, and disturbed sleep. In grief, these symptoms tend to come and go. In depression, however, there is a persistent quality to these symptoms, which may also be associated with suicidal ideation.⁵² Table 1 lists a number of symptoms and behaviors that may be found in unresolved grief.²⁸

Time-limited follow-up visits for supportive psychotherapy, with or without an antidepressant,

may be indicated for depression. Somatization complaints, panic disorder, or chronic pain complaints in the bereavement period may be effectively alleviated by the early use of tricyclic antidepressants.⁵³ In some cases an extended pathologic grief reaction with severe dissociative, behavioral, or psychiatric symptoms will require referral for more intensive psychotherapy and even hospitalization.⁵⁴ In any event, counseling during the bereavement process involves ventilation and support of the grieving family member in an effort to work through the grief period to a point where the surviving family is actively engaged with the next stage of their lives. Grief work involves three basic elements: catharsis, reconstruction, and reintegration. For the average adult, it takes between 18 and 24 months before this process is complete.⁵⁵ It is useful to inquire into details of the death or recollections of the lost family member to facilitate the process of catharsis. Visits to the cemetery may be encouraged as well as talking about the loss with friends.²⁸

By way of summary, Table 2 presents a variety

Table 2. Stage-Related Considerations in the Care of the Dying Family Member

Stage	Consideration
Preterminal Care	<p>Communication with patient and family concerning: Diagnosis, treatment options, prognosis Directive to physician; living will Personal and family preparations for death Desires concerning autopsy, organ donor programs Desired setting for terminal care</p> <p>Diagnostic and therapeutic interventions as desired and indicated</p> <p>Regular physician visits</p>
Terminal Care	<p>Location of terminal care "Carative" vs "curative" care "No code" if in hospital Family support system Social service, nursing, hospice support services Control of symptoms (pain, nausea, constipation, depression, etc) Regular physician visits: empathy, active listening, touch, support Facilitation of farewells Autopsy, if desired Viewing of body; funeral arrangements</p>
Follow-Up Care	<p>Initial family support after death: sedation, clarification of autopsy findings, assess status of surviving family members</p> <p>Later visit(s) to assess extent and resolution of grief reaction, identify and treat depression, and discuss other issues (eg, family planning, sex, remarriage)</p>

of considerations to be addressed in preterminal, terminal, and follow-up care.

Child and Neonatal Death

The same general principles relating to dying adult patients also apply to the dying child and newborn, but some additional comments should be made in the case of children and infants.

In the case of a child with terminal illness, open communication is usually helpful. Many children four years of age and older are quite aware when they have a serious illness. Although some will deny the disease, many will want to discuss it in

some manner and many feel isolated and lonely if not given that opportunity.¹⁶

Separation anxiety in particular needs to be dealt with in the care of the dying child. The child especially fears separation from loved ones and should be assured that he will not be alone. After the death, siblings more than six years of age should be encouraged to go to the funeral, since this is often preferable to fantasies that may otherwise develop concerning the death.¹⁶

In the case of neonatal death, it has been found that friends and relatives are often not supportive of families experiencing such a loss because they perceive the baby as replaceable and its loss as causing little need for grief.⁵⁶ In this instance,

viewing and touching the dead infant helps the mother to cope without fantasizing with the reality of death.¹⁷ The cause of death should be explained clearly to the parents and repeated as needed. Autopsy findings are frequently helpful in defusing the guilt that the parents may feel. Breast care is important, and breast binding, ice compresses, and analgesia are usually sufficient. For more painful breast engorgement, bromocriptine mesylate (Parlodel) is effective. Early discharge from the hospital should also be considered.¹⁸

After death of an infant, the parents often experience an intense grief reaction. Parent support groups may be quite helpful for parents losing a child through the sudden infant death syndrome. Family planning is important for at least 9 to 12 months to avoid the replacement child syndrome,⁵⁷ but discussion of tubal ligation, if it had been contemplated, should be deferred until the grief reaction has resolved.¹⁸ A follow-up meeting with the parents is advisable one week after the infant's death, with a second follow-up visit three to six months later to assess the resolution of grief reaction and to offer whatever supportive care might be needed at that time.⁴⁹

References

- Netsky MG: Dying in a system of "good care": Case report and analysis. *Conn Med* 41(1):33, 1977
- Bok S: Euthanasia and the care of the dying. *Bioscience* 23:413, 1973
- Krant M: The other dimensions of death. *Prism* 1:54, 1973
- Keene B: The Natural Death Act: A well-baby check-up on its first birthday. *Ann NY Acad Sci* 315:376, 1978
- Kass L: Man's right to die. *Pharos* 35:73, 1972
- Bok S: Personal directions at the end of life. *N Engl J Med* 295:367, 1976
- Natural Death Act, Washington Laws of 1979, chapter 112. Olympia, Wash
- Erikson v Dilgard*, 44 Misc 2d 27,252 New York State 2d 705 (1962)
- In Re Brook's Estate*, 32 Illinois 2d 361, 205 NE 2d (1965)
- In Re Raasch*, No 455;996 (Prob Div, Milwaukee County Ct, January 21, 1972)
- Natanson v Kline*, 186 Kan, 406-7, 350 P2d, 1104
- Gibson J, Derbyshire RC, Heffron WA, et al: Right to die: A medical, moral, or legal decision. *J Fam Pract* 7:1047, 1978
- Saunders C: Hospice care. *Am J Med* 65:726, 1978
- Barton D: The family of the dying person. In Barton D (ed): *Dying and Death: A Clinical Guide for Caregivers*. Baltimore, Williams & Wilkins, 1977, p 59
- Lascari AD: *Leukemia in Childhood*. Springfield, Ill, Charles C Thomas, 1973
- Lascari AD: The dying child and the family. *J Fam Pract* 6:1279, 1978
- Adolf A, Patt R: Neonatal death: The family is the patient. *J Fam Pract* 10:317, 1980
- Gilson GJ: Care of the family who has lost a newborn. *Postgrad Med* 60:67, 1976
- Young M, Benjamin B, Wallis C: Mortality of widowers. *Lancet* 2:454, 1963
- Parkes CM, Benjamin B, Fitzgerald RG: Broken heart: A statistical study of increased mortality among widowers. *Br Med J* 1:740, 1969
- McMahon B, Pugh TF: Suicide in the widowed. *Am J Epidemiol* 81:23, 1965
- Helsing KJ, Syklo M: Mortality after bereavement. *Am J Epidemiol* 114:41, 1981
- Clayton PJ: The clinical morbidity of the first year of bereavement: A review. *Compr Psychiatry* 14:151, 1973
- Lock SE: Stress, adaptation and immunity: Studies in humans. *Gen Hosp Psychiatry* 4:49, 1982
- Parkes CM: *Bereavement: Studies of Grief in Adult Life*. New York, International Universities Press, 1972
- Parkes CM: The first year of bereavement: A longitudinal study of the reaction of London widows to the death of their husbands. *Psychiatry* 33:444, 1971
- Lindemann E: The symptomatology and management of acute grief. *Am J Psychiatry* 101:141, 1944
- Lazare A: Unresolved grief. In Lazare E (ed): *Outpatient Psychiatry: Diagnosis and Treatment*. Baltimore, Williams & Wilkins, 1979, p 498
- Oken D: What to tell cancer patients: A study of medical attitudes. *JAMA* 175:1120, 1961
- Samp RJ, Curreri AR: A questionnaire survey on public cancer education obtained from cancer patients and their families. *Cancer* 10:382, 1957
- Branch CH: Psychiatric aspects of malignant disease. *CA* 6:102, 1956
- Veatch RM: Caring for the dying person—Ethical issues at stake. In Barton D (ed): *Dying and Death: A Clinical Guide for Caregivers*. Baltimore, Williams & Wilkins, 1977, p 150
- Dunphy JE: On caring for the patient with cancer, annual discourse. *N Engl J Med* 295:313, 1976
- Cassen NH, Stewart RS: Management and care of the dying patient. *J Psychiatry* 6:293, 1975
- Levenson SA, List ND, Zaw-Win B: Ethical considerations in critical and terminal illness in the elderly. *J Am Geriatr Soc* 29:563, 1981
- Freeman WL, Altice P, Betton HB, et al: Care of the dying patient. *J Fam Pract* 3:547, 1976
- Maier MP Jr: Patient attitudes toward physician inquiry about will status. *J Fam Pract* 12:139, 1981
- Gates GR: Terminal care in country practice. *Aust Fam Physician* 11:338, 1982
- Putnam ST, McDonald MM, Miller MM, et al: Home as a place to die. *Am J Nurs* August 1980, p 1451
- Bloom BS, Kissick PD: Home and hospital cost of terminal illness. *Med Care* 18:560, 1980
- Bergman JJ, Werblun MN: Chronic pain: A review for the family physician. *J Fam Pract* 7:685, 1978
- Narcotic analgesics in terminal cancer. *Drug Ther Bull* 18:69, 1980
- Paige RL, Looney JF: Hospice care for the adult. *Am J Nurs*, Nov 1977, p 1812
- Peck A: Emotional reactions to having cancer. *J Roentgenol Radium Ther Nucl Med* 114:591, 1972
- Craig TJ, Abeloff MD: Psychiatric symptomatology among hospitalized cancer patients. *Am J Psychiatry* 131:1323, 1974
- Goldberg RJ: Management of depression in the patient with advanced cancer. *JAMA* 246:373, 1981
- Flexner JM: Dying, death, and the "front-line" physician. In Barton D (ed): *Dying and Death: A Clinical Guide for Caregivers*. Baltimore, Williams & Wilkins, 1977, p 170
- Carson RA: A death of one's own. *Postgrad Med* 65:197, 1979
- Meares RA: On saying goodbye before death. *JAMA* 246:1227, 1981
- Glick IO, Weiss RS, Parkes CM: *The first year of bereavement*. New York, John Wiley & Sons, 1974, p 97
- Fulton R: Death and the funeral in contemporary society. In Wass H (ed): *Dying: Facing the Facts*. New York,

Hemisphere, 1979, p 236

52. Shanfield SB: Illness and bereavement: Unrecognized implications for prevention. *Ariz Med* 38:444, 1981

53. Katon W: Depression: Somatic symptoms and medical disorders in primary care. *Compr Psychiatry* 23:274, 1982

54. Stack JM: Grief reactions and depression in family practice: Differential diagnosis and treatment. *J Fam Pract* 14:271, 1982

55. Davidson GW: Hospice care of the dying. In Wass H (ed): *Dying: Facing the Facts*. New York, Hemisphere, 1979, p 158

56. Helmrath TA, Steinitz EM: Death of an infant: Society fails parents. Presented abstracted at the meeting of the American Pediatric Society and the Society for Pediatric Research, St. Louis, April 28, 1976

57. Sahu S: Coping with perinatal death. *J Reprod Med* 26:129, 1981

Appendix

Directive to Physicians

Directive made this _____ day of _____ (month, year).

I _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences from such refusal.

(c) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force of effect during the course of my pregnancy.

(d) I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____

Social Security Number or Birthdate _____

Street Address _____

City, County, and State of Residence _____

Witness

This directive must be signed by two witnesses. The following persons *may not* serve as witnesses: (a) anyone related to the declarer by blood or marriage, (b) anyone entitled to a part of the declarer's estate, by will or otherwise, (3) anyone with a claim against the declarer's estate, (d) the declarer's attending physician, or any of the physician's employees, (e) the employee of a health facility (hospital or nursing home) in which the declarer is a patient.

The declarer has been personally known to me and I believe him or her to be of sound mind.

Witness _____

Witness _____

Witness _____

Witness _____

This directive complies with the Natural Death Act, chapter 112, Washington Laws of 1979. However, additional specific directions may be included by the declarer.