

Nursing older dying patients: findings from an ethnographic study of death and dying in elderly care wards

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Submitted for publication 24 November 2000

Accepted for publication 22 March 2001

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COSTELLO J. (2001) *Journal of Advanced Nursing* 35(1), 59–68

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Background and aim. The aim of the study was to explore the experiences of dying patients and nurses working in three elderly care wards focusing on the management of care for dying patients. The majority of patients who die in hospital are over the age of 65 and evidence suggests that three fifths are over the age of 75. Older patients pose tremendous problems and challenges to nurses and doctors regarding the provision of good terminal care, particularly in relation to developing effective communication.

Method. An ethnographic research design was chosen. The research sample consisted of 74 patients, 29 nurses and 8 physicians. The principle data collection methods were participant observation and semi-structured interviews. All respondents were interviewed following a period of observation on each of the ward areas. The data obtained from participant observation were then used to structure the interview questions. The purpose of asking questions about meanings associated with observational material was to evaluate the extent to which convergence or divergence of the data was taking place.

Findings. The findings demonstrate that the care of older dying patients was defined by a lack of 'emotional engagement' with the patient and the institutionalized nondisclosure of information about death and dying. The study raises issues concerning the lack of effective communication about terminal diagnosis and the strategies used by nurses and doctors for disclosing information about death and dying. The findings suggest that although nurses provide individual care to dying patients, much of this was aimed at meeting patients' physical needs. Nurses reported psychosocial aspects including spiritual and emotional care to be important, although there was little evidence of them being orientated towards this in practice.

Conclusion. The indicative conclusions from this study suggest that terminal care for some elderly patients remains hampered by a reluctance of nurses and doctors to be more open in their communication about death. It would appear that hospital culture and the mores, beliefs and ideologies that emanate from the biomedical model, significantly shape the experiences of older dying patients.

Keywords: older patients, terminal care, death and dying, nursing, biomedicine, nurses, physicians

Introduction

The care of dying patients in hospital has been reported disparagingly by a number of writers and researchers. A number of studies highlighted the inadequacies of hospital provision, in particular, poor communication and standards of nursing care which leave much to be desired (Cartwright *et al.* 1973, Wilkes 1984, Seale 1991, Smith 1992, Seale & Kelly 1997, Copp 1999). In particular several authors have indicated that the care of dying elderly patients is a sadly neglected aspect of hospital life (Blackburn 1989, Mills *et al.* 1994, Costello 2000). Terminal care, defined as the care of people in the final stages of their lives, is of major concern to nurses who are often the professional group who have the most intimate contact with patients, their families and friends. More recently, the term palliative care has been used to denote patients for whom there is no curative treatment, but which also includes terminal care (Field & Copp 1999). A number of issues are raised by the study which have implications for improving the care of older dying patients.

Literature review

Background

Historically, terminal care in hospitals has posed problems for nurses. As Quint (1967) points out, this was due to terminal care being seen essentially as a nursing and not a medical problem. The difficulties associated with providing effective terminal care in hospital have been compounded by a number of demographic trends, an example of which is the marked rise in the number of older people, and the high incidence of those who suffer from chronic illness (Sidell 1995). Both of these factors have influenced the social management of dying, as patients tend to live longer with their 'dying trajectories' extended, as a result of medical intervention and improvements in health care technology.

The parlous state of terminal care in British hospitals and nursing homes in the 1960s became the focus of much public attention (Sheldon 1961, Townsend 1962). In a retrospective study of terminal care in hospital Mills *et al.* (1994) provide descriptive evidence of neglect and gross deficiencies in the care given to patients in four Scottish teaching hospitals. A working party report based on a review of terminal care in hospital, found areas where improvements were needed, primarily in education and training for staff and in improving communication (Scottish Health Service Advisory Council 1991). The literature reveals a number of areas of concern about death in hospital that fall into three main categories. First, lack of attention to the physical needs of the dying,

specifically symptom control. Secondly, lack of patient individuality and deficiency in personal dignity. Finally, lack of attention to the psychosocial aspects of care and problems associated with communication and disclosure of information about dying.

Control of symptoms

The number of dying patients experiencing distress in hospital due to poor symptom control has been reported to be a motivating factor behind Dame Cecily Saunders' decision to study medicine in order to make changes (James & Field 1992). Prior to the development of the hospice movement, numerous authors attest to the lack of success in controlling the symptoms associated with cancer, such as pain (Saunders 1963, Wilkes 1965, Hinton 1967). Other researchers used hospice in-patients as a comparison (Parkes 1985). Interestingly Parkes's (1985) study highlighted huge differences in the severity of pain between patients at St Christopher's hospice and outlying hospitals (as recalled by the patient's spouse). Parkes (1985) goes on to say that less than 10 years later 'there was no longer any significant difference between St Christopher's and other hospitals in terms of the severity of reported pain' (p. 156). Parkes and Parkes (1984) in a re-evaluation of hospice and hospital care, focusing on pain and personal distress assert that 'Pain and distress is no longer a major problem in either setting' (p. 120).

The literature on symptom control in hospitals is however, conflicting. Parkes and Parkes's (1984) study may have taken into account the development and contribution of hospital palliative care teams (HPCTs) initiated in 1976, providing pain and symptom control largely for hospital cancer patients. However evidence suggests that the effectiveness of palliative care in hospitals, in terms of measurable outcomes is limited (Higginson 1997) and the notion that equity in standards of symptom control between hospitals and hospices is not borne out by large scale studies (Eve *et al.* 1997). The claim is also made that the majority of hospital in-patients with palliative care needs are unlikely to have those needs met despite the proliferation of HPCTs (Field 1994). In particular, Clark and Seymour (1999, p. 156) point out:

Old people and people suffering from noncancer disease fall most frequently into a position of acute disadvantage vis'a vis palliative care provision.

More recently, findings from Seale and Kelly (1997, p. 93) cast doubt on the hospital's ability to provide effective care:

The busy public atmosphere of some hospital wards may not be conducive to the good care of dying people.

Despite the progress made in managing the physical symptoms of dying patients, and the introduction of palliative care to hospital wards, it would appear that care of the dying in hospital, particularly for older people, remains problematic for nurses.

Psychosocial care

The psychological experience of facing death and the impact that this can have on the individual and those close to them in terms of spiritual distress, challenges all involved in caring for the dying person (Sheldon 1997). Despite improvements made in controlling symptoms and the so called 'changing culture of truth' reported by some researchers (Seale & Kelly 1997, Field & Copp 1999), hospital care is often deficient in developing a positive psychosocial climate. Hospitals are variously reported as busy, noisy, places where personal dignity and privacy are lacking (Magnusson 1996). In an autobiographical account of a friend dying of cancer in hospital, Magnusson comments on the attitudes of some hospital doctors.

'Unless we can somehow screen out the supercilious, the unimaginative and the cold eyed, before they hit the wards, the chances of being dealt with kindly when our lives are on the line, will remain cruelly arbitrary' (p. 1602).

A number of authors identify that older people are vulnerable to many psychosocial problems associated with loss, and often their feelings become stereotyped with loss experiences reduced to being part of the ageing process (Thompson & Thompson 1999).

Communication about death and dying

Communication about death and dying, particularly within institutional settings has received varying emphasis in the literature (Glaser & Strauss 1965, Pine 1975, Field 1989, Seale 1991, Wilkinson 1991, May 1993). Many studies have commented upon the problems associated with caring for both dying and 'recovering patients' in the same setting. Many researchers focusing their attention on the extent to which doctors and nurses are truthful in their communication about death and dying (Tuckett 1998, Field & Copp 1999, Costello 2000a, Davey 2000). Field and Copp (1999) point out that changes in doctors' attitudes about information giving to dying patients indicate a greater willingness to communicate openly about death and dying. The implicit suggestion is that a patient's knowledge about dying is linked to their ability to cope with information about their own mortality. Blackburn (1989, p. 203) found that communica-

tion problems with elderly patients were common and their terminal diagnosis was not discussed with the dying patient. Blackburn emphasized that:

Elderly patients in hospital may have needs in the provision of their terminal care which are somewhat different from those recognized in younger patients.

Similarly, a post bereavement survey of patients' relatives following death from cancer in hospital reported by Rogers *et al.* (2000) included expressions of dissatisfaction from relatives following their experiences in hospital. A number of respondents reported poor communication with doctors and nurses and their hospital experience left them feeling devalued, dehumanized and disempowered.

The study

Aim and location

The aim of this paper is to explore the experiences of dying patients and nurses working in three ward areas; acute assessment, continuing care and rehabilitation. The latter ward formed part of an elderly care unit situated in a large hospital trust. The former wards were part of a specialist hospital specifically designed for older patients, all situated in the North-west of England. Whilst the three wards do not represent a homogenous group, for the purposes of this paper, the findings represent an analysis of the data relating to all three areas. Where clear distinctions were identified in the practices in each area, these will be highlighted within the text.

Methods

The principle methods used in the study involved the researcher utilizing participant observation and interviews to gather data. Initially, observational data was collected and documented in field notes. These data were then used to structure a loose interview schedule, which enabled an exploration to be made of respondents' perceptions of the researcher's observations. Data were analysed using a modified grounded theory approach (Strauss & Corbin 1990). The aim was to examine the data systematically identifying different phenomena, categorizing what may be seen as an array of distinct 'items' that are treated as an equivalent (Turner 1981). The data obtained from participant observation were then used to structure the interview questions. The purpose of asking questions about meanings associated with observational material was to evaluate the extent to which convergence or divergence of the data was taking place.

Data collection

Research population

The study took place in three hospital wards: one female rehabilitation; one continuing care; and one acute assessment. The research population consisted of 74 patients, 29 qualified nurses, 6 students and 16 auxiliaries, all of whom took part in interviews. Eight physicians comprising two consultants, two registrars and four senior house officers were involved in the study, although only five were interviewed, largely because of time constraints and availability. Patients were interviewed informally and with one exception, all died in hospital.

Observations

The study incorporated a range of data collection strategies, primarily participant observation. During 15 months over 250 hours of participant observation took place, with the researcher often involved in the provision of 'hands on' care during the initial entry to each ward, then towards the end occupying a more passive observer role. This approach based on a continuum described by Pearsall (1965) is an effective way for nurse researchers to operate within hospital settings. It allows researchers to develop their *entre* and also to engage more effectively with the research population.

Interviews

Two interview methods were used, first, oblique or 'opportunistic' interviews took place during participant observation in the wards, these were conversational in nature and formed part of the 'informal talk' between researcher and respondents. The latter approach was used exclusively with patients. Written field notes supplemented by audio tape recordings were made of this dialogue. Semi-structured interviews were conducted with ward staff outside the clinical areas, often in rest rooms. These were more formal than the opportunistic interviews and lasted approximately 30 minutes and were tape recorded. The observational data helped to constitute the structured part of the interviews that gathered biographical data as well as gaining the respondents' perceptions of the care and treatment of dying patients on the ward. This approach is recognized to be 'a reconstruction of themselves'. In relation to its validity, Emerson and Pollner (1988) point out that:

Only very careful probing can ever separate fact from fiction and for respondents even this will not be adequate (p. 82).

Field notes

Field notes and fieldwork diaries were used to supplement the data collection. Field notes were considered more tangible

evidence of factual events taking place in the ward that assisted in data analysis. Field diaries according to Williams (1989) are personal and consist of the researcher's feelings and perceptions about what is happening in the field. Williams points out that it is 'ethnographically unsound' to infer some kind of external facticity to fieldwork diaries and notes as they aid the construction of the account and do not constitute the account themselves.

Data analysis

The interview questions were designed to elicit the meaning and weight of consistency behind the processes associated with organizing terminal care. An example was the way in which care for dying patients was organized on the basis of time tabling nursing care during the morning shift, so that terminal care was given towards the end of the shift. When viewed in isolation, this reflected a certain lack of regard for dying patients. However, when questioned during interview, nurses stated that this tacit agreement allowed them to spend uninterrupted time with patients. One of the difficulties in using grounded theory is the selection of emergent categories that can lead to data being lost by forcing or leaving out certain types of emerging features of the fieldwork or interview data (Bartlett & Payne 1997). To prevent this occurrence, the fieldwork and interview data not immediately lending themselves to categorization in the initial stages of analysis, were kept as part of the data set until saturation point was reached. The research methods used in the study ultimately appeal to external structures and events in order to make sense of what is going on in the research field. Therefore, implicitly or explicitly, they utilize psychological variables to explain how the observed external states of affairs are transformed into the researcher's account. As we do not have access to the respondents' internal experiences, it seems clear that, as others have argued (Blumer 1956), we must examine the ways in which research subjects invoke structures, rather than impose them on the data. In this way we become more able to give an accurate account of orderly social action.

Ethical issues

Ethical consent was obtained following an extensive review process conducted by the hospital ethics committee. A number of ethical issues were raised, the first relates to the sensitivity of the subject and the way studies such as this are conducted with 'doubly vulnerable' research subjects (Moore & Miller 1999). The second was the need to protect dying patients from abuse and any overt invasion of their privacy,

in particular, elderly patients with physical or emotional pain. The third issue relates to patients, irrespective of their medical condition, being able to make an informed choice about whether they participate in research (Mount *et al.* 1995). In general, researchers also need to consider the ethical eligibility (Randall & Downie 1996) of the respondent, and ethically justify the inclusion of vulnerable groups. Such individuals, it may be argued, need to be made aware of the consequences of their involvement. Researchers need to be aware that they are asking respondents to evaluate the care that they are receiving. Asking painful questions and exploring perceptions of care can be very problematic and distressing for the patient.

The researcher utilized a three-fold approach to gaining informed consent. First by establishing the competence of the patient, second by verifying with the patient directly (and re-verifying at different stages) their agreement to continue and third, in some cases by ensuring that relatives were also aware of the researcher's role. The researcher as a bereavement counsellor also utilized counselling skills within the interview procedures (with staff and patients) whenever respondents dwelt on personal issues.

The thorny issue of how researchers in hospital wards ensure that research subjects provide informed consent was dealt with by making sure that staff and patients were made aware of the researcher's role and the aims of the research. Moreover permission was sought prior to interview and transcripts of taped interviews were provided for them to amend if necessary. The researcher and ward nurses explained that the study was focused on critically ill patients. Interviews with such patients were generally of short duration, questions often required one answer and in most cases relatives were present. These patients were made aware that I was interested in their hospital experiences as critically ill patients. No attempt was made to hide the fact that the researcher was interested in dying patients. However this was not made explicit to patients, as hospital staff felt that it could create undue anxiety. Their wishes, and those of patients who did not want to talk to the researcher were observed. Nurses however, were often keen to be interviewed, although I sensed reluctance from physicians that, together with time constraints, meant that their involvement was limited.

Another issue raised by the research is the position of the researcher witnessing what may be regarded as poor practice. I did witness practice that I felt was questionable in terms of poor standards of care. On one occasion I felt obliged to intervene to assist two student nurses who were with a patient who collapsed. At the time I temporarily abdicated my researcher role and intervened in my capacity as a

registered nurse, which I felt was my first and foremost professional duty.

Results

Three key themes emerged from the interview and observational data. The importance of meeting patients' physical needs; the problems associated with caring for patients who are not aware of their terminal diagnosis, and the significance of power relations between doctors and nurses.

Terminal care as physical nursing work

The respondents in all three areas showed compassion and sensitivity towards the needs of dying patients in their clinical interventions and sentiments. Despite many nurses demonstrating knowledge and awareness of the need to focus on patients' psychosocial needs, the main priority of nursing care in each area related to the provision of physical care. This focus on physical aspects of care was evinced through and by nursing work, which was most prominent in the continuing care ward. Many observations were made of nurses ensuring that patients' perceived physical needs were met, however, in the interviews, nurses identified the importance of psychological care:

It is necessary to make sure that dying patients are well cared for physically, but we (nurses on the ward) try to also make sure that we spend time talking to patients and meeting their psychological needs as this is very important too.

The time when most observed physical nursing care took place was during the morning, on all three wards this became a period of high activity. In wards one and three, the morning routine was punctuated by formal ward rounds twice a week and often the care of dying patients was carried out towards the end of the morning shift, so as to allow time for individualized care. Nurses would ensure adequate pain and symptom control before giving care to recovering patients. This rationale was explained by one staff nurse:

Those patients who are very poorly and dying need a lot of time and cannot be rushed, so we often make sure that we give them time after the others so that we can do all the things they need doing as well as making sure they have their pain relief beforehand.

The emphasis was placed on physical care but it was also observed that 'bracketing out' time in this way allowed nurses to ensure that the patient's psychological needs were assessed, although this was not made explicit by nurses during interview. Observational data were inconclusive in determining the focus of care during this 'bracket period'.

The nurses stated that the rationale was to provide what was termed 'quality time' with a view to enabling a bath to be given and time allocated for grooming and dressing. In 10 instances the patients were unconscious or semi-conscious and verbal interaction was limited.

Nondisclosure of terminal diagnosis

On all wards the operational strategy concerning knowledge about a patient's death was to inform the patient's relatives and to keep the patient in the dark, reflecting what Glaser and Strauss (1965) called closed awareness. In the acute assessment ward, this disclosure norm was implemented rigorously in all cases relating to terminally ill patients. Justification for adopting this paternalistic approach as others have indicated, was largely based on hospital staff attempting to protect the vulnerable patient from further harm and distress (Tuckett 1998, Field & Copp 1999, Costello 2000a). This type of justification was not shared by doctors and nurses as one sister pointed out:

I can appreciate that not telling them (the dying patient) stops them from getting upset but when they are able to cope with it, it's a different matter and we should treat each patient as an individual.

Nurses on all wards encountered a number of problems associated with applying ward disclosure policies based on closed awareness. Not least of these related to patients who had 'discovered' that the staff were withholding information from them and sought verification that they had a life threatening condition. An illustration of this type of situation, described by Glaser and Strauss (1965) as mutual pretence, was clearly evident in ward one where a dying patient became aware of the lack of investigations and general disinterest shown by medical and nursing staff, saying:

I know that something's up, I mean they used to be checking my blood pressure and temperature and taking blood samples and doing all sorts of tests. Now they do nothing and during the ward round they look at me and smile and say nowt, oh I know what's going on alright.

The origin of the nondisclosure policy on the assessment ward emanated from the ward consultant who made it clear to nurses that patients were not to be told their terminal diagnosis unless they specifically requested this information from doctors. Similar examples of mutual pretence were found in other ward areas where patients 'discovered' their terminal diagnosis as a result of poor communication between staff and patients. The tacit agreement on all of the wards was that most patients should be told the truth about their terminal diagnosis, although there was a lack of

consistency in the breaking of bad news to relatives. On the continuing care ward, when an elderly patient became very ill as a result of a chest infection, both relatives and staff shared the view that death was inevitable and thus communication about it was less evident than in the acute and rehabilitation wards. In one case an elderly patient who had suffered a profound stroke was dying from pneumonia. The relatives were not informed by the doctor that he was dying and saw no reason to seek the opinion of the doctor, as it was clear to them that 'there was no more to be done'. Other relatives on the continuing care ward were told only if they expressed concern about their family member. In situations on all wards where the doctor was unavailable, nurses, in response to a relative's request for information 'painted a black picture'. This involved creating a pessimistic and despondent image of the likelihood of the patient recovering, as one sister stated:

You have to make it clear to them that the patient is dying...it's just not fair otherwise, I usually ask them what would they like me to do if anything happens in the middle of the night, would they like to be called out?

The latter statement embodies the need to telephone the family if the patient dies, as well as acting as a form of confirmation that the patient's condition is so critical that they may die. For some relatives this formed the basis of breaking bad news, others were seen formally and given the news by the junior doctor, senior registrar or, rarely, the consultant. The daughter of one elderly male patient was unprepared for the news about her dying father:

I was quite shocked at first, although I realized he was very ill, no one told me how bad he was until I spoke to the doctor.

In general, the desire for nurses to inform relatives and patients about their condition was constrained by medical ideology and the reluctance of medical staff to involve nurses in decision making about disclosure of terminal diagnosis.

Power relations in elderly care wards

One of the distinguishing features of the way that the care was organized for dying patients was the interrelationship between doctors and nurses, in particular existing power relations between them. Invariably nurses have more contact with dying patients and their families, although it is often physicians who make the executive decisions. This situation has prevailed in elderly care for many years despite health care professionals working as members of the multidisciplinary team (Costello 1994). The data from both interview and observation in this study highlight the way in which nurses' decisions about dying patients were intimately

connected to directives from physicians. Three areas demonstrate this situation: treatment of symptoms particularly pain relief; disclosure of information about the patient's terminal diagnosis; and decision making about Do Not Resuscitate (DNR) orders. Nurses reported that their key role was to keep the patient comfortable and pain free. This was expressed in a number of ways:

One of the essential things about terminal care is making sure the patient is not in any physical or psychological pain.

I see my role as a nurse, to make sure the patient is not distressed in any way before they die and that their comfort and personal hygiene is my main priority.

Having clearly determined their role, nurses sought support from doctors in prescribing medication and reporting any signs of distress. Physicians considered their role in terminal care to be decision-making:

When a patient is dying it is up to me to ensure that they die with dignity free from pain and discomfort which often requires prescribing adequate medication and ensuring that treatment is aimed at alleviating any suffering (Senior House Officer).

I see my role as a doctor as someone who manages the treatment and care they receive so that there is a minimum of intervention and maximum support to the relatives (Registrar).

Physicians achieved their aims by making decisions on the patient's behalf, particularly pain control, although the impetus to prescribe narcotic analgesia was often initiated by the nurse. They also exercised control and power over disclosure of information about dying patients through the imposition of local rules about nondisclosure of information to dying patients. This nondisclosure, together with the imposition of DNR orders was not always based on a consensus opinion, although there was no evidence of nurses openly challenging medical decisions. Although physicians did write DNR instructions in the patients' medical notes, more detailed analysis revealed that in a number of instances nurses put pressure on doctors to make these orders. This change in the unproblematic subordination of nurses to doctors' wishes is described by Porter (1991) as an informal covert decision where nurses recommend patients treatments without appearing to do so. Nurses used similar strategies to increase or decrease medication by making deference to the doctor explicit, but also clarifying informally that it is in the patient's best interests. When doctors ignored such strategies, nurses would express their feelings, by being passively aggressive, adopting go slow strategies or through non co-operation. As one staff nurse pointed out:

I was not happy about Mr Brown having a DNR order he was so well and it wasn't as if he was dying or anything.

In situations like this where nurses disagreed with the expressed views of the medical staff, it was possible for nurses to forget the DNR order and not to point this out if a new member of the medical team joined the ward, a situation which did occur on ward one. The patient had a DNR order in his notes, which was well known to the nurses who failed to inform the newly arrived houseman who initiated CPR when the patient had a cardiac arrest. In this way nurses can be seen to influence the way interventions were made based on their own form of paternalism.

Discussion

This study has shown that despite improvements made in providing individualized care for dying patients (James 1986, Field 1987), their care does not appear to overcome some of the most important aspects, such as communication. The historical antecedents of elderly care such as shortage of human and material resources, may account for criticisms in relation to poor standards of care. This study reveals more fundamental issues, however, relating to truthfulness and a lack of willingness to engage meaningfully with patients about arguably the most sensitive issue of all – death.

In attempting to make sense of nurse's reluctance to 'open up awareness' about death, attention is drawn to two main areas. First, an examination of hospital ward culture, including interpersonal power relations, beliefs about nurse patient relationships and the protective strategies used to keep patients in the dark about their terminal diagnosis, reveals the existence of a number of tacit agreements. These unspoken rules appear designed to maintain a conspiracy of silence pivoted on compliance with medical instructions about nondisclosure of the truth to dying patients. Such tacit rules may be seen as an embedded part of ward culture in relation to dying patients when such conventions are developed and maintained by doctors and nurses and facilitated by traditional power relations between them (Porter 1991). Within this context, the truth about a patient's terminal diagnosis may be seen as a representational crisis. The truth is kept from the competent patient almost as if the prognosis were owned by professional staff who were reluctant to share it with the patient. In this way, as others have pointed out (Kelner & Bourgeault 1993), doctors and nurses exert control over how a patient dies. When a consultant documented in a patient's notes that they were....'to be kept comfortable, or that the patient was...for TLC', nurses understood such euphemisms and were expected to comply and not disclose

such information to the patient as this would upset what has been referred to as 'the sentimental order of the ward' (Strauss *et al.* 1982). This refers to the intangible, but real, patterns of mood that influenced the feelings of nurses and doctors on the ward.

The history of nursing is also a history of the subservience of nurses to the demands made by hospital doctors (Widgery 1988, Porter 1991). This is an important issue and when combined with the problem of having to manage a sensitive process like dying, it is understandable that nurses utilize, and even manipulate, their relationship with doctors. In allowing doctors to determine policy about dying such as ward disclosure norms, nurses may be regarded as conveniently abdicating responsibility for managing a complex and emotionally charged situation, avoiding what may be seen as the polluting effect of death. This may arise for several reasons, as others have affirmed, nurses find it very difficult to advocate on behalf of patients (Willard 1996, Mallik 1997). A further explanation could be that to offer older patients an opportunity to make choices about their impending death would, as Kelner and Bourgeault (1993) comment, be perceived as a challenge to the professional judgements of doctors and nurses.

Second, nursing care takes place within a culture that is influenced and shaped by both the personal and social context of the wider world. The professional culture in which many nurses work is based on acute rather than palliative care. This curative ideology places value on treatment and cure and not on death and terminal care, which may be seen as the antithesis of effective intervention. This, together with society's expectations for optimal health may contribute towards the isolation of death from everyday life. One of the tensions revealed in this study is the lack of congruity in nurses' stated beliefs about good care and the apparent lack of emphasis on providing effective psychological care to dying patients. This may be as a result of lack of training or the influence of stigma attached to death and dying. Blackburn (1994) argues that terminal care in hospital remains poor largely because of the lack of palliative care teaching received by doctors in their training. Although this is an area which is currently receiving attention, much palliative care is focused on patients diagnosed with cancer (Field & Addington-Hall 2000). Another consideration is the effect of caring for dying older people within institutional settings. Since the 1960s when hospitals were said to be 'cradled in anxiety' (Revans 1964), many researchers have highlighted the stressful nature of caring for dying patients within institutionalized settings (Wilkinson 1991, Ackroyd 1993). Organizational demands on hospital staff in general and the imposition of rigid ward routines and bureaucratic adminis-

tration place considerable strain that can often leave staff feeling emotionally blunted when considering the specific needs of dying patients. (Vachon 1987, Lawler 1991, Smith 1992).

Although this study focused on the role of the nurse in terminal care, which many writers claim is a nursing issue, Ahmedzai (1982) makes the case for doctors experiencing similar problems. Despite the fact that nurses have more contact with dying patients, Ahmedzai points out that junior doctors 'are almost always intimately concerned in the care of their dying patients' (p. 712). Ahmedzai's (1982) survey of junior doctors' experiences of managing terminally ill patients revealed 'areas of ignorance and insecurity among newly qualified residents dealing with dying patients' (p. 713), with 95% of respondents stating that terminal care was an important part of their role.

Study limitations

This study throws into relief some the problems associated with terminal care in hospital, but in particular the lack of communication about patients' terminal diagnoses. The author acknowledges that despite the limitations of focusing on only three ward areas, the study reveals a number of insights into the care of vulnerable individuals. The findings however, cannot be generalized widely in relation to hospital terminal care as the elderly are but one of many social groups who die in hospital. It is however, clear that the care of older dying patients is an area of concern for many nurses, particularly, the social management aspects of dying relating to resuscitation status (Candy 1991, Costello 2000, Payne *et al.* 2000). The evidence from this study relating to communication and DNR status remains inclusive and much more research is required in order to illuminate this sensitive and important area of nursing practice.

Implications for nursing practice

The management of terminal care in hospital requires diagnostic skill and sensitive nursing care which should extend to emotional support for those who are close to the dying patient. Providing effective care for the dying has enormous implications for enabling the bereaved to develop positive coping skills, causing them to reflect on death as a good or bad event in their life. The death of a loved one is often a crisis and in many cases can constitute a tragedy. The emotional damage caused by a lack of care can leave emotional scars not only on the bereaved but also on those who witness the death of fellow patients (Payne *et al.* 1996). Nurses and others have a professional duty to provide

terminal care of the highest standard. Where death is unavoidable, it should not be regarded as a failure and patients who are dying and their relatives/friends should become involved in their care. The study highlights implications for improving the way in which information about death and dying is discussed with all parties. Communicating factual information about the dying person's physical condition may be seen as a way of avoiding the formation of a more substantive and therapeutic relationship. Nurses may also avoid more meaningful contact with the dying because of the potential for becoming stressed which is a reality for many nurses who experience a range of problems when caring for dying patients (Maeve 1998). Workplace pressures are however, increased when caring for a patient who is unaware that they are dying. Nurses should confront their own dying philosophy and consider the detrimental impact that strategies for nondisclosure of information about dying can have on patients and nurses alike.

Conclusion

The findings from the study reported here suggest that terminal care in general remains hampered by a reluctance to be more open in communication about death. It would appear that hospital culture and the mores, beliefs and ideologies that emanate from the biomedical model, shaped terminal care for the older patients in this study. Hospital experiences of dying are problematic for many nurses who are aware that the end of a patient's life should not mean a reduction in the quality of care. The findings from this study although not statistically generalisable, indicate that one of the key areas for improving the care of dying patients in hospital lies in challenging professional practices and involving patients and their relatives in what, is a sensitive and crucially important part of human experience.

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