

Dying well: nurses' experiences of 'good and bad' deaths in hospital

John Costello PhD RN

Lecturer, School of Nursing, Midwifery and Social Work, The University of Manchester, Manchester, UK

Accepted for publication 30 November 2005

Correspondence:

John Costello,
School of Nursing, Midwifery and
Social Work,
The University of Manchester,
Gateway House,
Piccadilly South,
Manchester M60 7LP,
UK.
E-mail: john.costello@manchester.ac.uk

COSTELLO J. (2006) *Journal of Advanced Nursing* 54(5), 594–601

Dying well: nurses' experiences of 'good and bad' deaths in hospital

Aim. This paper reports a study investigating hospital nurses' experiences of death and dying.

Background. Despite advances in medical science and health care, together with the push towards individualizing approaches to patient care in the developed world, significant variation in the care of dying patients still exists. The international issues relating to differing types of death reveal both its complexity and diversity, with evidence of 'good death' experiences largely focused on hospice experiences, and a lack of research on death in general hospitals.

Method. In-depth interviews were conducted in 1999 with a convenience sample of 29 Registered Nurses in the United Kingdom based on their hospital death experiences. Semiotic analysis was used to identify the 'deep structures' that underlie and form part of cultural communication as a way of understanding how nurses made sense of death. Data interpretation was enhanced through the use of a typology of 'good and bad deaths'.

Findings. The findings suggest that different experiences of death are based on the extent to which nurses were able to exert control over the dying process. The management of death in hospital is a major source of conflict for nurses. Good and bad death experiences were constructed according to their impact on the sentimental order of the ward, the intangible, but real patterns of mood that influenced nurses' feelings. Moreover, good and bad deaths focused less on patients' needs and the dying process and more on the death event and nurses' abilities to manage organizational demands.

Conclusion. There is a need to improve communication with patients and families about diagnosis and prognosis to ensure that effective communication takes place and 'blocking behaviour' is avoided. The findings also challenge practitioners to focus attention on death as a process, and to prioritize patients' needs above those of the organization. Moreover, there is the need for guidelines to be developed enabling patients to have a role in shaping events at the end of their lives.

Keywords: dying, interviews, nurses, older people, qualitative research, research report

Introduction

The ideology of good death has its origins in the early hospice movement and has become an embedded part of contemporary Western palliative care. The characteristics of good death have their origin in hospices, where open communication, relief of symptoms, individual dignity and respect and

acceptance of death are prominent features (Seymour 1999, Bradbury 2000, McNamara 2003). The evidence on death and dying in Western Europe and the USA suggests that the majority of people die in hospital. A few studies have examined good deaths in the hospital context. Fewer have considered the relationship between types of death and the contexts in which they take place. The debate on dying well

pivots on definitions of good death. Smith (2000) asks how we can improve the state of dying in British hospitals. The answers can be related to what nurses, doctors and others regard as good death and have value beyond the United Kingdom (UK), since standards of nursing care related to death have universal applicability.

The international issues relating to differing types of death reveal both its complexity and diversity. An Australian study by McNamara *et al.* (1995) reported on hospice management of death, highlighting lack of control over end-of-life issues. Nurses' coping strategies were highlighted by Vachon (1995, 1998) in the United States of America (USA), and by others who have focused on stress and burnout caused by nurses' attempts to individualize death (McNamara 2003, Hopkinson *et al.* 2005). Hopkinson *et al.* (2005), in a UK study of hospital deaths, developed a theory of how nurses construct good death experiences by reliance on supportive structures when caring for dying patients. These included personal experience, reflection and coping with individual situations.

The evidence on symptom control for dying patients, including psychological support and bereavement, identifies how the provision of such measures can lead to what is regarded as good death (Taylor 2001, Higginson 2004). However, despite much rhetorical evidence largely based on hospice experiences, the question of what constitutes good death remains largely unanswered. As the largest professional group to provide care for dying patients; it is important that all nurses, not just those in palliative care contexts, have an awareness of what constitutes good death. It is also important to consider how organizational constraints shape the facilitation of such experiences. Understanding nurses' perceptions of death and palliative care in hospital can provide insight into the development of supportive strategies for ensuring effective care for dying patients. Moreover, it is envisaged that this would lead to improvements in the provision of care for dying patients and their families. This paper is a report of data from interviews with nurses' about their experiences of death and dying and reveals that nurses' perceptions of good and bad deaths focused more on the death itself rather than the process of dying.

Background

As an ideology, good death has been sustained from traditional times to post-modern society, permeating many aspects of contemporary palliative care (Kristjanson 2001, Taylor 2001, Hopkinson *et al.* 2003). Notions of death as good or bad are complex (Emanuel & Emanuel 1998), context-dependent (McNamara *et al.* 1995, Lawton 2000)

and involve a series of inter-relationships between patients' desires, the ability of others to meet their expectations and the extent to which social control is exerted over the dying process (Payne *et al.* 1996, Bradbury 2000).

The literature on good and bad death reveals three key areas. First, there appears to be ambiguity about what constitutes such deaths, with emphasis placed on good death; secondly, there is a lack of recognition about the influence and impact of context in shaping good and bad death experiences, and thirdly, there is a lack of definition about who benefits from a good death. Many studies focus on the individual stress-related impact of bad deaths on hospital nurses. Good deaths are often sentimentally idealized as being personal and individualized, evoking images of death as peaceful, natural, dignified and not prolonged (Keizer *et al.* 1992, Seymour 1999, Clark 2002). Good death involves a lack of patient distress, whereas bad death has the potential for causing trauma and a sense of crisis for dying people and others (Low & Payne 1996, Kristjanson 2001). Kellehear's (1990) conception of good death included an acknowledgement of the social life of the dying and the creation of an open climate about disclosure, with the patient being aware of their impending death, whereas bad death experiences (also referred to as traumatic, chaotic or gruesome) raised conflict amongst ward nurses. A number of studies indicate that the fewer difficulties patients experience in their passage towards death, the greater the likelihood of the death being perceived positively by nurses (McNamara 2001, Hopkinson *et al.* 2003).

A recurring feature of the hospital-based literature is the association of 'poor death' experiences with organizational issues such as staff shortages and lack of resources (Costello 2000, Rogers *et al.* 2000). Despite much rhetoric, most of the evidence on good death emanates from the perceptions of palliative care practitioners working in hospices (McNamara *et al.* 1995, Hart *et al.* 1998, Lawton 2000, Kristjanson 2001). This may well account for the ambiguity surrounding good and bad death experiences.

Despite the contextual variance and complexity of good and bad death, current authors argue that good death experiences facilitate effective functioning within the organization involving the features of control, knowing the diagnosis and respecting individual dignity and autonomy (Taylor 1993). Clark (2002) asserts that desire for 'good hospital death' has diminished as a result of moving palliative care into the wider healthcare system, resulting in a focus on problems of living with a life-threatening illness rather than dying. This assertion is not sustained; despite attempts to transfer best practice for dying patients from hospices to hospitals, the provision of quality care for dying patients

remains a major challenge to nurses (Ellershaw & Ward 2003).

Some hospital deaths are traumatic for both patients and staff, largely due to their unexpected nature, such as those occurring in accident and emergency departments or critical care units. Bad death experiences cause stress for nurses, although the precise nature of organizational and other factors impinging on bad death experiences remains ambiguous. Irrespective of the circumstances of death, we know little of the factors that contribute towards good and bad death in hospitals and what makes them so ambiguous. Much attention has focused on nurses' coping strategies and less on effective management of death by clarifying the influence of organizational culture. The literature fails to identify who specifically benefits from good death, instead focusing either on poor terminal care or specific contexts in which good death takes place. The evidence reflects the view that good death ideologies in hospital are under-researched and conceptually muddled.

The study

Aim

The aim of the study was to explore hospital nurses' experiences of death and dying.

Design

The study formed part of a wider ethnographic research project, observing nurses caring for older dying patients. The design was informed by an ethnoscientific frame of reference following Spradley (1979). Ethnoscience provides objectivity, which qualitative researchers can use to give greater rigour to data collection through eliciting cultural knowledge and classifying this into a typology of different types of death. Ethnoscience assumes that all cultures have their own rules about members' conduct that are situationally dependent and not fully understood through observation.

Participants

A convenience sample of three wards in two hospitals was chosen, representing different types of care for older people and enabling a range of experiences to be explored in each ward. Hospital one had a large unit specifically for older people; the second was a specialist hospital caring for older people. The choice of wards was determined by the conditions of the wider ethnographic study, which focused on older patients in different hospital settings in order to capture a wide range of experiences.

In 1998, 29 Registered Nurses were interviewed about their experiences of death and dying in hospital. Their mean time working on the ward was 3.2 years, with a range of 2.6–7 years. In-depth interviews lasting 40–50 minutes took place in a non-clinical area. In-depth interviewing is far more than a conversation with a purpose and may be likened to 'prospecting for the true facts and feelings residing within respondents' (Gubrium & Holstein 2003, p. 70). This process involves the researcher projecting the subject behind the interviewee, conferring a sense of what Gubrium and Holstein (2003) call 'epistemological agency' on the interviewee to achieve a greater understanding of the relative validity of the information provided. Questions were asked about the individual and collective impact of death and how nurses typically managed death in terms of cultural rules, tacit agreements and local conventions. Spradley (1979) argues that information about how individuals work together in organizations or 'cultural knowledge' can be elicited through a systematic process using description and explanation. Such an approach requires interviews to be more focused than the semi-structured interviews often used in qualitative studies.

Ethical considerations

The Local Research Ethics Committee approved the study. Informants received an explanation of the study aims and methods. Written informed consent was obtained prior to interview, and confirmed at the start and end of each interview. Transcripts of the interviews were given to informants to check for accuracy. They were assured that all information would remain confidential. Names used in presenting the findings are pseudonyms.

Data analysis

Data were interpreted using semiotic analysis informed by the work of de Saussure (1974), who argued that elements of speech derive meaning from their relationship with other elements. Semiotic analysis is particularly useful for qualitative researchers wishing to isolate concepts and distinctions by focusing on cultural features surrounding the text rather than the text itself. Data were elicited not by asking the informant the meaning behind their responses, but by analysing how terms were used in order to develop relationships between them. Following Saussure, good death as a sign has two components: a signifier, which is the sound or image conveyed (peaceful end of life) and a signified, which is the concept attached to the signifier (dignified, pain free, respectful). Together the signifier and the signified make the

sign. The relationship between signifier and signified may be seen as conventional, social or cultural and internal to the pattern of meanings used within the culture at that time.

Typologies were constructed as a device for organizing data and were useful in categorizing nurses' experiences. The good death typology was determined by deaths involving control, awareness, dignity and peacefulness; conversely, bad death was defined by determinants such as lack of control. Each typology was developed from interview data, the purpose being not to classify each death into discrete entities or a fixed categorization. Their utility was based on the notion that nurses' perceptions of death differed according to the individual's cultural knowledge. A recurring feature of nurses' perceptions of death included its disruptive impact on ward routine, the death event, the patient's dying trajectory and nurses' retrospective feelings concerning the aftermath of death.

Rigour

Reliability of method was achieved in three ways. First, interviewees were asked about a memorable patient death as well as the collective perceptions of others. This assisted in assessing the degree of truthfulness and accuracy in their recollections. Secondly, questions were repeated with different informants to assess response consistency. More experienced staff had similar recall of events, enabling them to provide broadly similar accounts when asked to comment on memorable deaths. Thirdly, informants were given copies of their interview transcripts and asked to check them for accuracy. However, exploring perceptions in this way is problematic as respondents may provide 'a reconstruction of themselves' (Emerson & Pollner 1988, p. 191) and, as Emerson and Pollner (1988, p. 192) state, 'Only very careful probing can ever separate fact from fiction and for informants even this will not be adequate'.

Findings

The typologies took into account 71 deaths occurring on the three wards in a 20-month period. Most of the deaths were expected, although informants described 12 cases of sudden death. Two major typologies emerged – good and bad death. The determinants of each formed the basis of the findings, which report on the way nurses made sense of death. A key feature was that their perceptions of the way a patient died were influenced by the degree of disruption caused to the ward routine or, more specifically, what Strauss *et al.* (1982, p. 254) refer to as 'the sentimental order of the ward', 'those intangible, but real patterns of mood influencing nurses'

feelings'. These patterns had their origin in the particular attributes of nursing work that reflected nurses' beliefs and values. Good death had positive benefits for nurses, with control over death being an important determinant. In contrast, bad death had a traumatizing effect on nurses because of its negative impact on morale and the potential for creating conflict amongst nurses and doctors.

Good death

Nurses signified good death in a number of ways in response to questions such as, 'Could you expand on your description of (patient's name)...death, telling me what was going on at the time they died and how others felt about it?' Sue (Staff Nurse) described the good death of Elsie:

Elsie, she went quietly one night. Her relatives were informed and probably (were) relieved that she went at that time...they never bothered coming in (at the time of death). We talked about it – I said, What do you want us to do if, she, you know, takes a turn for the worse?...They understood and I told the night staff they could ring but (the relatives) would not come in immediately.

Elsie (aged 86 years) had what Bradbury (2000, p. 61) refers to as a 'medicalized death'. She developed a chest infection following a fall at home and died 3 weeks after admission with pneumonia. During her stay, she remained largely unresponsive and was treated with antibiotics. Nurses described her death as 'a blessing in disguise' and 'a relief' for her daughters and son.

Clare (Staff Nurse) was asked to describe Elsie's death in relation to other deaths on the ward:

Oh, Little Elsie, she was a sweetie. Yeah, it was sad, but we knew it was going to happen soon. Unlike Harold who died bang on 9.00 a.m. It couldn't have happened at a worse time – he had experienced another bad night and was very poorly, but he had been like that for ages. His relatives had a vigil at the bedside but became tired and went home. They were not there when he died, even though they wanted to be. It was chaos, the ward round was about to start, we were short-staffed and it was right in the middle of the morning routine. It was awful for him and a nightmare for us – we just closed the curtains and left him for a couple of hours.

Elsie's death had all the elements of a good death in terms of being expected, being medicalized, with a high level of awareness by relatives (it was unclear what the patient's level of awareness was), and an absence of distressing symptoms because she was unconscious. Moreover, the death had limited impact on the day-to-day activity of the ward and almost no impact on the sentimental order. Without reference to the meaning of good death, nurses' accounts invariably

focused on the element of control over the death, as the following comments identify:

Sylvia (Ward Sister): There have been times when a patient's death is so private and quick that it is hardly noticed by other patients. We have had good deaths on the ward, where it has been so peaceful for patients, relatives and staff, really. We are able to get on with things without any problems.

Ken (Staff Nurse): We do have good deaths, even though I recall some really bad (ones). I think we all know the good deaths, because we tend to know the family and the patient well. When it's expected, we can plan and make arrangements and be prepared for the relatives. It's always better if you can anticipate the likely time of death and be ready for it.

Susan (Staff Nurse): For me, when a patient is dying we need to provide spiritual care and get the chaplain in, if that's what the patient wants. To go peacefully is important, and to go without a fuss and without being in pain is important both for the patient and us.

Good deaths were socially constructed and perceived by nurses to involve elements of control and implied passivity on the patient's behalf. Good death benefited nurses as much as patients and relatives. Moreover, such a death does not disrupt sentimental order, which is a negotiated one. The notion of the 'gentle passing' of patients, who were expected to die with their family aware of the impending death and nurses 'painting a black picture' in preparation for death, meant that irrespective of time, the impact of death was minimized. Sentimental order had less to do with 'house rules' and more to do with tacit understandings that required judgements and sensitivity to be applied to specific instances. This type of order, in the hospital context, referred to the maintenance of humanistic considerations, examples being prolongation of life when nurses felt the patient should be allowed to die in peace. This type of death had the potential to become 'bad', depending on its management. Timing of deaths was key, with those occurring at night referred to as natural and peaceful. Deaths involving unconscious patients such as Elsie, whose symptoms were well-controlled, were considered 'good' because of their medicalized nature.

Table 1 gives the determinants of good death, which largely cluster around nurses' abilities to prevent the death having a 'pollutant effect' on the rest of the ward. Where a patient's death was expected, and in some cases desired, nurses discussed what they could do to make the end-of-life care as stress-free as possible for relatives and themselves. This included ensuring that religious needs were met and the patient made as physically and psychologically comfortable

Table 1 Determinants of good death

Control over death event including disposal of the body
High degree of predictability
Staff and (sometimes) patient awareness is well established
The patient's death is desired by staff
Death takes place at an appropriate time, i.e. during the night, to minimize disruption to the ward

as possible, as well as alleviating family concerns about end-of-life issues.

Bad death

Bad death was characterized by limited control over the events leading up to and including the 'death event'. Lack of preparation and time to get to know the family and make an accurate assessment of patients' needs constituted a risk to the smooth running of the ward. Bad death prevented nurses from providing patients with religious rites such as the sacrament of the sick. These deaths constrained the development of optimal communication with families to prepare them for the impending death, as the following statements illustrate:

Joe died too quickly. We were not ready at all. It was a very bad death for him, us and the family.

Joe's family should have been better informed. They said they didn't know he was dying, but we were of the opinion that they knew. The relatives made us feel so guilty – it was very poor communication really.

Talk about getting to know your patients. David came in at 4.00 p.m. and died five hours later. We hardly had time to complete the documentation. Most of the staff had not even said 'Hello'.

We had no idea that (Dennis) was going to die – otherwise we would have planned things, like asking the priest to call and speaking to the family in an effort to prepare them.

Bad death was also determined by patients who died out of context:

Edna had an awful death – she died on her way back from an endoscopy investigation. Rather than admit that she died in transit, we pretended that she died sometime later, when back on the ward.

Other deaths were considered traumatic because of their circumstances. One patient (George) died following inappropriate cardio-pulmonary resuscitation (CPR) attempts (when his case notes said he was not for resuscitation), as Laura (Staff Nurse) described:

It was a dreadful situation. We should never have started CPR – it was so undignified. There was blood everywhere as he had been

Table 2 Determinants of bad death

Often sudden and unprepared, causing disruption to the sentimental order of the ward
Nurses unable to make preparations for death due to time/context constraints
Death takes place outside of the normal ward confines
Patient and family not aware of impending death, family conflict a feature
Insufficient time for nurses to get to know the family
Distinct lack of dignity and respect
Substantive diagnosis not made, climate of uncertainty about future prognosis
Death is traumatic, patient experiences pain or dies with unrelieved symptoms

anti-coagulated – it was like an abattoir. What an awful way to go.

In some cases bad death was signified by the absence of an accurate diagnosis as Liam (Staff Nurse) pointed out:

What could we say to the family? We never knew what was really wrong with him. We just said it was his heart, but have no idea what the post mortem will reveal – we felt like idiots.

Bad deaths included those where patients died in pain or with unrelieved symptoms, leaving nurses with a sense of guilt about being unable to relieve suffering:

I wish we had done more in terms of giving sedation and pain relief. The family watched him die in agony. It was such a shame – surely we could have done more? He was in pain and we were not quick enough to respond – it was a really bad death. (Karen – Staff Nurse)

Table 2 shows the key determinants of bad death. Dying patients with unresolved physical and psychological problems, such as pain, nausea, vomiting or spiritual distress, and who were unresponsive to treatment or nursing care, were invariably regarded as experiencing bad death. In other cases, patients without a substantive diagnosis, for example, were more likely to be retrospectively perceived as having a bad death, but only if their relatives became upset about other issues, such as poor communication. Their distress might be exacerbated if the patient died suddenly. Invariably bad death included a number of determinants, often based on the death event rather than patients' dying trajectory.

Discussion

The management of death in hospital has been variously described as being ritualized (Chapman 1983), controlled (Lawler 1991) and highly structured (Field 1989). The good deaths in this study were often anticipated, with a high degree

of predictability and clear benefits for nurses as well as patients and families. Many of the perceived bad deaths could have been prevented if the patients' dying processes had been monitored more closely and effective communication developed and maintained between professionals and family members earlier. There was also a tendency for nurses to judge the death itself in isolation from the dying process as the key determinant. The findings illuminate issues associated with a lack of effective communication between doctors and nurses in at least one case (George). The findings are consistent with the literature in terms of nurses adopting strategies for coping with death that used personal resources and informal support networks (Hopkinson *et al.* 2005). Bad death scenarios included those where lack of material and human resources was an issue (especially at night) rather than the interventions of the nurses (Vachon 1998). It is noteworthy that research into good death conceptions reports that such deaths in hospices were those that ensured the smooth running of the institution.

In my study, nurses' general responses about the management of death related to the maintenance of cultural practices. These were often behavioural in nature, involving everyday ward activities such as 'the washes' (behaviour focused on meeting patients' hygiene needs), and 'toileting' (assisting patients to mobilize to the toilet). When an unexpected death occurred, for example, during a mealtime, this disrupted the ward routine. This reinforces the interpretation that nurses tended to view death in isolation from the process of dying. A patient's dying trajectory may involve suffering and, when terminated by death (in whatever circumstances), can be perceived positively by those attending the death, although not always by the nurses.

In relation to the management of an expected death and its impact on nurses, it became necessary to consider the potential threat death posed for the emotional well-being of those caring for the dying, including families and friends. Berger and Luckmann (1995, p. 119) argue that death threatens the 'taken for granted' realities of everyday life, and integration of death within the reality of social existence is of great importance for any institutional order. Institutional deaths, where a curative ideology prevails, challenge the recognized routine of the ward to find a way to accommodate this so-called terrifying threat; however, when there is no hope of cure, the threat is diminished. This may explain why hospice good death, referred to by some as natural (Seymour 1999), is more likely to be seen in this way.

In my study, caring for older dying patients was stressful not only because of the impact of death on nurses' emotional stability, but also because the wards often experienced staff shortages and poor skill mix with few Registered Nurses on

What is already known about this topic

- Most empirical studies of death and dying focus on cancer patients in hospice settings.
- The concept of good death is an ideal reflected in the hospice literature and characterized by individuality, symptom control, dignity and peacefulness.
- Ambiguity exists around the notion of death as medicalized or natural.

What this paper adds

- Hospital nurses' perceptions of death focus more on the death event and less on the dying process.
- Good deaths maintain the sentimental order of the hospital ward with minimal impact for disrupting organizational stability.
- Nurses manage death by using concealment rituals such as closing the curtains around beds when a dead body is taken from the ward, in an attempt to hide the social fact of death from other patients.

duty compared with care assistants and the regular use of agency nurses. These problems were often compounded by a chronic lack of material resources. These issues support arguments that patient death is often associated with a sense of personal failure amongst nurses (Field 1989, Kristjanson 2001). These authors argue that a good death may be seen as a collective exercise in the way that management of death and dying is socially constructed using strategies for informing patients and relatives of the diagnosis and prognosis and family collusion to ensure that, wherever possible, patients remained compliant with the hospital regime.

The phenomenon of death in hospital is cloaked in secrecy. Nurses' attempts to conceal it from other patients by closing curtains and not disclosing information about individual deaths reflects discomfort about what is, in some settings, a regular event. The findings suggest that nurses want patients to die without distress, including distress to themselves and others in the settings in which they work. Seymour (1999) and Bradbury (2000) found that nurses often preferred 'medicalized deaths' which optimized control, compared with more natural deaths that were unpredictable and sometimes prolonged. This is consistent with the findings of Payne *et al.* (1996), who point out that good death needs to include a degree of social control, with the patient in a position in which they are 'ready to die'. This type of preparation begins with diagnosis and requires a high level of communication between nurses, patients and multiprofessional groups.

Moreover, the present findings challenge nurses to question cultural practices that seek to deny death as a social reality and demonstrate a lack of dignity about death itself. In particular, it is not the death event itself that is important, but the process of dying and the extent to which patient and family expectations are met through effective and sensitive communication.

Study limitations

Notwithstanding the time period since data collection, there has been no new research in this area (Higginson 2004). Despite the rhetoric, we are still unclear about what constitutes a good hospital death. Nurses have little evidence to use as a basis for organizing end-of-life care in hospital. The findings challenge healthcare providers to consider critically the organizational factors that prevent hospital patients experiencing a good death. As with any qualitative study, it is not possible to generalize the findings, although they are indicative of the meanings nurses give to the types of situations they experience when caring for dying hospital patients. The findings are based on nurses' perceptions of their work at the time and therefore comment is not possible on the outcomes or processes involved in care. However, since the findings were corroborated by the previous literature, it could be that nurses in other hospital wards share similar ideas about death and dying. The convenience sample of informants may have had particular interest in providing their accounts and so bias may have been introduced. Unlike quantitative studies, this was not considered a particular issue, as the aim was to explore informants' perceptions.

Conclusion

The increasing institutionalization of death and dying in Western societies poses a major challenge to nurses as patients continue to die undignified deaths with uncontrolled symptoms. The transfer of hospice principles to wider health care has caused a shift in emphasis from the provision of good death towards caring for patients living with life-threatening medical illness. The focus on quality of life for the living may distract attention from providing patients and families with good death experiences. This poses a major challenge to palliative care practitioners and those working with dying patients. When planning care for dying patients, nurses need to be aware of the need both to ensure quality of life and the provision of positive experiences at the end of life. In this way, death can develop the potential for personal growth for practitioners, patients and those emotionally close

to the dying person. The findings have a number of practice implications. First, there is a need to improve communication with patients and families about diagnosis and prognosis in order to ensure that, despite lack of preparation, where death is likely to happen, optimal communication takes place and so-called blocking behaviour avoided. This raises educational issues such as the need to focus attention on death as a process, prioritizing patients' needs above those of the organization. Secondly, guidelines should be implemented to ensure that patients have a role in shaping events at the end of their lives. Palliative care should begin at diagnosis and become an integral part of on-going care. The management of dying patients should be considered and discussed sensitively to establish individual wishes and desires, thus ensuring that patient partnerships move from rhetoric to reality.

References

- Berger P.L. & Luckmann T. (1995) *The Social Construction of Reality*. Penguin, Harmondsworth.
- Bradbury M. (2000) The 'good death'? In *Death, Dying and Bereavement* (Dickenson D., Johnson M. & Katz J.S., eds), Open University/Sage, London, pp. 59–63.
- Chapman G.E. (1983) Ritual and rational action in hospitals. *Journal of Advanced Nursing* 8, 21–28.
- Clark D. (2002) Between hope and acceptance: the medicalisation of dying. *British Medical Journal* 324, 905–907.
- Costello J. (2000) Dying in a public place: an ethnography of terminal care for older people in hospital. Unpublished PhD thesis, Manchester Metropolitan University, Manchester UK.
- Ellershaw J. & Ward C. (2003) Care of the dying patient: the last hours or days of life. *British Medical Journal* 326, 30–34.
- Emanuel E.J. & Emanuel L.L. (1998) The promise of a 'good death'. *Lancet* 251(5), 21–29.
- Emerson R.M. & Pollner M. (1988) On the uses of members' responses to researchers' accounts. *Human Organisation* 47(3), 189–198.
- Field D. (1989) *Nursing the Dying*. Tavistock/Routledge, London.
- Gubrium J.F. & Holstein J.A. (2003) *Post-Modern Interviewing*. Sage, London.
- Hart B., Sainsbury P. & Short S. (1998) Whose dying? A sociological critique of the 'good death'. *Mortality* 3(1), 65–77.
- Higginson I. (2004) Supportive and palliative care: the state of the evidence base. *Paper to the British Psychosocial Oncology Society Meeting; Helping People to Live With Cancer*, London, December 2004.
- Hopkinson J.B., Hallett C.E. & Luker K.A. (2003) Caring for dying people in hospital. *Journal of Advanced Nursing* 44(5), 525–533.
- Hopkinson J.B., Hallett C.E. & Luker K.A. (2005) Everyday death: how do nurses cope with caring for dying people in hospital? *International Journal of Nursing Studies* 42(2), 125–133.
- Keizer M., Kozak J. & Scott J. (1992) Primary care providers' perceptions of palliative care. *Journal of Palliative Care*, 8(4), 8–12.
- Kellehear A. (1990) *Dying of Cancer: The Final Year of Life*. Harwood Academic Publishers, Melbourne.
- Kristjanson L.J. (2001) Palliative care nurses' perceptions of good and 'bad deaths' and care expectations: a qualitative analysis. *International Journal of Palliative Nursing* 7, 3.
- Lawler J. (1991) *Behind the Screens: Nursing, Somology and the Problem of the Body*. Churchill Livingstone, South Melbourne.
- Lawton J. (2000) *The Dying Process*. Routledge, London.
- Low J. & Payne S. (1996) The good and 'bad death' perceptions of health professionals working in palliative care. *European Journal of Cancer Care* 5, 237–241.
- McNamara B. (2001) *Fragile Lives: Death, Dying and Care*. OU Press, Buckingham.
- McNamara B. (2003) Good enough death: autonomy and choice in Australian palliative care. *Social Science and Medicine*, 58, 929–938.
- McNamara B., Waddell C. & Colvin M. (1995) Threats to the "good death": the cultural context of stress and coping among hospice nurses. *Sociology of Health and Illness*, 17(2), 222–244.
- Payne S.A., Langley-Evans A. & Hillier R. (1996) Perceptions of a "good death": a comparative study of the views of hospice staff and patients. *Palliative Medicine* 10, 307–312.
- Rogers A., Karlson S. & Addington-Hall J. (2000) All the services were excellent. It is when the human element comes in that things go wrong: dissatisfaction with hospital care in the last year of life. *Journal of Advanced Nursing*, 31(4), 768–774.
- de Saussure F. (1974) *Course in General Linguistics* (translated by Baskin). Fontana, London.
- Seymour J.E. (1999) Revisiting medicalisation and 'natural' death. *Social Science and Medicine*, 49, 691–704.
- Smith R. (2000) A "good death". *British Medical Journal* 320, 129–130 (editorial).
- Spradley J.P. (1979) *The Ethnographic Interview*. Holt, Rinehart and Winston, New York, NY.
- Strauss A.L., Fagerhaugh S., Suczek B. & Wiener C. (1982) Sentimental work in the technologised hospital. *Sociology of Health and Illness* 4(3), 254–278.
- Taylor B. (1993) Hospice nurses tell their stories about a "good death": the value of storytelling as a qualitative health research method. *Annual Review of Health Social Science* 3, 97–108.
- Taylor B. (2001) Views of nurses, patients and patients' families regarding palliative nursing care. *International Journal of Palliative Nursing*, 7(4), 186–191.
- Vachon M.L. (1995) Staff stress in hospice palliative care: a review. *Palliative medicine*, 9(2), 91–122.
- Vachon L.M.S. (1998) Caring for the caregiver in oncology and palliative care. *Seminars in Oncology Nursing*, 14(2), 152–157.