

**ROYAL AUSTRALASIAN COLLEGE OF SURGEONS**

**GRAHAM COUPLAND MEMORIAL LECTURE 2007**

AUGUST 18th

**A TRIBUTE: SURGEONS' REFLECTIONS ON  
DYING, DEATH AND BEREAVEMENT**

PREPARED BY PETER COUPLAND

Mr Chairman, distinguished guests and members of the NSW Division of the Australasian College of Surgeons, ladies and gentlemen. It is with great pride that I present the 25<sup>th</sup> Graham Coupland Memorial Lecture.

In preparing for today, I spoke at length with 22 surgeons over the course of the past 6 months. You told me about your memories of my father; what he was like as a surgeon and what he was like as a man. On my request, you also told me of your experiences with dying, death and bereavement. You offered your time out of deep respect for Graham and I feel privileged to have learnt from your experiences. Thank you for your generosity. Building on your thoughts, plus some of my own, the following includes some reflections on Graham's life and also your experience of dying, death and bereavement. I combine these 2 themes as a tribute to my father.

I speak on behalf of many in saying that my preference is that there was no need for this Memorial Lecture and rather, Graham Coupland could be standing here delivering to you what would be reflections on 45 years of an outstanding and distinguished surgical career. From what many of you told me, he would have much to say; he would be excited about the many surgical advances that have occurred over the past 25 years; he would be fascinated with the advances in technology and the benefits of electronic communication; he was handy with a camera and the slide projector so he would love what is possible through modern media and digital photography. He would lament changes to the things he was most attached to and he would probably give you an ear full of the 'good-old-days'.

He would share his despair at some of the challenges you all currently face, particularly those of poor access to decision making and the frustrations of administration, bureaucracy and the political process but despite this, he would probably be active in the debate regarding access, fairness and quality issues created by the widening gap between the public and private systems. He would be horrified to see how run down some medical services have become particularly the changes at Royal North Shore Hospital, and he would be concerned with the conditions some of you work in.

Although there would have been many at both clinical and leadership levels, he would minimise his achievements and highlight those of his peers, his contemporaries and above all his students. He would acknowledge the critical role of the nursing staff and would pay tribute to those who worked closely with him at clinical, administration and research levels. Some people I remember well are Sistersø Jo Lannon and Annie Larkins, and also his administration assistants Marie Dwyer and Terri Fisk.

Although a private domain for him, he would express his gratitude and appreciation for the hard work that fell to his wife, Robyn Coupland, to raise our large family, run the house, maintain records and accounts for his practice and provide the love, support and tolerance that enabled him to work in the way he did. Her support was never taken for granted. In mentioning this, he would be implicitly acknowledging the support you all receive that enables you to achieve in your careers.

He probably would have challenged you on many dimensions too: such as the fees some of you charge, the inflexibility and isolation created through surgical specialisation and he would push and prod individuals and the College where he perceived there to be any complacency or laziness. Like most of you, he would be dismayed and angry where patients suffered due to incompetence and to make his point, where required, I imagine he would do the current day version of wrapping the relevant few over the knuckles.

Finally, he would comment on the critical role mentors play in ones surgical career and in so doing, he would acknowledge and pay respect to his mentors in particular Professor John Lowenthal, Professor Lewie Lowenthal, Dr Harry Cumberland and his close mentor and ultimately friend Emeritus Professor Tom Reeve.

At the end of his talk, he would embrace your friendship and share a few laughs around the table. Here I imagine, he would boast about his wonderful grandchildren and tell stories about his love of the land and the ups and downs of his farming exploits. Having built up the courage over the years, some of you might even take the opportunity to tease him about his fashion sense, particularly the legendary

shorts and other nuances of his personality that you grew fond of. He would probably then duck off to the hospital to see patients, because, like most of you, he would not understand what retirement means. Finally he would head home to spend time with his family and probably do some gardening. For those of you who did not know him, that is what he was like.

However, his untimely death at 47, cut short his life and his career and in an effort to remember his contribution to surgery plus remind yourselves of his values, his role modelling qualities and his friendship, the College pays tribute to Graham Coupland through this lecture. It honours his legacy and in a way, soothes some of the pain of his absence.

In your words, Graham Coupland was a gifted surgeon and a leader. Some suggest the complete surgeon. You told me that from early in his career he was technically sound at general and specialist levels ó a talented anatomist, a dedicated paediatrician and an innovative vascular surgeon. Amongst many achievements, he did important work in the prevention of pulmonary embolism and the treatment of peptic ulcer. In all his surgery and patient care, he believed in team work and this was evidenced by his weekly meetings with all health practitioners on his ward where, each patient was discussed in detail.

Graham was a dedicated teacher where he found the time to help students over minor and major hurdles. You told me that ward rounds were a work out in many ways: from the physical where he moved quickly up and down countless flights of stairs; to the intellectual where you needed to be on your toes to discuss the condition and treatment plans for anything up to 40 patients each round. He was tough and demanding as he expected the best possible care for each patient. Although his method could be politically incorrect and his bluntness could be intimidating, many of you are grateful for the particular attention he gave throughout your training and for the pivotal role he played in your development as a surgeon. Some of you continue to monitor your performance through the standards he set and therein, pass on this ethic to those you now train.

As you know better than I, he was a committed researcher and prolific writer. Consequently, his reputation extended beyond Australia and he was increasingly sought after for international symposia, training and leadership roles. In these and all his undertakings he was an uncompromising task master, an efficient administrator and communicator, a committed and loyal colleague, a team player and for a few, a deeply trusted and valued friend. He was a student of the old school and like his teachers; he could be calculating, stern, intimidating and blunt. Apparently, beneath that outer layer, he could be quite funny, and it seems, as well as being shy he was a very warm- centred man. These traits endeared many of you and many of his patients to him.

Of course, all of these qualities and characteristics came together in the Operating Theatre, he loved surgery, it was his craft and he was a master. More than one person was needed to cover his load after he died. Quite what he was to go on to do and how he would have coped with the changes that you all have to live with day-in-day out, we don't know. What we can assume is if he remained on the same career trajectory, his contribution would have continued to be significant.

As his son, although vaguely aware that he was like some of these things, I knew him as a great provider to our family, an energetic and tireless worker and a dedicated husband to his wife. To me he was often tough, where trying your hardest was the base level expectation and meeting this could be very challenging. He was a very efficient disciplinarian, that is, he only had to look at me once to know that I was on very shaky ground. The rub for me, for Mum and my sisters, was he was not around that much. We still find this hard to reconcile.

However, despite this, the enduring lessons I have from his life are that he introduced me to the land, a passion he felt that has been passed onto every cell of my body. And, secondly, in his way, he introduced me to the care of others a value I now express through one of my professional roles as a Bereavement Counsellor.

So today, on this 25<sup>th</sup> lecture, because of his achievements and influence in life and the impact of his death, you get me, Graham's son, part of whom is a boy holding fond memories of a privileged and happy childhood; part of whom is a 16 year old

teenager shattered by the death of his father who rebelled against just about anything that moved; part of whom is a young man who took many risks in an effort to explore and make sense of the world around him, to find meaning, purpose and direction; and now, a man very content in my various family and professional roles.

All of whom stands here today to express my personal view that a rich and full life is not one that is not oblivious to dying and death, or avoids the realities of bereavement; rather, a rich life is one that feels, understands and integrates the pain and despair of loss into a life full of adventure, purpose, passion, love and most importantly, relationship with others.

With this view having become clear in the last few years, it has been a source of curiosity as to what my father would have to say about the subject of dying, death and bereavement. It is this topic that I have chosen to talk about today.

## **Surgeons' reflections on dying, death and bereavement**

As I mentioned earlier, to understand your experiences and challenges related to dying, death and bereavement, over the course of the past 6 months I interviewed 22 surgeons each of whom were at different stages of their career and from different fields of surgery. Although it is not possible to cover all of what you told me a number of themes emerged and these fall under the following headings:

1. Exposure to death
2. Circumstances of death and surgeons reactions
3. Emotional impact
4. Challenges
5. Coping strategies

After describing key points raised under each of these themes, I will provide some input from the bereavement counselling point of view and then close with a few summary thoughts.

### 1. Exposure to Death

Surgeons are exposed to a wide range of deaths from emergency situations to those occurring during palliation. The type of surgery you undertake determines your exposure and this ranges from very infrequent such as early intervention or minor procedures to frequent in the case of major traumas or critically ill patients. Over the course of your careers, actual numbers of deaths you are directly exposed to range from less than 30 to more than 300.

For many, their first experience of coming face-to-face with death was in the anatomy lab or on your first block as a med student. Some of you, but not many, had personal experience prior to this event. Some of you told me that your first encounter with a patient who died corresponded with you having to give the news of this death to the patient's family. A practice you said was most inappropriate.

It seems that the more experience you have with death the more prepared and resilient you are in dealing with the various challenges that follow, such as communication with family. Many of you indicated that you build up a tolerance to the emotional effect of this exposure but you were clear in saying that if tolerance ever becomes indifference then you should stop doing what you are doing. Additionally, those of you who have suffered personal loss through death or chronic illness report that you are more able to combine tolerance and resilience with understanding, empathy and compassion. For some this was an important ingredient in your ability to cope with the various challenges inherent in your role.

## 2. Circumstances of death and surgeons reactions

You indicated, that from a surgeon's point of view, not all deaths are equally confronting but rather, depending on the circumstances, your reactions differ in relations to a subjective scale that ranges from low level to high level confrontation.

The least confronting of circumstances is where death is anticipated or inevitable and where the patient has lived a relatively long life. This is particularly the case where the surgeon has the chance to consider or try treatment options, including the no treatment option. For some of you, an important part of this situation is having the opportunity to discuss issues with family members. Important elements of this situation include: good communication, effective teamwork, time to consider options and where appropriate, quality palliation.

More confronting are unexpected deaths and emergency situations such as the acute unwell, trauma, heart failure, malignancy, congenital abnormalities and complications in surgery. Confrontation is higher when the person is young, even worse when death occurs in childhood. It hits harder when you have established rapport and trust with a patient, when you have to go to know them and their families; particularly when you genuinely believed that death, although possible, was not likely. The extent of confrontation varies depending on the degree to which you have had time to consider options, talk with peers and to the patient and their family. All this varies depending on the abruptness of death.



However, the most confronting of circumstances, at both professional and emotional levels, are deaths where you question if there was more you might have done, something different you might have done, or something that you might not have done. That is where death may have resulted from your action, or inaction. This was explained to me in several ways, either as an act of omission, commission, or lack of initiation or the result of an overall failure of the system to provide adequate patient care. Included in this group are patients who suicide because they do not want to live with the drastic changes that have occurred in their lives as a result of illness or consequences of surgery. Many of you reported the sense of failure when you are not able to save a life, where despite all your experience, there is nothing more you can do.

### 3. Emotional reactions

You said that on a case by case basis surgeons are generally well placed to cope with the emotional effects related to dying, death and bereavement. You are trained to be objective and rationale, you are natural decision makers, you see yourselves as reasonably tough and you are professionals with a defined role to perform ó that is to treat illness and to save lives. On most days, despite what happens, you have the ability to accept the situation, to adjust your bearings and to get on with the task at hand.

However, each surgeon interviewed recounted the details of at least one patient death that has had a profound and formative effect on their attitude and experience with dying and death. For many of you, even if it occurred over 20 years ago, the experience is burnt into your memory and for some these experiences resurface from time to time in both positive and negative ways. Sometimes your recollections are useful in that they guide learning and improvement; sometimes they are perplexing, worrisome and distracting.

At an emotional level, most of you indicated that over time things can build up. The inevitable stressors and responsibilities of your role and your busy lives can collide in a way that adds significant pressure to your already full load. It is at these times where a significant death causes the surgeon to do more than pause to recollect

their bearings. As mentioned before, the impact is greater when it is personal with the death of a either family or friend being the most difficult to cope with. For some of you, the combined effect of these things has lead to various degrees of shock, fear, rumination, lack of concentration and disorientation.

At these times, you do not question the wisdom of returning to work, rather, most of you seem to dig deep and work even harder and longer hours, some of you find solace in your interests, hobbies or addictions, a couple of you talk to your partners and very rarely, you talk to each other.

One description of the cumulative impact of this type of exposure was that you experience a type of "creeping paralysis" which is characterised by emotional withdrawal. This pattern influences you all in different ways, in some cases; it affects the choices you make regarding surgical procedures. It can also factor in your decision as to when you stop practicing surgery, or at least, some forms of surgery.

#### 4. Challenges

In meeting the responsibilities of your role as a surgeon with respect to this topic, you identified six key challenges. Three are challenges experienced at the individual level, the other three relate to systemic and organisational level challenges.

1. The first challenge you described was regarding the need for, and complexity of, communication. This was at professional, peer, team, patient and family levels. With respect to patients and families, you said that an honest appraisal of the situation using non-technical language is required and you seem to vary somewhat with your use of optimism and hope. You said, some of you are skilled communicators and some of you are not. Some of you are able to be present in other peoples' distress and pain and whilst many of you limit your exposure as much as possible. Some of you take responsibility for communication and are actively involved in multiple ways with patients and their families, some of you pass this task off to others. Finding the right words, saying them in the right way and at the right time is a challenge in most settings, it is increased around the events of dying, death and bereavement.

2. The second challenge relate to family dynamics. As someone is dying and at the time of death, family dynamics are unpredictable and challenging in many ways. You described a diverse range of experiences from families who are understanding, accepting and appreciative to those that are aggressive, hostile and accusatory.

You encounter the full range of our multi-cultural society and within this, the vast expressions of grief. These range from those who are private and contained to those who are public and expressive. Also you see reactions that seem to be immediate to those that can be delayed for some time. You indicated that some individuals and families can hang onto and remember ever word you tell them whilst others are not able to take in any information at all. You never quite know how a family will respond to the news of a patient's death and therefore a key challenge is to be flexible and honest in your response to their needs.

3. The third challenge you highlighted was that of personal and professional support. It struck me, but did not totally surprise me, that at the personal level, you kept very close counsel when talking about dying and death. For some, I was the second person in their life that they had talked to about their experiences, the other being your wife or partner. One or two of you said you had a colleague who you would feel comfortable discussing the emotional effects of a death on you, but in fact, you rarely did that. On the whole, you do not seek support in understanding and reflecting on your experience of death. *„we don't talk about that sort of thing“.*

However, when burden is very high, you believed you were not at your best and that support from a trusted and understanding peer could be extremely helpful. Most of you saw this as a concern and a challenge to the profession generally but you were not sure on the best way to meet this type of support need.

Just briefly, the three organisational level challenges you identified were firstly: issues related to the work environment such as under-resourced medical facilities and challenges of administration; secondly, the pressures of the medico-legal process and finally; some limitations in current surgical training, such as low levels of patient contact early in training, lack of continuity with mentors and early specialisation.

## 5. Coping strategies

The presence and frequency of these challenges have a direct bearing on your experience and satisfaction as a surgeon. Actually, some of you seemed pretty worn-out. These challenges impact on the way you react to dying and death and how you relate to others at this time. To help manage and cope with these challenges, you identified a number of strategies that you use to cope with the direct and cumulative effect of this aspect of your working life.

You indicated that the key coping strategy is drawing on your strengths, such as your natural decision making abilities, adherence to standard protocols, relying on logic and remaining rational and objective. This helps you to stay focused on your role, to analyse the sequence of events and to be honest in your judgement of the factors that led to a patient's death. As highlighted before you indicated that communication is critical in all aspects of your work and you mentioned it also as core coping strategy. That is, surgeons cope better with negative outcomes and bad news where your communication has covered all options and contingencies, where you have been disciplined and thorough in your communication with all involved. This can extend to remaining available to talk with the family over the course of months or years that follow.

Receiving good news related to your work from patients is always satisfying and this helps to recharge the batteries for a while to come. Finally, you said that team work and peer support is critical and that a healthy balance between high and low pressure case loads can make a big difference. At the end of the day, you said that you cope best when you spend enough time in 'life' - enjoying your friends, family, faith and interests.

## 6. Bereavement Counselling Point of View

From a bereavement counsellor's perspective, I was encouraged by what I learnt in my discussions with you. I appreciate the impact these issues can have at an individual level and it makes a lot of sense that communication, family dynamics and support are some of the big challenges you face. I offer the following in an effort to put these issues in a broader context, and also, to challenge you on some dimensions.

Current thinking is that dying, death and bereavement are separate but overlapping experiences which have highly personalised and often unpredictable responses for individuals, families and communities. There may be familiar patterns and directions in grief but there is no 'standard' way of grieving as age, personality, family, cultural factors and factors related to the death combine to influence one's reaction.

Some people are passionate grievers, some are covert, some are passive, some are active. Yet the most reliable predictor is that we are a more exaggerated form of our pre-grief state; that is, cautious people will be more cautious, sensitive, more sensitive, controlling, more controlling, rational, more rational, and so on. We can be vulnerable in different ways, for example, the high level of emotional intensity that occurs in grief can affect our cognitive ability therefore influencing concentration, decision making and one's capacity to take in and process information. At another level, people become hyper sensitive to things around them making them intolerant of many of the sensory assaults present in the day-by-day environment.

Added to this is the effect of regression where both adults and children revert to a younger version of themselves. This process, which underpins grief reactions, is an unpredictable and subtle process which is seen as a natural psychological defence mechanism that aims to solicit care or protection from others. Also, contrary to previously held myths, although they show it in different ways, kids also grieve, they experience similar reactions to adults but they show it in different ways.

As my mentors remind me frequently, the best term that describes this major life event is chaos. Not surprising then, dying, death and bereavement are experiences that can change the course of one's life in both positive and negative ways.

To help live through and adjust to the reality of a death, on the whole, involvement in the dying process, being present at the time of death, viewing the person who died, and active participation during the course of bereavement assists with understanding, integrating and adjusting to life without the person who has died. The length of time it takes to adjust and integrate this experience varies significantly and this usually corresponds to the proximity and significance of the relationship. Key words here are integration and relearning as distinct from resolution and closure.

Families and their support systems are best placed to deal with the many changes that occur in their lives through a death and most of the time this is what happens. At times, however, their resources are too stretched and additional community and or professional support may be required.

In terms of a challenge to this group, being at the nexus between life and death, surgeons have a unique opportunity to assist people through this most difficult period of personal, psychological and social adjustment. With respect to your role, as some of you indicated, both dying and bereaved people require honest, clear and understandable information given in a sensitive and caring manner. Platitudes and euphemisms are generally not helpful. They need to know they are in a safe pair of hands, technically, and to and varying extents, also emotionally. If you show you are averse to strong emotions, or hesitant and anxious on the topic of dying and death, you are creating a barrier to communication and this will ultimately effect the extent to which they trust you.

If you are a poor communicator, this may contribute to their distress and maybe cause enough to blame you for a death irrespective of the actual cause. You will be seen as an antagonist to their grief; that is, if you cannot acknowledge their distress and pain, they may take action to show you this in their anger or frustration. We hear many stories where this occurs. If you are a good communicator, you are likely to become an ally in their grief. A trusted advisor who can provide them with much

needed information at different points along their road to understanding and integrating the death of someone they loved. We also hear many stories where this occurs. The best stories we hear is where support is received from multiple sources over the course of time through a well coordinated and dedicated team of health professionals.

At a practical level there are several things to keep in mind. Your beliefs and attitudes are visible and these will effect your interaction with the bereaved person or family. For example, it will show in your willingness for them be with a patient who is dying or who has died; it will show in the respect you display through your action in the way your treat the body of the person who has died; it will be obvious in the conversation you have with respect to organ donation; and, it will be most obvious when you have to give bad news. Importantly, all these things will also be observed by those you work with and your behaviour will be cues for others to follow.

My view is that, as a surgeon, with respect to your specific skills, your experience and your personality, you have an important role to play for those who are dying and those who are bereaved. Your emotional resilience, your knowledge and experience with dying and death and your ability to assist those in despair are important enablers for you to succeed in this role.

## 7. Close

It is my hope that this talk will assist you to pause and reflect on the extent to which you integrate the experience and challenges of dying, death and bereavement into your life in healthy and sustainable ways so that you can enjoy a long-term and successful career; a career that does not end in emotional paralysis.

As an advocate for bereaved people, I encourage you to update your skill set, expand your coping strategies and strengthen your support resources, to ensure that you have a full tool kit enabling you to competently respond to the needs of dying and bereaved people. My wish is that you help, not hinder, their grief. This of course, is an individual, team and organisational challenge. Ultimately it is a cultural challenge,

maybe one day, instead of hearing: *“We don’t talk about that sort of thing”;* you might hear: *“How about we grab a coffee and talk through how your patient’s death has effected you”*.

In returning to the purpose of this tribute, I respect your view that in life and also in memory, Graham Coupland’s character, values and behaviour provided an important role modelling influence to those in the surgical field. It would seem to me that although some things are done differently, he would want this opportunity to be a reminder of a couple of principles that guided all his work as a surgeon; first was to go out of your way to be available to help a patient and their family; and second, to always do your absolute best, because, in surgery, near enough is not good enough.

In closing, my family and I appreciate the honour extended to my father through the existence of this memorial event. In our appreciation of your invitation for us to be here, we share with you some of our favourite photos, including fond memories of him and some important times that he has missed out on.



## **Acknowledgements**

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Interviewees (20)

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Bereavement Care Centre: [www.bereavementcare.com.au](http://www.bereavementcare.com.au)

Association for Death Education and Counselling: [www.adec.org](http://www.adec.org)

National Association for Loss and Grief: [www.nalag.org.au](http://www.nalag.org.au)