Meeting the needs of a dying patient

Title: caring for a patient who is dying is an experience most nurses willface at some stage of their career. With reference to patients you have caredfor, describe how you were able to meet the needs of dying patients.

As a certainty, all of us will have to face death at some stage. Some of us are fortunate enough to be able to do so with caring, supportive and empathetic people around us. (Seale C et al. 2003). Nurses must be able to discharge their professional responsibilities in this area with this comment in mind. In this short essay we will explore how a nurse can empathise, understand and assist the patient in dealing with the various issues that arise.

We will discuss these issues in relation to one specific case, Mrs G. The case was complex, but, in essence, it involved a lady who had just been given a terminal diagnosis and entered into a phase of complete denial and overt avoidance behaviour. She would change the subject when talking about her health and keep herself almost manically occupied with trivial tasks so as not to have to consider the reality of the situation.

Dobrantz (2005) points to the fact that it is well recognised that some patients deal with life crises simply by ignoring them, other will use mechanisms of varying degrees of cognitive distortion (CDs), which may range from undue optimism to complete denial (as Mrs. G did).

The main nursing dilemma here is should the nurse actively confront Mrs. G’s denial and allow her to see the reality of the situation or is it perhaps kinder to allow her to continue in her state of overt denial. (Dean A. 2002)

On first analysis, one might take the view that, given the fact that Mrs. G had only a short time left to live, it might be a kindness to allow her not to confront the psychological pain of anticipating her imminent death. Against this argument is the concept of " a good death". (Cuttini et al. 2003). Many authorities (viz. Roy C 1991)

that in order for a patient to have " a good death", they need time to accept the inevitable and to mentally come to terms with it, make what preparations they need (financial, practical, spiritual, personal) so that they can approach it in a calm and considered way. Clearly this cannot be achieved if they are actively entering into a degree of denial about the situation. (The A-M et al. 2000)

Demonstrate ability to apply relevant nursing knowledge to individualised patient care

The immediate therapeutic problem to be confronted by the healthcare professionals involved is to decide the degree of collusion with the denial that can be ethically employed. (Sugarman J & Sulmasy 2001). To a degree, this is a matter of personal and clinical judgement. Most experienced healthcare professionals would suggest that truth is generally the best policy, the degree of truth however, can be a matter of negotiation. (Parker and Lawton 2003).

The important concept to embrace in this type of situation is that of individualised patient care. In order to come to a considered decision, the nurse must carefully consider all the elements of the patient's coping mechanisms and assume a holistic approach to the matter. We note that the

concept of holistic care can best be visualised with the understanding that the concept of “ Health” is based on a translation of the Anglo Saxon word for “ wholeness” (or holism). The key to this approach is that it recognises that health has both spiritual and psycho-social elements as well as the overtly physical. (Wright et al 2001)

The main elements of managing Mrs. G ‘ s case seem to revolve around the ethical concept of autonomy (Coulter A. 2002). One has to make a professional decision whether or not Mrs. G is considered to have the right to make completely autonomous decisions for herself. In many clinical situations (such as consent, for example), the issue of autonomy is virtually inviolate. There are other situations, and we suggest that this is one, where other ethical principles may take precedence. The Principle of Beneficence suggests that the healthcare professional should effectively do “ goodness” or more accurately in these circumstances, as doing what is the best for the patient. (Dordrecht et al. 1983

Demonstrate ability to make own judgment and decisions based upon the evaluation of the nursing situation.

There are a number of nursing models which could be used to construct a response to this situation. They all assimilate the general nursing scheme of assessment, planning, implementation and evaluation. (Fawcett J 2005)

The Roper, Logan, Tierney model (2000) would be appropriate to assess the activities of daily living in a problem solving manner, but this process is primarily of use in those situations that are physically orientated and

therefore the psychological denial element is not clearly addressed by this model.

The Roy Adaptation model (Roy 1991) is certainly more useful in explaining the adaptive processes that the patient experiences as they come to terms with the “ illness role”. Mrs. G however, did not adapt and, by adopting a strategy of denial, was able to maintain her belief of “ wellness” almost until the end, when her illness eventually forced her into accepting it. In real terms, Mrs. G did not adapt at all.

The Johnson Behavioural System model (Wilkerson et al 1996) suits our purposes better as it clearly describes the processes of illness denial, but it doses not combine it with the adaptive processes that eventually overtook Mrs. G at the end of her life.

Wadenstein (et al. 2003) sums up this type of situation with the conclusion that when there is multifactorial aetiology in a given situation there is seldom one nursing model that will encompass all eventualities.

Conclusions

Mrs. J.’s emotional pain of trying to cope with imminent death was clearly too great for her to assimilate. This must be understood by her medical attendants if she is to have a “ good death” (Marks-Moran & Rose 1996)

In order to try to provide Mrs. G with the best care that she could have, the clinical staff tried to help Mrs. G towards the realisation that she should confront her own imminent mortality. Unfortunately for all concerned, this proved to be impossible and Mrs. G died about two weeks after her

admission, only openly acknowledging the imminence of her death when she became too weak to lift a cup of tea to her mouth on the day before she died. Arguably, when this acceptance came home to her, the nursing staff were actually able to help and support her more than Mrs. G had allowed them to in the preceding two weeks. (Yura H et al. 1998

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