Personal Narrative

Have we become indifferent to the whispers of loss? A forensic pathologist's perspective

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Disclaimer

The socio-medical vignettes presented here are entirely fictional and do not depict real places, persons, or events. Any resemblance to actual entities is coincidental, and the content is created for illustrative and educational purposes only.

Socio-Medical Vignette-1

A mother, mourning the death of her 14-year-old son, visits the forensic pathologist's office during the autopsy, imploring him to make every effort to uncover the exact cause of death. She reveals that her demanding work schedule had constrained her from spending time with her son, and she wasn't home when he passed away. A senior-ranking army officer, she emphasizes her commitment to seeking the truth about her son's death. The autopsy surgeon preserves samples from the deceased for additional investigations, and keeps the cause of death pending. The mother returns daily to the morgue, anxiously inquiring about why her son died and expressing guilt over not being able to attend to his medical needs when he was alive. Although police allege a history of recreational drug abuse causing sudden death, in this case, no such element is found in the death investigation. Instead, there is evidence of tuberculosis in the lungs, and also mediastinal lymphadenopathy. With these findings and owing to the extent of the disease, the pathologist opines that the cause of death was pulmonary tuberculosis. The mother is devastated and continues to visit the pathologist with questions that underscore her struggle - both with the tragedy of her son's demise and with her guilt at failing to act in time to prevent the boy's death. The pathologist ultimately suggests to her that she seek counselling.

Socio-Medical Vignette-2

A teenage girl, who is preparing for the entrance examination for admission to the Indian Institutes of Technology, jumps from the top of a five-storey building and dies. The police authorities complete the formalities and shift the body to the morgue. The next of kin arrive from a faraway place the following day and allege that it is a case of homicide. During autopsy, the pathologist finds 'multiple injuries' consistent with a fall from height, and attributes the death to the injuries. Further police investigation also rules out the possibility of homicide. The decedent's mother is a senior lawyer at the Bombay High Court and has political connections. Aggrieved by what she considers is a poor investigation process, she files a slew of cases in the jurisdictional high court, alleging

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negligence by the hospital where her daughter was first taken, by the police for a shoddy investigation, and by the autopsy surgeon for manipulating the autopsy report.

Socio-Medical Vignette-3

A 17-year-old boy is killed in a gang rivalry. The sympathizers of the deceased are reluctant to take over the dead body after the autopsy. They protest in front of the morgue against the police, dismayed that those accused of the murder are still at large. Their sloganeering leads to heightened emotions, and the situation gets out of control, creating a law-and-order problem inside the hospital premises. The autopsy surgeon moves out of his cabin and announces that if they do not wish to take the dead body, it will be handed over to the municipal authorities for final rites. A war of words breaks out between the doctor and the protestors, ending with a violent attack on the autopsy surgeon.

Socio-Medical Vignette-4

A teenage girl is caught in the act of intimacy with a boy from a different caste by her father. He reprimands the girl in front of her partner and other onlookers. After a while the girl jumps from the roof of the building and dies. The matter becomes a caste issue and the father comes under pressure from his caste elders who wish to get to the bottom of the matter. Rather than admit that his daughter had jumped to her death after he had shamed her, the father alleges rape and murder. The police investigating the death find that the girl had written an extensive account of her romance in her diary. They seize the diary as an important piece of evidence and a handwriting expert confirms that the entries are in the decedent's handwriting. The autopsy surgeon finds 'multiple injuries' and opines that fall from height was the cause of death. Sexual assault is ruled out after further thorough ancillary investigations. The family members refuse to accept the cause of death and run from pillar to post for 'justice'.

The common thread joining the vignettes

Each of these stories is about the unexpected loss of a loved one, which is a catastrophic event by any reckoning. Such a loss places doctors in the difficult position of communicating the bad news to the next of kin. In some cases, as we see in the vignettes, the doctor is the forensic pathologist, since these are medicolegal cases and there is a need for an autopsy. Although what was once a living person is now a dead body in a morgue, ethical principles must still be followed and professionalism must still be practiced, as must compassion, empathy, and clear communication. Not all of these attributes are exhibited by the professionals responsible for the post-mortem care of the deceased in the vignettes above, although the classical cardinal objectives of a post-mortem examination are fulfilled. Strikingly, grief counselling for the next of kin is also not offered.

The role of communication in general and of grief counselling in particular

The vignettes exemplify a gamut of possible responses of family members to situations involving sudden - unwitnessed or witnessed - deaths of their loved ones, whether in suicidal, accidental, or homicidal circumstances. They have questions, but the person who can answer them from a position of absolute truth is no longer alive. They turn to the forensic pathologist, who may not consider it their duty to provide counselling beyond giving the family the autopsy report (vignette-1); who may not have the time or the patience to explain the situation to the family, or may get caught in the cross-fire between the relatives and the police (vignette-3); or, who may not be believed when the autopsy report differs from the family's narrative of events (vignette-2) or if the family has vested interests in hiding the true story (vignette-4).

Except for vignette-4, where the father knew the truth but preferred it not come to light, most family members are battling grief, and struggling with the guilt that they could perhaps have prevented the death. They may also be aggrieved if they feel that their version of the story hasn't been heard. Breaking the news to them about the cause of death at a time when they are in an extremely vulnerable emotional state requires great sensitivity and skilled communication.

I have encountered numerous situations where the next of kin seek a space to share their version of the story and come to terms with their loss. They might not want to open up to the forensic pathologist since that person is the harbinger of bad news in the first place. They are also unlikely to trust investigation officers and other police officials, whose goals – to their mind – are not aligned with theirs. For example, in case of death by hanging, the police often prioritize the confirming of suicide to complete their investigations, while the family requires insight into why the deceased took such an extreme step. The family might, however, consider opening up to an empathetic professional counsellor, should one be readily available. Grief counselling may provide closure to the grieving family members in these cases.

In the realm of forensic medicine practice, it is heart-wrenching to witness people grappling with guilt, vehemently denying the suicidal nature of their loved one's death, and hinting at a possible homicide. I, and many others like me, strongly believe that it is high time we introduce grief counselling services in all mortuaries as an essential part of forensic pathology services in India. While the legal and technical considerations and the investment of time and money in such an endeavour may be daunting, and may not guarantee anticipated results, there could well be tangible benefit for people facing the extreme challenges of a complicated bereavement - or even an uncomplicated but sudden one.

Medical students receive some degree of training in breaking bad news during their undergraduate years, yet, in my stint as a forensic pathologist, I found forensic postgraduate students floundering in the face of unnatural deaths. Unnatural deaths, as the vignettes showcase, may be associated with feelings of guilt, hatred, animosity, vengeance, and extreme helplessness. While communicating empathetically remains key, there could be added benefit from intervention by professionals who can help family members cope with the complex and violent emotions associated with such losses. These vignettes were chosen to underscore the need for professional grief counsellors to talk to the next of kin and help them navigate through the grief. Perhaps some of the untoward incidents – the secondary trauma - could have been avoided had grief counsellors been present alongside the forensic pathologist when the autopsy report was being discussed with the next of kin.

The treatment planning in grief counselling involves establishing a relationship with the bereaved, creating a comfortable environment for the expression of their grief, being an active and empathetic listener, normalizing grief reactions, and preparing them for rebuilding their lives. In general, the grief assessment encompasses understanding the nature of the relationship and the attachment with the deceased, manner of death, historical antecedents, personality variables, and social variables. Each person mourns loss differently, and the complexities of grief, especially in children, pre-pubescents, and adolescents, adds an additional layer of intricacy. All of this could much better be done by a trained counsellor than by a forensic pathologist. This is especially important as the forensic expert risks compromising objectivity of opinion if a degree of detachment is not maintained. The grief counsellor, in fact, can act as a bridge between the stakeholders in an autopsy service.

The timing of grief counselling services within the context of autopsy services is worth thinking about. The vignettes suggest that the best time for the counsellor to talk to the relatives of the deceased is at the time of autopsy; it is also convenient since both the relatives and the counsellor would be present in the same space. However, it would be challenging for the relatives to spend the required period of time with the counsellor, given the strong sociocultural pressure to complete the last rites as early as possible in our country. Perhaps, the initial brief session [on the day of the autopsy] could be followed by a physical session after a week or once the religious ceremonies are completed, and subsequent sessions could be

telephonic or virtual follow-ups depending on need. Additionally, a referral service to higher centres could be offered for those experiencing depression or post-traumatic stress disorder alongside grief.

The role of the forensic pathologist above and beyond the autopsy

My advocacy for the presence of a grief counsellor during an autopsy does not in any way mean that forensic pathologists should abdicate their role in the counselling of relatives during critical moments. Indeed, they must still use these skills in the communication of bad news and offer an empathetic response to relatives' grief. Our training should be rooted in preparing us to take on this responsibility when needed, ensuring a holistic approach to patient care.

I feel that these vignettes can be used to initiate discussions with medical students and with forensic medicine postgraduates on how to humanely navigate the challenges ensuing when a death is sudden and unnatural. The stories showcase that not everything in autopsy practice is black and white and there are a lot of grey areas which sometimes need to be explained to the next of kin, to investigation officers, and to the courts. Hence, clear and effective communication is one of the fundamental principles of forensic pathology practice. The prevailing secrecy, bureaucratic hurdles, and highly classified nature of our work in morgues are barriers to clarity in communication. To bring about meaningful change, there is an urgent need for the democratization of services. Perhaps listening to the whispers of loss and helping people navigate through the aisles of grief is a way forward.

In the sphere of grief counselling services for loss, the concerns of a forensic pathologist are primarily centred on situations faced at morgues in a teaching hospital or in any autopsy service facility. There are additional critical areas, such as emergency departments in hospitals and clinical wards, where such services are unequivocally essential. The addition of grief counselling services in all such areas could serve the best interests of all stakeholders.

The challenges and solutions

A significant challenge for implementing a grief counselling program lies in the lack of interest or awareness among individuals about such services. Then there are logistical and manpower hurdles, ethical concerns, and financial implications to be considered. To overcome some of these challenges, perhaps we can start by involving the departments of psychiatry and psychology in providing grief counselling. The support can gradually be enhanced by establishing an independent facility that offers holistic post-mortem care. Meanwhile, as suggested earlier, doctors in general and forensic pathologists in particular can continue to provide counselling support during emergencies.

Implementing medical education changes focused on undergraduate students, such as training in breaking bad news, communication skills, and Objective Structured Clinical Examination (OSCE) models that incorporate grief counselling elements, will equip the next generation of doctors for various scenarios associated with sudden, unnatural death. Grief counselling can be integrated into postgraduate curricula as well, in a fashion similar to the AETCOM modules (Attitude, Ethics and Communication) for undergraduates. Combining grief counseling elements into our healthcare education and practices may not only refine our approach to medical care but could also ensure that compassion and understanding remain intrinsic to the healing we offer our patients and their relatives.

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