THE EFFECT OF WITNESSING DEATH
1: NURSING IMPLICATIONS

LEARNING OBJECTIVES

1. Describe the positive and negative ways that patients may be affected by a fellow patient’s death.
2. Consider how your own work environment is managed in relation to the care of patients who are dying.

This is the first part of a two-part unit that examines how patients are affected by witnessing a death. When patients die in a hospital or palliative care environment it can be a common occurrence for them to die in a shared area. Individuals may be affected by the death of a fellow patient. Having a greater understanding of this issue may have implications for nursing practice in relation to communication, privacy and dignity, and bed allocation for patients. Part 1 covers the background and literature review, and discusses implications for practice.

INTRODUCTION

In a hospital or specialist palliative care unit it can be a common occurrence for patients to die in a shared room. The issues detailed here are equally relevant to both settings, although it could be argued that on a general ward, staff, relatives and patients may be less prepared for the death of a patient ‘because there is less assumption that these patients will die’ (Sadler, 1992).

It has been observed in practice that other patients are affected by a death occurring close to them. However, nursing and other care staff are often busy attending to the person who is dying and her or his family and may have little time to spend with the other patients to talk over how they are feeling.

Historically, death has been confronted on an open and regular basis because people normally died in their own homes, surrounded by members of their family and community. In developed countries today, where life expectancy is higher than ever and with advances in medicine, death is often ‘hidden’ (Aries, 1981, in Lawton, 2000).

Most of us have little experience of seeing people dying but we can all expect to be affected by the death of someone we know, whether it be that of a close family member or an acquaintance.

LITERATURE REVIEW

When patients are diagnosed with a terminal illness they may be afraid of dying and wonder what it will be like. Thomas (2003) suggested that: ‘For some patients entering the final stages of their lives, this journey’s end can seem terrifying or welcoming but usually both.’

When a patient is near to death they may be moved into a side room. Patients may be moved for a number of reasons, including:
- To maintain privacy and dignity for the patient and her or his family;
- To protect other patients from having to witness a patient who is dying who may be distressed, agitated or confused.

Dame Cicely Saunders (in Sadler, 1992) pointed out that if patients who are dying are moved to more private settings, this may prompt other patients to wonder what death is really like, and think: ‘It must be dreadful if we are never allowed to see it.’

Confronting death

The modern hospice movement advocates open confrontation with death. It has a philosophy that underpins practice in caring for patients who are dying in hospitals and specialist palliative care units. This philosophy gives ‘emphasis on care rather than cure and to the quality rather than the quantity of a patient’s life’ (Lawton, 2000).

An example of how such care can be offered in more general settings is the Liverpool Care Pathway for the Dying Patient (LCP) (Ellershaw and Wilkinson, 2003). The LCP provides an evidence-based framework for the delivery of appropriate care for patients who are dying and their relatives in a variety of care settings. It encourages services to take a multidisciplinary approach to the delivery of care focusing on the physical, psychological and spiritual comfort of both patients and their relatives.

The pathway is based on a number of goals that aim to provide guidance on the different aspects of care required by those who are dying and their families. Although it does not address the needs of the other patients around the person who is dying, its implementation is likely to make staff more aware of the effects of death on them.

In a study of patients being cared for in a hospice and their experiences of witnessing a fellow patient’s death, Honeybun et al (1992) speculated that ‘observing another patient die might be detrimental because of the distress associated with that death, as well as reminding those observing of their own imminent death. Alternatively, observing another patient die peacefully might be reassuring.’

Further studies have had similar findings. Lawton (1997) suggested: ‘It was fairly common for patients to assume that death must be a very painful and traumatic event. Consequently these patients often found it very comforting and reassuring to witness another patient dying peacefully beside them on the ward.’

Payne et al (1996) found that ‘witnessing the care and attention given to dying patients may be reassuring because patients believe that they will not be neglected when they themselves die’. In contrast, it may be upsetting to witness the death of a patient who is distressed, agitated or confused (Lawton, 2000; Payne et al, 1996). Payne et al also reported that
two patients mentioned their upset at having to carry on their daily activities while there was a dead body behind the curtains in the next bed. Some patients also felt awkward because they did not want to witness grieving relatives or invade their privacy at such a time.

From the perspective of both the patient who is dying and her or his family, she or he may wish to be in a single room rather than a communal ward. This was found to be the case in one instance observed by Lawton (2000). A widower had complained that ‘he had felt unable to express his grief at the time of his wife’s death because he did not want to upset the other patients and visitors present in the ward’.

IMPLICATIONS FOR PRACTICE

It appears that patients’ experiences and feelings about the death of another patient may be related to the way in which the other patient dies – that is, whether they die peacefully or in pain and distress. A study undertaken by Payne and Langley-Evans (1996) revealed that ‘patients described features of a “good” death as including dying in one’s sleep, quietly, being pain-free and dying suddenly’.

It has been shown that patients who had witnessed the death of a fellow patient are less depressed than those who had not (Lawton, 2000; Payne et al, 1996; Honeybun et al, 1992). However, if patients encounter a number of deaths this may have the opposite effect and they may become depressed and withdrawn, feeling that ‘the next one to go will be me’ (Lawton, 2000; Sadler, 1992).

In practice, it has been observed that sometimes patients are repeatedly exposed to the death of other patients around them. It can be seen that these patients, who have previously chatted to and befriended other patients who subsequently die, become withdrawn and unwilling to interact. They may choose to distance themselves from their fellow patients to protect themselves from being upset by witnessing the death of someone with whom they had developed a relationship (Payne et al, 1996).

These findings may suggest that the more times a patient witnesses the death of others within a specialist palliative care unit or hospital ward, the more detrimental this may be to their psychological well-being. This emphasises how important effective discharge planning and continuing care are, to enable patients to be in their preferred place of care as they are approaching death (Department of Health, 2006).

Considering these findings may have implications with regard to patients being offered a shared or a single room. In a study on this subject, Kirk (2002) found that when asked whether a patient would like to be moved from a shared to a single room, in certain circumstances (including if they were dying), 75% said they would.

‘Patients’ main reasons for wanting a single room were privacy, quiet and not upsetting others or embarrassing themselves’ (Kirk, 2002). However, only half said that they would wish to move if another patient was dying, which suggests many patients’ attitudes to death are inconsistent.

In considering the issue of where patients die perhaps we should ask the question: when patients cease to be aware, are the needs and interests of those who are dying being considered or addressed in the practice of keeping them on a ward? (Lawton, 2000). Should more single rooms be made available to patients who are dying and their visitors? It is acknowledged that patients should be able to live and die in the place of their choice wherever possible (Thomas, 2003).

Sometimes patients may have been admitted to hospital because of a crisis, when their preferred place of care is at home. If they are unable to be at home, we should find out from them how they wish to be cared for in hospital.

For example, it may be important to them to have their family around them or to have a single room in order to maintain their privacy and dignity. If possible these wishes should be accommodated.

As Kirk (2002) emphasised: ‘staff need to consider carefully how they support patients and manage the environment where patients are likely to upset others’.

Port 2 of this unit, on communication after the death of a patient and ethical considerations, will be published next week.

KEY REFERENCES


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