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REFLECTIONS

When a child dies in the burn ICU: The grief we carry

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I work in the burns intensive care unit (ICU) where children with serious burn injuries are admitted. Some of them recover. Unfortunately, many do not.

When a child dies, the monitors go silent, and everyone involved in the care goes silent as well. Documentation is completed, and the bed is prepared for the next child. Outside my office, a mother cries for the child she will never take home.

In the hospital records, another entry is made to the mortality register, another case to be reviewed in monthly meetings. But every child is not merely a "case" but someone's son or daughter — someone's entire world.

The children who stay with us

While working in a burns ICU, my colleagues and I see small children enduring the pain of their wounds, as well as of the treatment. They come to fear every anticipated procedure, like the daily dressing change. We see in the eyes of their parents hope as well as the fear of losing their child. And if the child's condition deteriorates, we see their hopes crumbling. If the child dies, something breaks inside us too.

It becomes very difficult for me to face parents. I must stand before a mother whose world has just collapsed. I may explain the cause of death, the burns, the infection, the organ failure, and everything my team has attempted, but I know that no clinical explanation, however accurate, can answer what her heart is asking for. I cannot bring her child back.

When care is out of reach

Some deaths are particularly hard to silence. At times I see a child deteriorating and know what to do, which medicine to prescribe, which investigation to carry out for further management. But it is not available. Or I cannot provide it in time, and in the ICU, every second matters.

My team and I try to find a way. We make calls to colleagues in other departments, seek donations from philanthropists, and sometimes contribute from our own pockets. At times, families rush to make the necessary arrangements. However, critical care cannot depend on donors or a family's ability to afford the treatment.

In some public hospitals, policy may also restrict clinicians from asking families to buy medicines or get investigations done outside the system. Such policies are intended to protect families from the financial burden, but they can leave clinicians unable to obtain an urgently needed medicine or test.

It is true that not every child with burn injuries would survive even if every medicine, investigation, and expert care is available, but without these, the chances of survival certainly become poorer. I am left asking myself: would the outcome have been different if it had been made available on time? This question adds moral distress to the grief I carry after losing such patients. In developing health systems, shortages of basic medicines, staff, and other resources have been repeatedly identified as important sources of this distress [1].

The ICU follows me home

Each time I witness the death of a child in the ICU, I find myself with nowhere to place the grief. To whom do I speak about this burden? Then, another patient becomes unstable, another family needs counselling. There is seldom a pause.

Sometimes, I do not want to enter the ICU for the round. I know that a child is gravely ill, and I dread witnessing another life slipping away. My hesitation is not indifference; it arises because I care and because something within me fears another loss. But I must go and see my patients and give them the best possible chance of survival.

The ICU follows me home. The sight of handing over the body to their families, their wails, and the fathers' pale faces appear in front of my eyes in quiet moments. The emotional response to repeated witnessing of death does not necessarily end with the shift [2].

Doctors are taught to resuscitate a child, manage organ failure, pronounce death, and communicate bad news. We are rarely taught what to do with the grief afterwards. People often assume that repeated exposure makes us immune. It does not.

Who cares for those who continue to care?

Professional grief is profound yet often poorly supported [3]. Evidence suggests that peer support groups, critical incident debriefing, reflective practices, and access to psychological support often help to cope with professional grief [4,5]. A structured, peer-to-peer bereavement support programme for the staff working in the ICU at a tertiary care children's hospital showed a positive effect on the staff's coping strategies [6]. However, many hospitals lack such facilities.

There is no end to what I could write, as there is no end to my thoughts. I pray that no parent ever loses a child. And I hope that someday, those who care for dying children will no longer be expected to carry every loss alone.

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