

# Review Article

## DEATH AND DYING

Mary Jean Etten\*

David Field, *Nursing the Dying*, Routledge, London, 1989, 175 pp., pbk £8.95, ISBN 0 415 015043, hbk £25.00, ISBN 0 415 01503 5.  
Richard W. Momeyer, *Confronting Death*, Indiana University Press, Bloomington, Indiana, 1988, 184 pp., \$25.00, ISBN 0 253 31403 8.  
Lindsay Prior, *The Social Organisation of Death: Medical Discourse and Social Practices in Belfast*, Macmillan, London, 1989, 230 pp., pbk £12.95, ISBN 0 333 46435 4, hbk £35.00, ISBN 0 333 46434 6.

Richard Momeyer's *Confronting Death* is about the values used in making choices when confronting our life, our dying, and our death. Often these choices involve others. They can be as basic as whether or not to go on with life or they can relate to our feelings, thoughts and attitudes about life's values and goals. The choices examined have long been an integral part of religious considerations and beliefs, but here the author maintains a consistently secular point of view. In examining these issues an attempt is made to tread a path between the principle of the sanctity of life, that life should be maintained over all else, and the position that self-determination and individual choices are sufficient to define the values of a life. In fluctuating between these viewpoints, the author agrees that death is always an evil for the person who dies, and that individuals should have an unrestricted range of choices for death.

Three basic beliefs of the author are outlined. First, while endorsing a wide range of morally legitimate choices for death and maintaining that death is an evil, something good might be said for certain ways of dying. For example, some living conditions may be more unbearable than death itself. Secondly, he believes that human beings are unique among living creatures, since at least in part they create and define their own characters and personalities. The achievement of rationality and consciousness also distinguishes human beings. Thirdly, Momeyer believes that humans demonstrate their self-creation by the tendency to

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struggle against limits to creative achievement. As death inhibits overcoming these limits and the individual's struggle for growth, it is resisted. Momeyer is sympathetic towards this approach to death which he calls 'rebellion'.

Lastly, the author hopes this book will assist its readers to live 'the examined life'. By this he refers to the implication of confronting death, that it requires confronting the questions of what it is about life that we value and what interrelations we elect to have with other individuals. He believes that meditating on death is an integral part of living an examined life.

Death mystiques, denial, acceptance, and rebellion are discussed extensively in chapter one. Denial is described as a persistent attitude of finding it inconceivable to consider the reality of our own death. It is an attitude or manner of coping with frightening information we would prefer to ignore: it is self-deception or lying to self. Limitations of denial are then outlined. Denial cannot be maintained unless everyone consistently maintains the illusion. Furthermore, it does not prepare an individual for dying since it inhibits communication, creating an even more painful situation of pretence and hypocrisy. Momeyer believes that denial deprives one of a satisfying life, providing instead an unexamined life of superficiality. Denial may also exist in every social interaction and gesture, whether between relatives and friends or in the law office, doctor's office or funeral home.

Acceptance is perceived as a more appropriate strategy for facing death, since denial is so humanly inappropriate. The 'death awareness' movement advocates openness about death which the author calls the 'mystique of acceptance'. The mystique is believed to be perpetuated in death counselling, in the physician's discontinuance of life-sustaining measures for the terminally-ill, and in academic endeavours to make it acceptable through greater theoretical knowledge. The mystique of death acceptance tends to deny all human responses to death except acceptance. Because death is a universal and inevitable human experience, the author contends that it cannot be beneficial for it to be faced with peace and reconciliation. Resistance to the acceptance of death, Momeyer states, gives rise to rebellion – the third approach to death. It is rooted in the belief that our world is not altogether a good place for humans, displaying as it does inequity and oppression. Rebellion is seen as a commitment to affirming the value of every human life. Only by striving against that which limits human options for fulfilment and achievement would it be possible to experience the fullness of what it means to be human. Death is believed always to be a great evil for those who are dying, because it is the loss of the possibility of further gratifying experiences.

The value of fearing death and of caring for the dying are then discussed. Fear of death may be unavoidable and an understandable reaction to fear of the unknown and loss of loved ones. A care-giver's fear of death is not necessarily an impediment to providing supportive, sensitive care to the dying. In fact, the author contends, a personal fear of death might be indispensable in meeting the needs of a dying person.

Whether natural death is a good death is discussed in chapter five. The meaning of natural is examined using six categories: scientific, statistical, anthropological, conventional, theological and evaluative (moral). The author concludes a good death is not synonymous with a natural death. What is meant by a good death needs close examination when attempting to understand the right to die, guidelines for public policy, and making treatment decisions concerning life prolongation. The author believes that the right to die with dignity is secondary to the right to continue living. Curing disease should, of course, not be an end in itself but a means of helping people afflicted with diseases. Thus Momeyer argues that nursing and medicine should be more concerned with the dignity of the person, body and soul, than merely with physical curing. Dying with dignity is described as preserving consciousness and self-awareness as well as maintaining absolute openness and truthfulness with the patient. It requires respecting the patient's right to make choices and the implementation of identified choices.

Part II of the book focuses on choosing to end life, such as in suicide, by refusing life-sustaining measures and in receiving assistance for persons unable to do so for themselves. Suicide is preferably defined neutrally as 'self-killing'. It is a human action, the analysis of which involves elusive concepts such as will, knowledge, intention, desire, causation, coercion, compulsion and suffering, as well as distinctions between voluntary, involuntary and non-voluntary doing. Ten suicide case studies are discussed. Historical and contemporary attitudes toward suicide are described with the conclusion that rather than condemning suicide, contemporary society finds it praiseworthy. This attitude is reflected in literature and in organisations that promote active euthanasia, assisted suicide and the 'right to die'. The author concludes that individuals have the right to choose death based upon their entitlement to liberty, as an autonomous individual deserving moral respect, and through the tenets of human dignity. While suicide rarely expresses or enhances human dignity, it can reflect the individual's liberty and the right to live with dignity.

Since there is a paucity of professional literature related to nursing the dying in England, the British teacher of thanatology to medical and nursing students relies primarily on United States' publications. This

dearth has prompted David Field to write *Nursing the Dying*, based on his studies of four clinical settings in England. The study focuses on the interrelation between the attitudes of nurses toward the dying and the social organisation in which they practise nursing.

The book is divided into three parts and eight chapters. Part One provides general background information. Here the author describes patients' knowledge of their terminal condition and how this knowledge influences the dying process. Attitudes of professional care-givers toward dying people seem to correlate with psycho-social experiences and the manner in which people die. Negative societal attitudes toward death and dying are often reflected in care-givers' attitudes, which then influence the patient's dying process. Frequently, terminal diagnoses are concealed from patients in England, and both doctors and nurses are reluctant to convey this information. Rationales for and against the practice are outlined.

Next the organisation of nursing practice in the United Kingdom is described. Nursing continues to be viewed as subordinate and ancillary to the medical profession. About 90% of nurses are female, the turnover rate is high, and salaries remain relatively low. Implementation of the nursing process has professionalised nursing somewhat, but it has not been accepted by all practitioners or in all practice settings. Doctors in England primarily determine, without patient input, whether active, curative treatment or palliative care is given to the patient. Nurses are even restricted by physicians from relaying information to the patient regarding their health. While some English nursing schools include thanatology in the curriculum, one study reported that both nursing and medical students found the content to be inadequate, especially in relation to clinical settings. Few good role models are apparently available to teach thanatology to nursing and medical students.

Part Two of the book compares and contrasts nursing of the dying in four settings; an acute surgical ward, a general medical ward, a coronary care unit and the home. Two themes are used to investigate the problems surrounding a dying person's awareness of dying and how these specific settings affect the patient's communication and interaction with nurses. Likenesses and differences characterise nursing the dying in these four settings. On the acute surgical ward, the observer had greatest contact with 13 of 40 terminally-ill patients admitted during the study period. The unit was staffed mostly by inexperienced nurses, there was high turnover and a high patient-to-staff ratio. The Sister in charge was aloof and communication was ineffective between herself and the staff. Nurses functioned primarily in technical roles and there was only limited and routine communication with the patients. Since

patients were not expected to die here, the nurses found it difficult to accept the fact that some patients returned from surgery with a fatal prognosis. Physicians generally did not inform their patients of a terminal diagnosis and the nurses were forbidden to do so, even if the patient asked. Only 5 of the 13 patients seemed unaware of their diagnosis, so while the physician escaped confronting the patient regarding their future, considerable pressure was placed on the nursing staff.

The general medical ward had sixteen qualified nurses assisted by students. The Sister delegated authority, allowing for more individual nursing practice than in the previous setting. She was supportive of the staff, and communication patterns were open between herself, the staff, and physicians. Since doctor–nurse communication was open, the physician often followed the nurse's lead in disclosing a diagnosis; nurses too felt free to share the diagnosis with a patient should the occasion arise. Nurses even reported becoming attached to patients. Good role models were present, which facilitated teaching students effective interactional skills with dying patients. The main problems identified by nurses were breaking the news to relatives and comforting the grieving.

The coronary care unit had eight beds. Patients tended to be younger and the average length of stay was short. The atmosphere was described as relaxed and informal. Nurses reported feeling positive about their work and relationships with physicians were good. Few patients died on the unit. When death did occur, nurses did not view it as a personal failure for they believed they did all they could to sustain life.

In 1984 26% of deaths in England and Wales occurred at home. Nurses interviewed in connection with the fourth clinical setting, homes, were studying for a certificate in district nursing. Eight currently worked in home care; the other six were new to this practice setting. These nurses tended to be older than hospital nurses. Most patients were elderly people suffering from chronic illnesses. Nurses practised in an autonomous and flexible manner with less specific protocols than in hospitals, but still under the direction of a physician. These practice-settings offered little colleague support. Nursing roles were perceived primarily as 'mutual cooperation' with the family, in which nurses counselled the patient and relatives while monitoring and controlling pain. This type of nursing necessitated intensive and sustained nursing input. The general practitioner did not normally approve of telling patients they had a terminal prognosis. Nurses likewise did not consider this their responsibility, even though they

believed open awareness was preferable. Relatives seemed to be the most significant barrier to informing the client of a fatal illness.

Part Three describes the organisation of nursing the dying and includes the wider considerations of holistic care and the methodology used in the study. It also summarises and compares the care in each of the settings studied. Overall staff were young with little clinical experience related to terminal care. Their hesitancy in these situations was mirrored in widespread societal attitudes towards dying and death. While in some settings nurses believed in creating open communication with their patients, subservience to physicians often dictated the creation of closed awareness.

The author recommends that nurses and physicians review their own attitudes toward dying. He advocates substantive, theoretical and clinical studies in thanatology to help them practise in a more supportive and less stressful manner with each other, and with the dying and their relatives. He also recommends that nurses are encouraged to display individual initiative and to take decisions. When reviewing societal and health care practices over the past 25 years, the author cites several authoritative sources which have suggested how and when to disclose a terminal prognosis. There is a trend for physicians and nurses to receive more formal education regarding terminal care; fewer seem to perceive a patient's dying as a personal failure.

The prospects for altered terminal care are considered in the context of trends in nursing education and practice in Britain. Increased specialisation is causing fragmentation. Fewer are seeking admission to nursing schools, as practising nurses continue to work in unfulfilling settings. Terminal conditions are still normally withheld from both nurses and patients, creating a depersonalised context of care. Even home care is assessed as being of poor quality. Overall, the author believes that the current pressures in the National Health Service, along with the organisation of nursing, contributes to an environment in which holistic care is not respected or promoted. The author questions if humane care can be given to the patient if care-givers are themselves exploited.

Lindsay Prior's *Social Organization of Death: Medical Discourse and Social Practices in Belfast*, describes a study of 10% of the deaths (415) registered in Belfast, Northern Ireland in 1981. Prior traces the social, medical, religious, legal and political activities from the time death was pronounced until the disposal of the body. Other than studying dying, the author analyses the knowledge and social practices the people used to organise these deaths. Death is represented in its public and private

realms. The former pertains to the state and its agencies through which death is organised and certified. The latter focuses on the expressions of emotions and feelings, rituals, and on the funeral home and cemetery.

The 1950s represent the transition from an era when death was hidden from people and repressed through denial to one in which death is observed and discussed openly. The meaning of death as it affects every day and the process of death have become a new interest. Three disciplines hold death as an object; demography, pathology, and sociology. Death is explained as it relates to historical, cultural, and social practices. Signs of death are seen on or within the body, causes are found inside the body, a death cannot be registered unless a body is produced; it is prepared by a funeral director, eulogised by a clergyman, and wept over by the bereaved. All of these are not possible without a body.

The changing accommodation of death is described. In present day Belfast, death is seen primarily as a medical problem with the majority of individuals dying in hospitals and nursing homes. Only physicians can confirm and explain death. The major causes of death are classified as circulatory, respiratory, and neoplastic diseases. Deaths are thereby classified as 'good' or 'bad' but not as natural or unnatural. For the most part, social actions have been deleted from the specific causes of death, thus easing the coroner's task of determining if the death is caused from a natural or normal cause.

In the chapter on the pathology of death, Prior describes the mortuary as a place where the state's investigative powers and the science of medicine combine to process the dead. Unnamed, isolated, and often outside city boundaries, its functions have an important impact on the activities of the living. The mortuary has three sections; the post-mortem room where the causes of death are investigated, the mortuary where bodies are prepared and kept until burial, and the chapel where they are viewed. Specific documentation is made and each body is marked for identification with a number and a tag. Determining the cause of death is not only medically important, it is also a concern of political and legal agencies. Whether or not an autopsy is performed is dictated by using specific criteria. Autopsies are performed more often on men under age 60 years, those dying violently and manual workers. Social factors are also considered along with clinical criteria in the selection of bodies for autopsy.

Part Two of the book focuses on the private realm of death. A triple isolation is described of the church from the cemetery, the cemetery from the village, and of persons from each other. Members of Catholic and various Protestant groups often do not share the same cemetery

and if they do, each have their own sections. Its architecture and the epitaphs reflect the purchaser of the stone, age, sex and kin relationships or how the person died. Segregation in the cemetery exists also in regard to one's age, socio-economic status, and diseases causing the death.

In investigating the historical and anthropological aspects of grief in its public manifestations, the author finds that grief is conditioned by social status. The content and place of publication of funeral notices reflect the sentiments of the bereaved. For both Unionist/Protestant and Nationalist/Catholic, not only is the death announced in the newspapers but also printed are expressions of support or sorrow from relatives and friends. There vary from none to over one hundred. Sex, occupation, marital status, age, and cause of death influence their number.

Funeral practices in Ireland focus on three states of the person: the corpse, the soul, and the persona or social-being. After announcing the death, three days normally elapse before the disposal of the body. After death the body is taken to a mortuary under great secrecy. Catholics are not but Protestants are likely to be embalmed or cosmetically made-up for viewing. Both Catholic and Protestant funeral directors believe the body should look restful and peaceful. Bodies are normally new-clothed and placed in a coffin. Viewing is usually possible for three days following the death.

Irish Protestant culture believes the ascent of the soul occurs on the day of the funeral while Catholics view the soul's entrance into heaven as a process rather than an event. Irish Anglicans and Protestants do not believe in prayers for the dead, whereas Catholics offer prayers for the dead who may not be in heaven but in purgatory. The major theme of Protestant services is to console the living and to emphasise the rebirth of the dead, while Catholic ritual focuses on the passage of the dead to the hereafter. The social persona of the deceased are defined in the social, political and cultural symbols used during body disposal. The dead are politicised when they are used as totems by which groups enhance solidarity, political movements are mobilised, and political actions legitimised. An attack on the individual then represents an attack on the community.

The three books under review articulate remarkably different approaches to the subjects of death and dying. Momeyer presents a philosophical consideration of the choices that may be made by an individual, building from an examination of basic issues related to the 'sanctity of life' and the 'death mystiques' of denial, acceptance and rebellion. Throughout, the author holds firmly to the premise that

death is always an evil for the person who dies, and thus each person deserves to be free to make choices for this death. Through facing death, Momeyer believes, we are challenged to examine all that life means to us. A continuous confrontation of death is considered to be part of the 'examined life' which he hopes his readers will accomplish.

The book elucidates these crucial issues through several case studies. Contemporary life support systems and chemo- or other therapies choices mean that patients are often not presented with enough information to make their own choices. Neither have many professionals come to terms with critical issues of life and death and the associated ethical issues. Furthermore, the fear of lawsuits further restricts choice for the dying person. Decisions to refuse extraordinary therapies are often made at the expense of human dignity and family suffering. For an individual whose attitudes toward life are derived from the Judeo-Christian view of the immortality of the human soul, death is not a total evil as the author purports.

While it may not be necessary to dispel all fear of death, most authors believe that care-givers benefit from coming to terms with the inevitability of death. Failure to do so may reinforce care-givers' fears to the point where they are unable to be of therapeutic benefit to the dying person. *The Guidelines on Termination of Life-Sustaining Treatment and the Care of the Dying*<sup>1</sup> may be of assistance to care-givers as well as the book *Deciding to Forego Life Sustaining Treatment*.<sup>2</sup> Lynn's (1989) recent book *By No Extraordinary Means* presents a view of the issues from a historical, moral and legal viewpoint as it relates to particular populations.<sup>3</sup>

Field's *Nursing the Dying* describes communication modes and organisational structures as they relate to nursing care of the dying. Contrasts and likenesses are drawn from research in four clinical practice settings, and he reviews other societal and nursing trends which have influenced nursing care of the dying. While the book primarily studies a small and probably unrepresentative sample of nurses in four care settings, it might prompt other researchers to carry out further studies of larger numbers or in other special care settings. Such data could become a valuable rationale for both the National Health Service and educational institutions to improve the care given to the dying and thanatological education.

Since England has long-established hospice care, could not its best practitioners be a strong voice for more humane care for the dying throughout the United Kingdom health care system? About ten years ago Dr Cicely Saunders from St Christopher's Hospice advised health service providers in the United States to be wary of losing the vital

components of the hospice philosophy when implementing hospice care. While some degeneration may have occurred, the United States has by and large maintained an impressively faithful model of hospice care.

Field's book might be used as a text for classes in nursing and medicine, to convey the current state of care of the dying, and to stimulate the inclusion of more clinical practice and theory relevant to nursing the dying. It is not however as useful a basic textbook in teaching students how to care for the dying as others.<sup>4</sup>

Prior presents an interesting historical view of death in Belfast in 1981 in *The Social Organization of Death*. Social, religious, legal, medical, and even political activities are traced from the time death is pronounced until the disposal of the body is complete. While certainly of value to those interested in this city's current practices, the book may be of greatest general value as a supplementary text or for an in-depth discussion of how a city has dealt with the public and private realm of death in the past and present. The book would however not seem to be appropriate or useful as an overall text in teaching death and dying to students. All three books are perceptive accounts of their respective subjects and are recommended to those interested in expanding their personal knowledge and as background material for teaching and counselling.

## NOTES

- 1 *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*. A report by the Hastings Center, Indiana University Press, Bloomington, Indiana, 1987.
- 2 *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical and Legal Issues in Treatment Decisions*. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Government Printing Office, Washington, D.S., 1983.
- 3 Lynn, Joanne, *By No Extraordinary Means*, Indiana University Press, Bloomington, Indiana, 1989.
- 4 Gonda, Thomas A. and John E. Ruark, *Dying Dignified: The Health Professional's Guide to Care*, Addison-Wesley, Menlo Park, California, 1984; Amenta, O'Rowe Madalon, and Nancy Bohnet, *Nursing Care of the Terminally Ill*, Little Brown and Co., Boston, 1986; Kubler-Ross, Elisabeth, *To Live Until We Say Goodbye*, Prentice-Hall, Englewood Cliffs, New Jersey, 1978.