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Introduction

This chapter focuses on the way in which death and dying are managed in different hospital settings and examines some of the experiences faced by a range of patients and staff in different contexts. The aim of the chapter is to critically review the origins of hospital care, examining the problems and challenges facing nurses and doctors who work in environments that are not conducive to terminal care, but where death is all too familiar. The chapter will consider the key areas where death regularly takes place and highlight the challenges facing nurses caring for patients with a variety of different medical conditions. Reflective incidents are used to describe scenarios illustrating the complexity of death and dying in diverse areas such as the Accident and Emergency department (A&E), elderly care wards and Intensive Care Units (ICUs). The death of a baby in A&E and in a maternity unit is contrasted with the death of a young woman in ICU and an older person in an elderly care unit. All the deaths, although sad, reflect social attitudes about death and dying; revealing that age is an important factor influencing the way nurses respond when a person dies. By examining the context in which patients die in hospital, the reader can see how differing hospital contexts help to shape expectations about dying and also make a difference to the way professional staff behave when a person dies.

The origins of hospital care

Despite the shift from hospital to community care seen in the 1990s, by far the majority of people still die in institutions, primarily hospitals (Field & James 1993, Costello 2000). Despite home being
the preferred place of death the majority die in institutions with one quarter of all hospital beds being taken up by patients in the last year of life (Higginson et al 1998). Historically, the death of a person in hospital, especially when the institution originated from a workhouse, was often viewed in a derogatory way with some older people believing that if they went into hospital they would never come out alive. Although for some, this was sadly true, more recently increasing numbers of people are discharged following a short period of hospitalisation and make a full recovery at home.

Originally, hospitals were not designed to care specifically for the dying, and many are more suitable for managing situations in which the patient gets better and then goes home. This curative ideology has permeated the philosophy of many doctors and nurses and may be seen as one of the motivating factors 'in the push' towards improvements in medical technology. Unfortunately, many people admitted to hospital, particularly older people, have numerous medical problems and despite improvements in health care and medical technology, the care they require may not always be based on cure. Care should be aimed at improving the quality of life by adopting and implementing palliative care principles. From within this paradoxical situation, where cure is the aim of doctors and nurses, rather than caring, the social process of dying in hospital is examined.

What’s wrong with hospitals?

Hospitals have rarely occupied a popular public image and as the history of voluntary hospitals portrays, patients were also not highly regarded. Cohen (1964:20) points out that patients in voluntary hospitals were regarded as:

Miserable objects of charity who were severely disciplined for minor infringements of hospital rules.

In the London Hospital anyone found complaining about treatment was disqualified from further attention. Other hospitals imposed strict regulations about swearing, gaming or drinking, and lights out by 20.00 hours. At Guy’s Hospital anyone found smoking was immediately discharged.
Since its inception in 1948, the National Health Service (NHS) has sought to provide high quality care for all its patients irrespective of their means, creed or medical condition. The history of many British NHS hospitals is one replete with evidence of staff shortages and facilities and peppered with numerous scandals about lack of care and patient neglect. May (1995:85) has pointed out that:

The organisation of the general hospital is profoundly hostile to the expression of the patient’s deepest emotions.

More recently media constructions and public perceptions of hospital care have been shaped by bed crises, a term which has been ushered into common parlance in the last decade. What may be argued to be lacking in hospitals is the personal touch and individuality afforded to people in their home environment. Mills et al’s (1994) study of 13 wards found that there was evidence of neglect and poor standards of terminal care being provided to dying patients. Despite the poor history of care for the dying patient in hospital, the care of dying patients has often been seen as an important part of hospital care and treatment as The NHS Cancer Plan (Department of Health 2000) points out:

Providing the best possible care for dying patients remains of paramount importance. Too many patients still experience distressing symptoms, poor nursing care, poor psychological and social support and inadequate communication from healthcare professionals during the final stages of an illness.

This part of the book considers the experience of dying in hospital and looks closely at some of the key issues surrounding hospital death including: lack of individual care; the management of dying patients in a variety of contexts; and the challenges facing doctors and nurses in providing terminal care within a curative environment not designed to meet the needs of the dying and their family. Despite the negative connotations of NHS treatment, as well as the preferences for people to die at home (Seale & Cartwright 1994), many people find comfort in the fact that hospitals offer security and are generally considered to be safe
environments to occupy when ill. A significant number of people find it impossible to care for their dying family member at home and for many others death at home is not a preferred or viable option. Hospital care offers the security of knowing professional help is on hand, together with a degree of social contact with others. The security of having physical needs for warmth, shelter, protection and social contact met within an environment where doctors and nurses are available 24 hours a day, appeals to many vulnerable patients, such as older people, who may not have carers available at home who can meet their particular needs.

Processing patients: the warehousing model of care

Hospitals, particularly psychiatric institutions, have received much attention from social scientists, sociologists and others in relation to the impact that such organisations have on those who reside in them. It is clear from the literature that treatment of illness is only one part of a hospital’s function. The relationship between the professional care provider and the care recipient also forms part of the patient’s trajectory, as well as the relationship between the patient and the organisation. Many traditional writers conceive of the hospital as a social system functioning in an environment, a system that is created and maintained by patients and staff alike (Etzioni 1964, Goffman 1968, Miller & Gwynne 1972). Some of the features of institutional life reflect surviving in a setting that depersonalises the ‘inmate’ and causes them to learn patterns of behaviour and subservience which more accurately reflect the needs of the organisation not the individual. The following anonymous poem called Rapid Access and Me was written by an out-patient and illustrates the patient’s sense of subservience:

Rapid Access and Me
I have been booked in the clinic and I have been taken to a room,
I am asked to strip from the waist upwards and the consultant will be in soon,
I am sat on the edge of the bed my heart all of a flutter,
In comes the consultant and I start to stutter,
Many questions are asked and lots of answers returned,
I look at the consultant and wonder what he has learned.
The attitudes and ideology of hospital staff play a significant role in shaping the approaches nurses and doctors make towards treatment and care. Miller & Gywnne (1972) discuss two models of care that take place in residential settings making reference to hospital based care. Warehousing is a term used to describe care based on a need to prolong physical life by enabling the patient to develop a greater sense (and practice) of dependency of the care of elderly patients on the professional caregiver. Baker (1978) used the term to describe her findings in an elderly care hospital. Today nurses use the term ‘sheep dipping’ to describe situations when physical care is prioritised above all else due to a range of organisational constraints (largely due to staffing problems). The patient’s role in this model is to develop a dependency and have their role defined. Any attempt by patients to break out of their institutional role prevents the warehousing process from working effectively. Hospital residents are therefore encouraged to be ‘good patients’ in terms of their physical problems. The process works well if the patient accepts their situation and acts in a compliant manner. An example of the types of sanctions used to ensure compliance are labelling, illustrated in a psychiatric context by Johnson (1993).

In contrast, the horticultural model is based on encouraging independence in the patient who has a number of unfulfilled capacities. The professional’s role in this model is to develop the patient’s capacities. The thrust of this progressive approach is to rehabilitate the patient in the belief that he/she is capable of becoming more effective and independent. The nurse’s role is to help the patient by nurturance of strengths and to provide opportunities for personal growth.

Both models of care are not without their weaknesses. The warehousing model is inhumane and has obvious inadequacies. These include lack of attention to patients’ physical and emotional needs and the reinforcement of patients’ problems at the same time highlighting the needs of the organisation as being of greater importance. Having said that, acceptance of dependency may suit some more than others and depends much on the stage in their illness. Terminally ill patients need physical care but also recognition of the many psychosocial needs which can arise at the end of life.

The horticultural model with its obvious idealistic appeal is however flawed in terms of seeing people as being more than their physical difficulties, especially when the person is terminally ill or
in some cases unable to be rehabilitated, for example those with profound MS or MND. For some, accepting the loss of their personal freedoms may be a small price to pay for receiving effective skilled physical care, which may be their priority and suit their needs better than attempts at providing psychological care. The person with MS or MND may feel as disempowered in a context utilising the horticultural mode, as the relatively healthy young counterpart with cancer cared for using a warehousing model.

**Dying in acute care contexts: a matter of life and death**

It may be argued that few are ever prepared for the death of a loved one and when faced with the loss, it can still come as a shock. Within hospitals, deaths can and do happen unexpectedly and present a number of challenges for hospital staff, particularly those working in acute areas such as the operating theatres, A&E departments, ICUs, and Coronary Care Units (CCUs). In these areas, designed to save life and improve the quality of that life, death may be felt as a sense of failure, particularly if the patient is a child or if the staff experience a sense of guilt because it was possible to save them ‘if only’ circumstances had been different. Describing the unexpected death of patients in A&E departments, Wright (1996) points out that sudden death is one of the most traumatic crisis events that can be experienced by both patients and hospital staff. Not only is the death of a patient a major source of distress, also the subsequent bereavement of the family can reduce their coping abilities, leaving an emotional scar that may be felt for the rest of their lives.

**Reflective incident**

Karen (Staff Nurse) was on a late duty in A&E when a young couple came in carrying a baby wrapped up in a blanket. Bypassing the usual formalities they were ushered into a cubicle and were seen immediately by a doctor. The baby (7 months old) was very pale and still, Karen could see that it was not breathing. The parents were en route to visit friends and although the baby was asleep, the mother Zoë sensed there was something wrong. They stopped the car and found that baby Matthew was not breathing and drove straight to the hospital, a 10-minute drive away. Karen
had never seen a dead baby before:

I will never forget the look on the mother’s face when the doctor said ‘I’m sorry I’m afraid there is nothing we can do for him’, I felt angry, very, very sad and upset, I didn’t really know how to react. I was angry at the doctor for not making it sound more positive, but also I was angry at myself. I also felt very useless, all this technology and expertise, all this power and yet we couldn’t do a thing for the baby, I will never forget their faces, their shock and sadness. I realised I should have been more professional, but I cried with the parents who were roughly the same age as me, it was as if I shared their sadness, I became a casualty that night, it was awful.

The emotional trauma associated with sudden death is often experienced by both staff and patients alike, challenging the professionals to not only manage the anxiety of others, but also to cope with their own anguish. Reflecting on this incident with the baby, some may be critical of the staff nurse who could perhaps have remained in control of her feelings in order to offer support to the traumatised parents. However in some cases it can be comforting for recipients of care to be able to see the human side of ‘the professionals’ and a greater sense of security can be gained from knowing that the experts are also human. How nurses and doctors react in such situations depends on the particular circumstances, previous experience and the way they are feeling at the time. Jolley & Brykczynska (1992) point out that expressing the way we feel as nurses and having the courage to show our sensitivity and become aware of our own vulnerability, can help us to stay in touch with our sense of compassion. Much depends however on the climate in which we work, the supportive nature of those around us and the extent to which hospital staff are able to feel supported when dealing with traumatic circumstances, a topic which will be further discussed later in the chapter.

Death and dying in maternity/paediatric care units

The birth of a baby is one of the happiest moments in our lives, which makes the death of a baby one of the most tragic events
that we may experience. In the Middle Ages, when the death of a child was more commonplace, as it still is today in certain developing countries, the death of a child caused relatively little disruption to the community in which it lived (Aries 1974). Today, the death of a baby at or shortly after birth gives rise to personal crisis and an extreme form of grief, which often requires sensitive professional support in order to make sense of what many regard as a family tragedy. The hospital staff in maternity units share in both the joy of birth and the grief of mothers whose babies are stillborn (born after 24 weeks gestation, and show no signs of life) as well as perinatal deaths (stillbirths and those who die within the first 7 days of life, irrespective of gestation time). Special Care Baby Units (SCBUs) often admit babies who are born premature (before 28 weeks gestation) and die within the first 28 days of life, who are referred to as neonatal deaths. Stewart & Dent (1994:54) point out that medical terminology used at the time of stillbirth can have a profound effect on parents; terms such as foetal distress, in lay terms can be perceived as an implication that the baby has experienced pain and discomfort.

Reflective incident

Susan (24 years old) was expecting her first baby and throughout pregnancy had been experiencing blood pressure problems, but despite close monitoring by her community midwife was admitted 3 weeks before term to the antenatal unit for rest and observation. Subsequently during labour Susan experienced problems and the baby became distressed necessitating an emergency caesarean section. Despite the maternity team working as quickly as possible, the baby was born alive but died in the labour room after a few minutes. The news was broken to Susan and her partner Alan in the side room, once Susan had fully recovered from the anaesthetic. They were both devastated:

It’s like your worst nightmare … I worried about something happening to the baby and something going wrong but not this, not this, it’s just so unfair and wrong, we were going to be so happy.

The maternity staff were also devastated and the atmosphere in the unit was palpable with sadness. Susan’s parents arrived and
asked for the hospital priest. Susan and Alan were given time with the baby and a staff midwife waited outside the room. Alan took a photograph of the baby boy whom they called Edward after Susan’s grandfather, who died the previous year. A piece of hair was taken from the baby and later that morning a short religious service took place in the hospital chapel. The maternity staff arranged for a handprint to be made of baby Edward. The Co-op funeral services came to pick up the baby and took him to the chapel of rest. Susan stayed in hospital for three days to recover from the surgery and was discharged home on the fourth day. The following day the funeral took place at the local Catholic Church with an abundance of flowers and mourners. Susan’s parents arranged for the funeral party to take place at their house. The cost of the funeral was minimal because of the baby’s age, the Co-op played a role in helping Susan and Alan consider Edward’s death as a major loss, sending the family a memorial card after the funeral with a picture of Edward. One of the staff midwives who attended the delivery represented the hospital at the funeral. Two weeks after the funeral, the unit social worker rang Susan and Alan and asked if there was anything they could do. Susan had already contacted The Compassionate Friends (TCF) who provided bereavement advice and support. (See Useful contacts section)

The death of a child in our culture is a tragic event that challenges everyone involved with the family, in attempting to help the parents and other family members come to terms with their loss. Some parents feel a sense of comfort in not wanting to come to terms with the loss, rather appearing to want to feel the full impact of the death by embracing death and experiencing the full brunt of their loss. Others may appear to block out, deny or consider anything but the loss, as their way of coping. Sometimes these two extremes can cause conflict when they are experienced by people in the same family or by the parents themselves. Hindmarch (2000:34) points out:

Whether personally or professionally involved, the death of a child is seen as the most difficult loss to cope with… to talk about and anticipate.

In hospital settings, where staff and families often share the same sense of impotence when coping with the death of a child, Hindmarch (2000:81) suggests that good practice involves the
following:

- Be sensitive to the parent’s needs.
- Avoid platitudes and statements that imply criticism of the child’s care.
- Be prepared to listen: share feelings and memories.
- Do not give up visiting the family for fear of intruding (unless they request no visiting).
- Familiarise yourself with hospital procedures regarding police, funeral arrangements, social workers, chaplains and national bereavement resources.
- Be there for all the family, including siblings and grandparents.

As a professional staff member, it is always useful to know and be familiar with support agencies such as the Foundation for Sudden Infant Death (FSID) as well as TCF, a Quaker group who carry out invaluable bereavement support for families facing and dealing with loss. (see Useful contacts section) Richies & Dawson’s (2000) research into family responses to death, highlights the need for professionals to appreciate both the complexity and diversity of grief reactions. They reinforce the need for doctors and nurses to be sensitive to the difficulties faced by families, as many individuals in the family experience the impact of loss in a different way. This they argue is a major challenge to the skills of the medical and nursing practitioners.

Death and dying in critical care contexts

Death in critical care areas such as ICU, CCU and High Dependency Units (HDUs) often takes place following attempts by doctors and nurses to ‘save’ the patient’s life; numerous interventions are employed, notably the use of life preserving technology such as ventilators, in order to both extend life and improve its quality. Death in this context therefore carries with it enormous distress and sadness for the patient’s family, along with numerous challenges and frustrations for staff working in situations of crisis. Many people would agree that areas such as CCU and ICU are places in which life saving measures become routine and the use of ‘heroic’ emergency measures add to the ‘mystique’ of these areas. Media portrayals such as ER and Casualty depict a glamorous
image of doctors and nurses making life and death decisions, almost by the hour. Many would argue that in large critical care settings such as ICU, these media images are not far from the truth. There is also evidence that the glamorous image of ‘high tech’ areas is the reason why nurses find such places attractive areas in which to work, especially when compared to the comparatively mundane general medical, surgical and elderly care wards (Baker 1978). Despite their attraction as glamorous places in which to work, situations arise in ICU that create tremendous stress for staff, patients and relatives alike (Vachon 1987). In many cases ICUs record higher numbers of deaths per month compared with other hospital areas. Often staff turnover rates are much higher, partly because of the nature of the work, staff:patient ratios as well as the increasing amounts of stress experienced by nurses and doctors when staffing falls below optimum levels. When situations like this occur, managers often find that sickness-absence increases, giving rise to additional stress experienced by some nurses. Harry is a Senior Nurse managing one of the biggest and busiest ICUs in the country with a large complement of nurses; he finds it very frustrating when staffing levels mean nurses not only have to work harder, but also stress levels increase:

When patient dependency and staffing resources do not correlate the increase in workload results in higher levels of stress within the unit. When we are full and there are some very complicated cases this can have a very adverse effect on the staff as a whole.

Mary Vachon (1987), a Canadian Nurse who has written extensively about the effects of terminal care and death in critical care areas, argues that staff stress and burn-out occur frequently in intensive care areas as a result of the high number of patients facing impending death and the complex and often very personal decisions made, concerning end of life issues.

Reflective incident

Kim was a 23 year old lady who was brutally attacked and raped by a man outside a nightclub in Manchester. She was brought into the A&E department unconscious, in a state of shock and
with severe breathing difficulties as a result of her attack. She was transferred from the A&E department and attached to a ventilator in ICU. Neurological investigations revealed that she had in fact suffered damage to her brain stem as a result of the assault. Kim was unable to breathe unaided and if she were to be taken off the ventilator it seemed clear that she would imminently die. The hospital neurologist diagnosed her as being in a Persistent Vegetative State (PVS). Her attacker was apprehended by the police and was in custody having been charged with the assault, which he admitted to the police. Despite verifying Kim’s condition with another neurologist together with two physicians and an anaesthetist, Kim’s parents and immediate family could not come to terms with the diagnosis and prognosis and believed that she would one day regain consciousness. Their distress was compounded by a number of pressures placed on the medical staff to come to an early decision about taking Kim off the ventilator and allowing her to die with dignity. Kim’s assailant was awaiting trial and likely to be charged with murder or manslaughter. Any decision to take Kim off the ventilator would result in death and would in legal terms reduce the possible charge to manslaughter. The hospital was informed that on no account could Kim be taken off the ventilator because of the legal implications involved in charging the assailant. The trial therefore did not take place for several months.

The family were offered counselling by the hospital, but declined. Kim’s parents, her brother and sister, overwhelmed by grief, refused to accept the inevitability that she was going to die and had to experience a very traumatic period observing her in this state. Patients who are unable to communicate effectively with others when they are dying are said to be experiencing social death (Sweeting & Gilhooley 1991). This rather strange and distressing phenomenon related to a loss of personhood, renders the individual outside the normal boundaries of social contact, remaining in what Van Gennep (1972) refers to as ‘a liminal state’. The staff on the unit experienced tremendous stress as a result of the traumatic situation that prevailed. Many of the staff experienced personal distress, which was compounded by the problem of having to face the family on a regular basis and help them make sense of what was occurring at a very traumatic time. Kim was being cared
for with great sensitivity, she received intravenous fluids and full monitoring. The family insisted on spending most of the day with her, returning the next morning. Sadly the situation deteriorated and Kim was removed from the ventilator the day before the case went to trial. At their request, the family was present when Kim was extubated and she died shortly afterwards. Arrangements had been made for Kim to be taken to the chapel of rest in order to bypass the mortuary. The family had previously planned the funeral arrangements and members of the ICU attended, as they had become very close to Kim and the rest of the family. Eventually Kim’s assailant was found guilty of manslaughter and received a 10-year prison sentence.

Kim’s death was a sad event, but also a great source of relief for both the family and the staff who shared the anticipatory grief (Costello 1999) of knowing 5 months earlier that death would take place. During this time adaptation to the death had taken place and many of the so-called ‘stages of grieving’ had been reached. Anticipatory grief is the affective experiences people undergo when they are aware that they are dying, with often the patient and their loved ones adapting to the impending loss and sharing similar reactions. Anticipatory grief may enable some people to prepare for the loss by adapting to the death, although as Rando (1986) has pointed out, the length of time spent awaiting death can sometimes have a detrimental effect on the soon-to-become-bereaved, especially if a child is involved.

Reflecting on Kim’s situation, which was taken from a real hospital experience, there are a number of features of her death, which reveal insights into death and dying in hospital. First is the management of her death and the all-consuming way in which agencies of social control, such as the police, the legal system and medical science collectively determine that the patient’s life and death are taken out of the family’s hands and become a matter for the experts. Secondly, Kim’s death had an impact on both the family and hospital staff. The hospital made every effort to support and assist the family in their grief, but the staff on the ICU were not offered any counselling. This raises the familiar issue of who cares for the carers in situations like this, when hospital staff members are sharing the experiences of the family. Although their experiences are not the same, their need for support may be just
as intense and valid. A member of staff on the unit recalls his experiences of Kim’s time on the unit:

For the first time in my career, I found myself nursing a corpse, but at the same time attempting to reassure family members that this was not so. On the rare occasions when relatives were not present I felt more stressed, as it seemed that to all intents and purposes Kim was dead.

Death in critical care units takes place within a context that is shaped by a number of forces, both political and social. This reflective incident highlights some of the imponderable issues raised by a high profile death, which it may be argued was somewhat atypical. It remains the case however that so-called ‘high tech’ areas such as A&E departments and renal/heart transplant units are contexts subjected to different influences when a patient is dying. In these life-defining contexts, the emphasis is on the maintenance of life and preservation of the quality of that life at all costs. In essence this curative ideology influences the way in which nurses and doctors behave towards the patient, who, as an acute case may be viewed in a different light to a patient in a different context.

The social management of dying in hospital

Dying in hospital can be socially defined in terms of staff perceptions of the nature of the patient’s illness, their attitudes towards the appropriateness of the impending death and the context in which terminal care takes place. The time a patient spends dying and the events involved in the patient’s passage from wellness to illness loosely referred to as the dying trajectory (Glaser & Strauss 1965) also influences the way in which the terminal care is managed.

When a person is admitted to hospital, a number of factors influence the way in which he/she is treated, least of all the medical condition and the context in which the treatment takes place. A wide range of social factors impinge on the way in which a patient’s trajectory through the hospital occurs. The patient’s age, gender, social class, race and ethnicity play a part in shaping the perceptions of both staff and patients towards the person. Staff
attitudes towards patients with learning disabilities or mental health problems can have an adverse effect on the patient’s passage through the hospital. For many patients the process of admission to hospital, especially for the first time, can be traumatic in more ways than one. Goffman (1968) and others have discussed the dehumanising effect of hospital admission which can be very distressing if the patient is not made to feel welcome by the staff. For a number of unfortunate patients their first contact with hospital takes place as a result of an accident or trauma. Admission through A&E departments involves assessment and often facilitates acute treatment taking place, especially if the patient’s condition is life threatening.

The following case scenario focuses on age as a social factor influencing a person’s experience of hospital. Age is often a key factor in the assessment and initiation of treatment. Similarly, the experiences of some older people in hospital reflect the way in which attitudes about older people can be based on notions about the deserving nature of the patient’s condition (Health Advisory Service (HAS) 2000). A young child with rheumatoid arthritis (Still’s disease) may be treated differently to the older person with osteo-arthritis. Both conditions are painful and distressing. However, the child’s treatment will invariably include acute intervention which may not apply to the older person due to the arthritis being seen as a disease of old age, not susceptible to cure, unlikely to respond well to treatment and may be due to other factors such as obesity, which can be dealt with by the patient themselves. The child’s illness may give rise to acute pain and an increase in temperature that can be alleviated with drugs and is likely to resolve with the appropriate treatment. In an adequately resourced health service, both patients would receive treatment and health education to prevent a recurrence, in practice the indications are that age does make a difference in relation to the way that many older people are treated in hospital (Health Advisory Service (HAS) 2000).

Patients entering acute and critical care areas in many cases may be younger than those in other areas, such as elderly care units. Therefore public perception of the ‘deserving nature’ of their death and the social management of dying may influence hospital staff in considering decisions made about ‘end of life issues’ particularly if the patient is perceived to have ‘had a good innings’.
Age appears to be a significant factor in the management of death and dying along with the patient’s gender, race, social class and mental health. In particular for older people perceived to be ‘nearer death’ their passing may be perceived as ‘a blessing’ for staff and family alike, depending on circumstances. A frail older person with multiple-pathology and a debilitating stroke may be considered in a different light to the young child rushed into the A&E department. These factors reveal issues not only about the differing context(s) in which dying takes place, but also about the attitudes of hospital staff regarding their own mortality and to a certain extent ageist attitudes towards older people. Evidence from the HAS report (2000) suggests that older people admitted to hospital are often treated in an inferior way to their younger counterparts. The death of an older person in hospital can often reflect the mores of the setting in which death and dying takes place (Costello 2000). The extent to which emergency treatment is initiated depends on the context in which care takes place. Continuing care units often do not have emergency life saving equipment with which to initiate cardiac resuscitation for example, therefore, unlike areas for younger patients with acute illnesses, such life sustaining treatments are not available to older people in certain elderly care contexts.

Summary

This chapter contrasted the reactions of hospital staff to the death of a neonate in maternity where shock and disbelief were blended with profound sadness. When faced with death, the maternity ward context which strives to provide life is challenged to be able to manage effectively the death of a baby which is regarded as a tragedy. The structures, which are normally used to celebrate birth, have to adapt to providing support to the bereaved family and this can be difficult when the overarching ideology is focused on life. The social structures used to help memorialise life such as hand prints and photos of the baby serve as sources of comfort and can enable parents to cope with the crisis. Equally in critical care contexts, where saving lives is the key aim, staff need to be aware that death is ever present. The critical care context can be very constraining when death occurs, as little privacy is available and lay observers are made painfully aware that apparatus designed
to monitor bodily functions are everywhere and serve to remind observers of the life saving purpose of ICU. In this critical care context, as the reflective incident of Kim illustrated, staff members can feel constrained from acting individually as there is pressure to work as a team, even though at times nurses and others may feel that the efforts being made to preserve life are futile and the patient should be allowed to die in dignity.

Chapter 2 will examine in more detail the nursing care of dying patients, taking a ‘day in the life’ approach to the care of terminally ill patients in the hospital context.

Further reading


This chapter describes the traditional practices that took place at the beginning of the 20th century in a North England town. It is highly regarded as a classic account of the behaviours and attitudes of families at the time of death.


This book includes ten chapters written by different experts and takes a social historical view of death covering a period from the Pre-Bronze age up to and including the death of Princess Diana. The theme of the book is placed on the changing societal attitudes towards death and although very comprehensive and well illustrated is an academic text that chronicles the way in which attitudes towards death reflect changing social values.


This very readable book is aimed at professional caregivers and covers a wide range of issues relating to terminal care and the management of death in institutional and community settings. The book is easy to read and although it covers a range of topics including communication, symptom control and bereavement support, some are not covered in detail. The authors pose the question what is a good death and challenge the reader to consider some of the practical issues associated with providing effective care to the dying patient.

This is a very interesting and well written book which contains a clear glossary. It is based on the author’s doctoral research and professional experience of working in intensive care. The book deals with a number of critical issues such as withdrawing treatment and the notion of good and uncertain deaths. One of the central themes of the book is decision making as a social process and the organisational constraints placed on staff in ICU which serves to support the idea that often individual decisions about patients are rarely made without being influenced by the context in which care takes place.


This is a very interesting, excellent and thought provoking book written in a style that has become popular amongst both academics and lay readers. The book is focused on the modern day funeral and seeks to illuminate on how funerals can meet the needs of a diverse multicultural society. Included in this comprehensive book are chapters on cost, the afterlife and how funerals should be conducted. The author poses basic questions such as what is a funeral?, considers the various ways in which families can adopt a do it yourself approach or deal effectively with what he calls the funeral trade.


This book is a classic, mainly because it covers topics not considered in such detail before, and also because Walter’s writing style has appeal for the academic and lay reader alike. It is extremely well written and fully referenced. The main thrust of the book is placed on highlighting the interest that people have developed in all aspects of death and dying. Walter’s argument is based on a reconsideration of the death denying theses and he carefully constructs a case for society not being as afraid of death as it was fifty or so years ago. I highly recommend this book to anyone interested in finding out more about death and dying.
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