Death in American society generally has negative connotations. People fear death and try to deny that it exists because they find it unexplainable, or they have not learned how to deal with it. They know that some day death will affect them by taking the life of someone they may love, or their own life. Death, therefore, is more than a biological state, it is also a psychologic reality.

Three-fourths of all deaths occur outside the home, and one-half occur in hospitals. In the American culture, fears concerning death certainly are reflected within hospitals in the behavior of nurses toward the dying. Often the dying patient is not seen as a total person, and this communication between the nurse and the patient is hindered. The dying patient is a symbol of what every human fears, and what nurses know they too must face eventually.

Nurses have special relationships with the terminally ill, in contrast with other hospital staff, because nurses and patients usually are together for a time sufficient to establish a relationship. The way nurses perceive the act of dying, e.g., as painful, upsetting, indifferent, or a blessing, influences the treatment the dying patient will receive during the last days in the hospital or nursing home. The terminal period of dying is a major transition time for the family and the patient that nurses can affect by their day-to-day activities. Nurses have the potential either to enhance understanding of death for the patient, or create even more problems for the patient in understanding the changed physical state.

A Humanistic View of the Nurse and the Dying Patient

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In the past nurses seemed to have had more direct physical contact with patients, but the increased use of medical technology has resulted in a depersonalization of patient care. The benefits of medicine and technology will be lessened if there is absence of affection and trust between nurses and dying patients. The major purpose of a hospital or nursing home is to help people recover from their illnesses. This purpose is not as relevant when the patient is dying. How should the nurse behave toward a patient who has reached the point where there is no more "workable life-activity" to perform? In this instance the goal of saving a life is not fulfilled. There appears to be no commonly ac-
must keep myself in good standing in order to get care. If I have pain and need something, I know that the nurse might get angry if I turn on that light too frequently. I’m saving it.”

Obviously a power play can develop between the nurse, who gives, and the patient, who receives, care.

Qualitatively, this kind of struggle for attention occurs in many nursing homes. June B., an 87-year-old resident in a nursing home, who was dying of cancer and tended to complain frequently, got almost no help from the nurses. A visitor who spent an afternoon with this quite obviously sick woman reported that no nurse checked on her for several hours. Only after the call bell had been pressed for more than 25 minutes did a nurse’s aide respond. Nurses in effect sometimes “reward” and “punish” patients by the promptness, or attention, shown in the aid given.

After a time the dying patient’s sense of helplessness is reinforced when communication with the nursing staff is cut off consistently. One effect of this is decreased communication concerning the patient’s feelings about death.1 Nurses tend to reward patients for maintaining a denial of death, as this denial protects the nurses from socioemotional involvement, and the likelihood of facing the reality of their own feelings about death. In turn, patients are made to feel dependent on the nurse, and to feel grateful for the care given.

The Dying Patient

How does a person find out that he or she is dying? Who provides this information, and when? As Feifel stresses, there seem to be two sets of criteria used by physicians or nurses when “breaking the news” to the patient.6,9 The first set of criteria stresses the situational context in light of the patient’s psychologic state: (a) do not tell the patient anything that might induce psychopathology; (b) hope must never die too far ahead of the patient—hope of getting better, and hope of future enjoyment of conversation; (c) the gravity of the situation should not be minimized, but speak the exact truth of the situation without making it better or worse than it is; and (d) manage the timing of telling the patient about his death so that the patient is not sitting idly waiting to die.

The second set of criteria also places emphasis on the patient’s psychologic state, but with greater stress on the individual’s psychodynamic makeup, and the effects such patient knowledge would have on others, including family, physicians, and nurses: (a) the psychologic maturity of the individual; (b) the coping techniques of the patient; (c) the influence of religion, age, and gender on the individual; (d) the severity of organic degeneration; and (e) the attitudes of the physician and other significant persons in the patient’s world.

Upon learning of his impending death, a person can have one or a combination of three basic responses. First, the person approaching death may experience negative feelings about self. Second, the person may feel totally alienated from others, including the nursing staff. Third, the symptoms of death may not be readily apparent to the patient, creating a denial of death.10 Furthermore, the patient may not know the extent of his physical condition because either no one has told him, or he has indicated he did not want to know. The patient’s awareness of his death affects the way people react to him. The way people act with one another depends on what each thinks the other knows. If the patient is dying and knows it, or if the patient knows it but thinks other people do not know, the interaction between the dying person and others is affected greatly.10

Nurses and the Dying Patient

Nurses have varying motives for developing relationships with patients. They may wish to test the strength of their own personalities...
A Humanistic View

by getting the patient to act in ways they desire. Or, to justify or minimize inner conflict, a nurse may think: "This patient is much worse off than I am." A relationship may begin to enhance the nurse’s own personal gain above peers—a nurse who can get a difficult patient to eat a meal without difficulty gains the approval of coworkers or supervisors. The nurse also may be acting out personal conflicts in other areas by taking out personal frustrations on the patient, e.g., a fight with a spouse the night before, or dissatisfaction with pay. Or the nurse may be caring for a patient only because the supervisor has so instructed.11

The Dying Process and the Nurse’s Understanding. Nurses are people first and their reactions to death, like anyone else’s, are influenced by significant events and people in their own past. Thus, the nurse’s first step in improving care for the dying is to understand personal feelings and attitudes on death and dying.4 As one nurse said about a patient, "I most certainly did know that Mrs. Johnson was dying—perhaps unconsciously, but I did know it. That was why I did not stay with her; I was frightened."12 This nurse has begun to recognize her own feelings about death.

Kübler-Ross13 conducted a study in a geriatric hospital in the late 1960s using a 60-item questionnaire designed to assess the inner feelings some nurses had for the terminally ill. One of the more revealing questions was: "The first time I was with a dying patient I (a) had no particular feelings, (b) had feelings and tried not to let them show, or (c) had feelings and let them show." Ninety percent of the respondents chose alternative (b). Using the same three response alternatives, another insightful question was: "When I am with a dying patient I usually..." Response (b) from above was chosen by 94% of the respondents. A third pertinent question was: "When a patient starts to go downhill my feelings about him usually (a) become weaker, (b) stay the same, (c) become stronger. The results showed that 3% chose (a), 40% chose (b), and 57% chose (c). Thus, it seems that nurses believe that they should control their own emotions, but at the same time be sympathetic to the patient’s needs.

Collegial Support. To understand their feelings about death, nurses also need support from their colleagues. Social psychologists agree that a person’s self-concept is shaped through communication with others, which may influence how they communicate with others.14 The feedback that nurses receive from each other will affect how they deal with dying patients. The nurse needs to talk about the meaning of the experience of death in order to meet the role expectations of providing comforting words, understanding, and support to dying patients, and to help resolve their own feelings.6 As pointed out by Ross,8 discussing these concerns with nurses enables them to become more open to responses about death from dying patients. It is suggested that normally it takes nursing personnel a year to 18 months to become confident in working with dying patients and their families,15 but the behavior exhibited in dealing with death generally is the nurse’s own style of coping with any stressful or unexpected situation.

With these personalized coping styles, all too common occurrence is the nurse’s denial of the reality of death. If the fact that the patient is dying is suppressed, the nurse does not have to deal with the patient on that level.1 However, when the reality of death is faced, another common reaction, especially when the patient is in the final stages of death (perhaps in a coma), is to treat the patient as if already dead. The patient is viewed as “socially dead.” That is, the patient no longer can make any relevant social contributions: conversations and activity occur as if the patient were already deceased.16 Many times the patient is drugged in an effort to help ease pain and is unaware of the surroundings. However, some patients prefer to have a little discomfort and be able to remain alert. This can present a problem to the nurse, whose duty to provide comfort is being hampered.4

Knowledge and Awareness of Patient Condition. The nurse’s relationship with the dying patient also is affected by the nurse’s knowledge of the patient’s condition and by the knowledge the nurse thinks the patient has. Browning and Lewis17 stated that the level of awareness of death knowledge between the patient and nurse can be specified as one of four types: (a) closed awareness—the patient does not know about his coming death but everyone around him does; (b) suspected awareness—the patient may suspect what others know and tries to confirm the information; (c) mutual pretense awareness—both nurse and patient know he is dying but pretend not to know; and (d) open awareness—both the nurse and patient know about the impending death and act openly about it.

In some relationships, e.g., with a patient who is slightly ill, the nurse has no need to guard against talking about death. If a patient is known to be dying, however, there is reason for the nurse to guard against involvement with the patient, both to preserve the nurse’s own composure and to maintain an appropriate professional order within the working area. When a patient reaches the point where there is "nothing more to be done," the nurse’s approach may change from one of helping the patient improve to one of providing satisfying comfort. The whole attitude changes toward serving comfort, and the nurse uses many personal strategies for maintaining professional composure in this situation.4

Loss of composure occurs when nurses become emotionally attached to patients, when they define themselves as negligent in helping, or when they are unable to perform in what they consider an acceptable professional manner. Some nurses become so emotionally attached to a
patient that they break down when the patient dies. The nurse may feel negligent, perhaps wondering what more could have been done, when a patient dies unexpectedly. A loss of professionalism may occur if the nurse feels unable to keep the family, the physician, or other staff members comfortable in dealing with each other about the patient's death.17,18

In this regard Glaser and Strauss19 have detailed four types of avoidance mechanisms that nurses use to avoid the topic of death: (a) They may listen selectively only for information that will help with their work, e.g., listening only to the patient’s “medically” relevant complaints, not to complaints of a social or interpersonal nature; (b) The nurse may not speak until spoken to and then say as little as possible, reducing any feedback from the patient that could involve the nurse further and threaten the nurse’s composure; (c) The nurse may select from a patient’s communication the least compromising subject and respond only to that, e.g., the weather, what is for dinner, what is on television; (d) The nurse can use “role switching” by telling the patient to “talk to your doctor about it,” or speak in technical medical jargon, or emphasize the scientific by referring to the patient as a case or disease instead of a person. The patient no longer is viewed within a social context, but only as a medical entity. All of these imply that the nurse is maintaining a closed awareness level. Browning and Lewis state succinctly:

As may seem obvious, nurses make maximal use of composure tactics to protect themselves from personal involvement, and their defense tactics increase when circumstances threaten to break down the composure facade they have developed. They are particularly vulnerable to deaths of patients whom they like, have known for long periods of time, or whose death carries a high social loss, and also they can be vulnerable because of involvement with the family.9

The Inference of Social Loss. The amount of social loss from a patient's death also can affect nursing care. The death of a baby usually implies more social loss than if an elderly person dies. The greater the patient’s social loss characteristics, the greater will be the effect of that patient's death on the staff. For example, Raines10 reports the experience of one R.N. who cared for a 26-year-old dying man. He was young, handsome, well-dressed, and a father. While in the hospital he needed to be in the intensive care unit. But he disliked the ICU, so the nurses supported and implemented the transfer of lifesaving equipment to another area of the hospital where the patient felt more comfortable. Would these nurses have done the same for a single 70-year-old man? Indications suggest that probably they would not.

Research has found that some patients in hospitals are treated differentially and often avoided by nursing and medical staff because they are “difficult” patients—poor, black, elderly, or disoriented.8 It has also been pointed out that many nurses tend to take a longer period of time to respond to a call bell of a dying person than that of a nondying person.21 This obviously affects the social and psychological condition of the dying patient during the last days in the hospital.

Nurse-Physician Communication. The way nurses interact with dying patients also is largely affected by the amount of communication between the physician and the nurse. Some doctors do not tell nurses what information has been given to their patients about the impending death.17 Nurses, if they do not know the amount of knowledge the patient has, may assume the patient has none. The interaction between the patient and nurse, therefore, lessens because the nurse does not know how freely to speak.22 If the physician tells the nurses what the patient and family have been told about the patient’s condition, then the nurses can manage interactions better with both the family and the patient.22

Emotional Caring. One aspect of nursing that applies well in tending to the dying is caring. The dying person needs someone to listen, and it is not necessary to be a psychiatrist to listen and care.11 The dying want to interact with a “real” person—someone who will respond to their call—not a cold professional.11 Some techniques of communication with the fatally ill recommended by Browning and Lewis4 are: (a) be respectful and tactful; (b) be reassuring; (c) prepare the totally unprepared patient; (d) use circumlocutions, analogies, and other verbal techniques; (e) emphasize hope in the patient. In short, nurses should strive to be empathic interactors in their relations with the dying person. In short, Browning and Lewis stress:

Perhaps we need to remind ourselves from time to time that patients who are dying are not just dying. They are also living. Whether or not they have the opportunity to live this final human experience to the fullest—each in his own way—is influenced in a great measure by those who take care of them.9

In support of this contention.

“I most certainly did know that Mrs. Johnson was dying—perhaps subconsciously, but I did know it. That was why I did not stay with her; I was frightened.”
Freihofer and Felton showed that the dying person as well as family members of the dying person desired that “nursing behavior be directed toward support, comfort, and ease of suffering of the fatally ill”.\(^2\)

**Conclusions**

Quite clearly, in American society, dying and death are events that both health professionals and non-professionals attempt to deny. As shown in many animated productions—initial frames showing the death (murder or pain) of a character followed immediately by frames in which the character is physically fine—death is not presented as a permanent state. Our society appears to support the notion that death is somehow unreal and less serious.

Similarly, our society tends to deny aging. Aging eventually results in death and, if one can deny becoming older, one can deny death.\(^1\) Attitudes about old age represent much ambivalence toward death. On the one hand it can be stated that “he has lived a full life and it is time for him to go,” and on the other, one can pretend the old person is not dying.\(^2\) The average nurse finds it difficult to work with the elderly because they are closer to death—a condition most Americans wish to avoid. As Browning and Lewis query: “Do we unconsciously fear them?”\(^3\) Some people who work in nursing homes tend to view the residents as terminal because they are old, reside there, and do not usually return to a normal life outside the institution.

Nurses, whether they realize it or not, have a great deal of control over what happens to a dying patient. A nurse can influence the patient’s social milieu by regulating drug use, controlling interaction between patient and family, and influencing the feelings of importance the patient has by talking with or ignoring the patient. Despite these concerns, personal experience within nursing homes and hospitals has shown that most nurses feel it is important to maintain a professional attitude as well as be humanistically concerned for the dying person. Nurses will have a start at being more effective in dealing with dying patients only when they have a clearer understanding of societal values. But, more importantly, nurses must understand the dying person’s values and needs, and their own values, attitudes, and needs.

**References**