The death of a patient presents the physician with one of the most challenging situations in the practice of primary care medicine. Negotiating the process of dying can also be one of the most rewarding parts of practice as it brings about an emotional intensity for the patient, the family, and other caregivers that can be moving and healing for all who participate. The knowledge of impending death can facilitate resolution of personal and interpersonal conflicts rooted in previous life cycle stages. Of course, that same emotional intensity can also prove traumatic or bring about long-lasting dysfunction for those families who are unable to resolve the challenges raised by the loss of one of their members.

Our society is only beginning to provide institutional support for patients and families facing these changes. On the whole, we are a culture that denies the reality of death (1). In the health care community, death is an event to be prevented, not accepted, and providers often seek emotional distance from the dying patient and the patient’s family. Overtly or covertly, the death of a patient is often seen as a failure of the provider’s skills. This aspect of our professional socialization makes it difficult for us to facilitate a healthy dying process for our patients or encourage constructive grieving for their families, and for ourselves. In this chapter we will challenge our culture’s tendency to deny death by providing a model for constructive interaction between the medical system, the dying patient, and the family. We begin by making practical suggestions about communicating a terminal diagnosis to a patient and family, then turn to treatment planning and making any decisions to limit treatment, notifying a family of a death, counseling around primary care grief issues, and recognizing unresolved grief reactions.
"I believe you may die from this illness"

Communicating the diagnosis of a terminal illness to a patient and family ideally involves clear, direct statements transmitted with a minimum of anxiety. While sometimes a terminal diagnosis is provided by a specialist, the primary care physician is uniquely qualified to communicate this information because of his or her long-standing relationship with the patient and understanding of the family's issues and needs. Several guidelines for clear communication of a terminal illness include:

- Communicate directly to the patient about the diagnosis, the treatment, and the prognosis of the illness. ("We don't believe your disease is curable.")
- Use clear, simple language. Avoid overmedicalizing or intellectualizing the information.
- Be honest and straightforward about the information as you know it, acknowledging areas of medical uncertainty. ("Most people with this illness survive 6–18 months.") Avoid giving an overly optimistic or overly pessimistic prognosis.
- Look the patient in the eye and speak calmly. Repeat the message several times.
- Avoid arguments over the diagnosis, or other diversions from the message itself.
- Set up another appointment to answer questions that will inevitably arise when the initial reaction wears off.
- Repeat this process with the family present. Create a safe atmosphere during the family conference for people to express their feelings honestly and directly if they so desire.
- Allow people their sadness or anger rather than trying to reassure them or brighten their mood. In this situation, depression can signal healthy anticipatory grieving, a process that needs encouragement rather than suppression.
- Allow patients some hope. Be humble about predicting how long a patient may survive.
- Meet regularly with the patient and family to discuss medical care, prognosis, and individuals' emotional reactions, even when the medical care is being managed by a specialist. Encourage children in the family to be involved in at least some of these meetings.

Dying patients force us to face our own mortality and that of those we love. Facing these personal issues can help us be calm and straightforward when communicating a terminal diagnosis to a patient, or accept a family member's anger on hearing about the death of a loved one (2). With very difficult or upsetting cases, discussion with a trusted col-