PROBLEMS RELATED TO THE NURSING MANAGEMENT OF THE DYING PATIENT

WILHELMINA DRUMMOND MILLS

MASTER OF LETTERS

FACULTY OF SOCIAL SCIENCE

UNIVERSITY OF GLASGOW

SEPTEMBER 1983

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

ACKNOWLEDGEMENTS

This study was able to proceed during a two year research secondment award under the auspices of the Nursing Research Committee, Greater Glasgow Health Board. I thank the Committee for their generous support.

To Mrs Catherine Cunningham, Area Nursing Officer, Manpower Planning and Research, Greater Glasgow Health Board, I extend my thanks. Her interest and support which helped initiate the project and her continued enthusiasm and encouragement played no small part in assisting towards the completion of this study. For this I am deeply grateful.

To Professor Fred Martin at the Department of Social Administration, the University of Glasgow who agreed to supervise the study, I owe a particular debt of gratitude. For his time and expertise which was given unstintingly, and his infinite patience and understanding I am indebted.

Of the many people who have helped in this study one of the most central contributions was undoubtedly that of the patients. For the privilege of being with them during their final hours and for the lessons learned which go well beyond the content of this study I owe an incalculable debt.

Finally and most importantly I would like to express my sincere thanks to all the nursing and medical staff at the hospitals involved for their forbearance, friendliness and willingness to help. The way in which I was accepted was very gratifying and much appreciated. Without their co-operation this study would not have been possible and I am indebted to them for their help and interest.

ABSTRACT OF THESIS

Name of Candidate.. Wilhelmina Drummond Mills

Address ..... 39 Netherblane, Blanefield, Stirlingshire. G63 9JW

Degree ..... Master of Letters Date ... 17 August 1983

Title of Thesis ... Problems related to the nursing management of the dying patient

The purpose of the study was to explore the nursing care of the patient who dies in the acute general hospital and to identify constraints relating to this care.

The descriptive, exploratory study was conducted in two parts. Non-participant observation was used throughout. During the first phase, the interactions between 193 nurses and 25 patients were studied. The following data were collected - the content of the interaction, the grade of nurse involved, by whom the interaction was initiated and the length of the interaction. During the second phase, the communication between 14 consultants and 22 senior nurses concerning 27 dying patients was explored with reference to - the guidance given on care, active resuscitation intervention possibilities and information conveyed or to be conveyed to the patient and his/her relatives.

It is contended that though 'caring' is identified as the major and central role of the nurse (Briggs 1972), the nurse functions within limits prescribed by the medical profession.

University of Glasgow
Regulations for Postgraduate Study

In accordance with this regulation
and as a Candidate
for
the Degree of Master of Letters,

I declare that this thesis has been composed by me and is a result of my own enquiries.

Wilhelmina Drummond Mills
17 August 1983

TABLE OF CONTENTS

List of Tables

Cont. List of Tables

Cont. List of Tables

Cont. List of Tables

List of Figures

Chapter 1

Introduction

This study is concerned with the nursing care of the dying patient in the acute general hospital and the factors which influence this care.

In recent years there has been an increase in the number of patients coming into hospital in need of terminal care, and consequently there is a growing interest in the management of the dying patient as reflected in the volume of literature available on the subject (Payne 1981). This literature is concerned predominantly with the physical and psychosocial needs of the dying patient. There is a marked shortage of material related to the givers of care or the nursing care the patients receive.

The writer's interest in the subject evolved from personal and professional experience over a number of years. Contact with death and with those who were dying left indelible impressions on the writer early in nurse training. The experience of 'dressing the body' is vividly recalled. Lectures had prepared one to execute with precision the rituals linked to the task but not to cope with the emotions of shock, distress and bewilderment associated with handling a lifeless form. Caring for the dying patient was difficult. There were feelings of inadequacy and helplessness - 'of not knowing what to do'. There were feelings of fear - in anticipating the moment of the patient's death. There were feelings of guilt - both when with the patient and on leaving the patient alone.

Student and pupil nurses currently express problems associated with the management of the dying patient. At the commencement of training they indicate concern when anticipating this area of work. With experience at the bedside this fear is partly overcome, but anxiety persists in association with the care of the dying patient and bereaved relatives (Birch 1978). Nurse teachers express a deep sense of inadequacy when attempting to guide the

learners in this area and speak of 'not knowing what to teach'.

The original interest was grounded in the researcher's conception of the emotional involvement of the nurse, but it was thought that a structured observational approach (derived from industrial work study techniques) rather than interviews to elicit other nurses' views was preferable. The underlying premise of this methodological tactic was that the nurses' activities with the dying patient should be observed within the natural habitat of an acute general hospital environment as they occurred so that sociocontextual factors which might affect what the nurse does could be noted. It seemed more useful to move from introspective reflections to a data collection method which allowed non-participant observation of the phenomena. It seemed more appropriate and less subjective to observe the activities of the nurses amid the stresses and strains of the ward. Thereafter examination of the data allows inferences to be drawn from these observations.

The emergent study moved a considerable way from the initial premise which concerned itself with the anxiety of the individual nurse in her relationship with the dying patient. The scope of the study widened to include a description of how nurses interacted with dying patients and with other health professionals, namely medical staff.

The study is organised in two parts. The first part describes the activity between the nurse and the dying patient. The second part involves the activities between the senior medical and nursing staff and the dying patient and the communication between these two key caregivers concerning patient management.

The first chapter examines some of the seminal work associated with the emerging identity of 'caring' nursing. Chapter two offers a general outline of the design for fieldwork. Chapters three, four and five are concerned with the data and ~~its~~ their analysis - namely, a description

of nurse-patient interaction, a description of the interaction between senior medical and nursing staff concerning the patient and finally an analysis of the communication between senior nurses and junior nursing personnel relative to the dying patient. The final chapter draws out key issues and speculates beyond the data to outline some of the wider implications which the study raises. Those include issues which concern the role of the nurse in the health care team.

Aims of the study.

The aims of the present study were

1. To describe the nursing care of the dying patient during the last week of life in an urban general hospital.

2. To determine factors which might influence the activity of the nurse during her care of the dying patient.

Chapter 2

Review of the Literature

> "Nursing did not set itself up as a novel discipline --- it evolved in response to a need, a need for the care of the sick in body and mind." (Hockey 1977).

The concept of what nursing is, has not changed fundamentally but what nurses do has changed, and is changing. Changes in the structure of society and developments in medical science have had an impact on both the nurse and nursing. Baly (1973) who studied the effect of social change on nurses wrote

> "Nursing has developed in response to changing social needs. As the pattern of society alters so new demands for health care arise. New habits and customs alter the disease pattern, while changes in the structure and grouping of the population create new problems." P.3.

The Committee on Nursing (1972) convened to review "the role of the nurse and midwife in hospital and community and the education and training requirements in that role" stressed the impact of the significant advancement in scientific and technical medical sciences

> "It is not only social changes or changing patterns of disease and distress which influence nursing and midwifery care in practice but changes in medical knowledge and performance. This element in the situation must never be overlooked." para 36.

Presently the role of the nurse is in a 'fluid state'. The search to establish an identity and acquire recognition of a unique function is intensifying. This coincides with a proliferation of paramedical occupations within the health service. These are defining their own areas of work, spheres of management and accountability, and thereby make it incumbent on the nurse to recognise and delineate her role precisely. If this is not done others will do it for her. This will result in less and less autonomy for the nurse as the others will inevitably encroach on areas

which seem to be within the province of nursing. (Auld 1980)

The image of a nurse as an obedient, subservient and dedicated member of the work force, an adjunct to the doctor, willing to follow rules without question and who has no specific domain over which she is master, is said to persist to-day.

> "Nursing retains an inherited image which belongs to the late nineteenth century. 'The lady with the lamp' or 'the ministering angel' and similar visions linger in the mind. para 81 --- it groups together doctors and nurses not as partners but as people in charge on the one hand and their 'handmaidens' on the other. In the process of providing care the doctor needed a skilled helper, and in the inherited image --- the nurse figures as such - a person who is strictly ancillary. para 83 --- It says much for the pull and power of the nineteenth century attitudes that some of the most basic of them have survived vast changes in medical and social history." para 90. Committee on Nursing (1972)

The inherited image rooted in Victorian values and the contemporary reality merge but are not the same. Nightingale (1859) wrote

> "I use the word nursing for want of a better ---- It has been written scores of times, that every woman makes a good nurse. I believe, on the contrary, that the very elements of nursing are all but unknown". P.2.

She maintained that the help which the sick required had to be based on knowledge, and in the care of nursing, on both the art and science of the subject (Skeet 1980). A century later McFarlane (1981) upheld this concept

> "Nursing practise is a unique synthesis of the art of caring and the principles of science. Without the science, the art is sheer sentimentality or, worse, the science is dehumanised and dehumanising."

The art and science of nursing in the Nightingate era were

directed to "put the patient in the best condition for nature to act upon him" and to control the environment to achieve this end P.110 (Nightingale 1859). This model of nursing took root within the voluntary hospitals which favoured the curative medical model. Initially nurses had autonomy to practise 'cleanness' nursing, however when medical knowledge increased and specialisation developed, the autonomous corps of nurses broke down and nurses became attached to medical teams as technical assistants. Subsequently as medical mastery of specialised techniques grew, so hitherto exclusively medical tasks were handed down to nurses. In turn on receiving these tasks, nurses devolved what had been regarded as exclusively nursing tasks to junior nurses or untrained ward personnel (Bellamy and Oribaber 1980). The acceptance of the medical model decreased nurses' autonomy and authority and nurses became more subject to medical dominance. Nursing was equated as a craft skill (Lancet 1932) and nursing practice as a series of tasks to be done (Committee on Nursing 1972).

This division of labour by tasks within the nurse work organisation remains and thrives within the hierachical nurse management structure (Pembrey 1980). Nursing activities focussing on a job-centred approach (otherwise known as task allocation, non-individualised care or routine care) uses nursing skills efficiently (Chapman 1976), and it satisfies the needs of the doctors, (Fretwell 1980) but though task allocation is "remarkably efficient" at "getting the work done it was bought at a price when viewed in terms of its failure to satisfy many nurses and patients" P.190 (Brown 1966). Studies indicate that task allocation fails to meet the patients' needs because many of the patients' requirements are not within the ward routine (Jones 1975 , Lelean 1973, Stockwell 1972). Nurses are dissatisfied because patient care by task allocation means diffusion of responsibility and no accountability by individual members of the nursing team (Matthews 1975).

Goddard (1953) following his work study of the 'proper task of the nurse' pointed to the deficit if nursing is equated

only with tasks. The Committee on Nursing (1972) emphasised that nurse function extends beyond a task conceptualisation

> "Since the provision of nursing and midwifery services must be directly related to the needs of the patient, nursing and midwifery services should not be considered, as they so often are, simply as a series of jobs to be done, but rather as a series of roles to be discharged. It is necessary to point to the unique caring role of nurses and midwives and to the dependence of society upon them." para 39

Nursing defined in terms of jobs, activities and skills commensurate with the traditional managerial framework based on a task or job-centred approach is now rejected. It is realised the activity in itself is neither 'nursing' nor 'non-nursing', but rather that nurse activities arise out of an ongoing process which in itself is geared towards complex but definable human needs. The emphasis has shifted from 'task' to 'patient', from 'cure' to 'care' encapsulated in 'patient-centred' activities rather than 'jobs to be done'.

Different aspects of nurse intervention are stressed when attempts are made to outline the nurses' contribution to patient care and to define the nurses' responsibility and accountability. Virginia Henderson (1969) concentrated on assisting and enabling the patient to work or to adapt to his present situation

> "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way to help him gain independence as rapidly as possible."

The Committee on Nursing (1972) stressed the care and comfort concept

> "Whether nurses are in hospital or in the community; working as part of a team or alone; whether they are tending the

> physically sick, the psychiatrically disturbed or the mentally handicapped; whether they are counselling young mothers or elderly people; whether they are nursing neonates or attending the dying, their central role is to ensure the care and comfort of the person being nursed, to maintain oversight and co-ordination of that care and to integrate the whole - both preventive and curative - into an appropriate social context." para 137.

This fundamental shift in the orientation of stated nurse thinking clearly identified nursing with 'caring'. Though the parameters of this concept are nebulous, and have yet to be defined, there is an inference that nursing is a dynamic activity which ebbs and flows to accommodate to the needs of the recipient.

> "Nursing is a process with definable phases which takes place in specific situations requiring a greater or lesser degree of independent judgment".

(Scottish National Nursing and Midwifery Consultative Committee 1976)

This process is initiated when the need is recognised. This implies active assessment using a conceptual framework, a review of the possible courses of action to be taken from a range of possible options, an intervention when the activity decided upon as most effective is introduced and finally over a period of time an evaluation of the nursing intervention. Throughout the process the practitioner accepts responsibility for the practice and planning.

More recently the Working Party (Royal College of Nursing 1981) suggested that the nursing process is a systemic framework and discipline which indicates the discrete activity of the nurse, for which she is given authority, has responsibility and is answerable.

> "Instead of the nurse acting simply as the "doctor's handmaiden" ---- the clinical nurse at the bedside in the ward ---- is responsible for her actions and is accountable for them." P.2.

The nursing process encapsulates the essence of the philosophy of current nurse leaders, mapping out an area of patient management which is uniquely nursing, for which in relation to her health care colleagues she (the nurse) has authority, reponsibility and is accountable. As stated by Henderson (1978).

> "It is my belief that while nurses are under ideal circumstances, health workers who act independently with other health workers, they should be masters of their unique role and a health care system should enable them to design, initiate and be responsible for all practices inherent in this role of the patient's altered ego".
> P.121.

Nurse education has endeavoured to keep pace with the changing philosophy of nursing practice. This is demonstrated in the change of emphasis from service commitment to the education needs of the students, from probationer/apprenticeship status to student status and from a medical model to a nursing model in nurse education programmes.

Scrutiny of the literature of nurse educators during this period indicated that fundamental rethinking of the content of the curricula was desired to bring the education programme into line with the developments within the health services and to equip the nurse for her position in the health care teams. The traditional system of training was task orientated, emphasised proficiency in the performance of procedures, focussed on disease and its treatments and advocated submission to those in authority both nursing and medical. This contrasted with the professional preparation of other health workers, which laid stress on a broad general education, a solid theoretical knowledge base and a liberal enquiring outlook.

Reports on nurse education pointed to the deficiency areas, notably the lack of content from the behavioural and social sciences and the emphasis on biological sciences.

The Special Committee on Nursing (1964) concluded

> "The present form of training fails to give the student an adequate understanding of human, social and psychological problems and at times leaves her unprepared for the performance of some technical procedures".

The Committee on Nursing (1972) suggested

> "We should move away from the situation where individual nurses --- who are trained in the physical aspects of caring are often left to discover for themselves the psychosocial needs of the patient along with the relevent social information.
>
> para 253.

In these reports there was general agreement that two fundamental changes were necessary. One concerned the nurse's concept of the patient, the other the development of the nurse's potential. There was a recognition that the social and behavioural sciences should form the core of the theoretical instruction, this meant a reorientation of the nurse education programme. The patient should no longer be viewed as a 'disease entity' but an individual 'who was a member of a family and of the community. The nurse was to be educated to enable her to meet the total health needs of the patient and to accept responsibility for the care to be given by nurses.

The World Health Organisation Expert Committee on Nursing (1966) suggested

> "Nurses should have an educational background comparable with that of other professional groups". P. 16.

and recommended

> "Good basic preparation is a prerequisite for nursing practice ----. Emphasis should be on the development of the following qualities and abilities; an understanding of human behaviour; an alert, questioning and critical mind; power of observation; insight and

> foresight; imagination and creativity; adequate knowledge and skills in nursing; ability to communicate effectively; and, within the ambit of their own competence, ability to make sound judgments and decisions; ability to anticipate health needs and to institute nursing measures; ----.
>
> Fundamental to this goal is the inclusion of a liberal education ----.
>
> Realistically, -- meeting the total health needs of the patient, treating the patient as a total person rather than a disease entity, ---- imply a preparation in the social sciences in far greater depth than at present attained ----.
>
> A problem solving approach should be adopted from the beginning of their education. Students taught in this way will be challenged to think; ---- to seek answers for themselves rather than rely on someone else's experiences or on the memorization of facts"; P.18-19.

The Committee on Nursing (1972) endorsed this dictum. This major report on nurse education stressed that more emphasis should be placed on 'care' which was the 'unique function of the nurse and demanded 'patient-centred' nursing, having rejected the current prevailing 'task' or 'job-centred' approach. para 39

> "Professional nursing and midwifery --- has as its objectives continuity and coordination of care in the interests of the comfort, recovery and integrity of the person being cared for --- the comprehensive and continuous oversight of care is a central nursing and midwifery role and the ensuring of the right services to the patient at the right time, the special responsibility of the nurse or midwife. To carry out this basic integrating function -- involves a sensitive understanding of all the person's needs, physical, psychological and social. -- The prescription of an appropriate social context for treatment is a major nursing skill which makes practical competence in social psychology no less important than expertise in aseptic techniques. para 41

This Committee called for 'the cultivation of the qualities of maturity, responsibility, insight and tolerance and the

ability to cope so that the nurse might fulfil her role as 'partners' to her professional colleagues in particular her medical colleagues.

The Committee believed that it was possible to distinguish the distinctiveness of the nursing and medical professions namely 'the caring role of the nurse' and the 'diagnostic and curative function of the doctor' and exhorted

> "there is a specific area of activity unique to each group based on knowledge and experience and it is necessary to ensure that each of the health professionals recognises the extent and competence of the others" para 138.

Having directed that nurse education should concentrate on preparing the nurse to 'care' as a professional co-equal with other professionals, the Committee did not define the central concept - care - which was to be specifically the nurses' function and for which she was responsible and accountable and did not define the boundaries of that responsibility which was distinctly nursing and for which the nurse had accountability.

The penumbra remains.

Nursing as a craft skill still retains the hallmarks of the era with which it was first associated. However, presently the province of the nurse is being identified as 'care' of the patient, with an emphasis on responsibility to the patient. Instead of the nurse acting only as 'a handmaiden to the doctor' recognition as an individual practitioner responsible for her actions and accountable for them is increasingly identified. Multidisciplinary understanding and support are essential in health care. Understanding and recognition of each other's goals are preliminaries. (Royal College of Nursing 1981).

Medical and nursing are distinct but related 'professions'. Sometimes the roles of the doctor and the nurse are complementary to each other eg. in intensive care units. On particular occasions the roles may be interchangeable

eg. in counselling patients, in supporting relatives and at times of emergency almost indistinguishable. In situations where the 'curing' function (as distinct from the caring function) is subordinate or non-existent (for example, in the case of the chronically disabled or terminally ill) the role of the nurse is central (Committee on Nursing 1972 para 42). In the care of the dying patient, medical treatment may have little to offer, cure is no longer envisaged, care is essential. Here it might be that 'nursing, as an art, can come into its own' (Hockey 1977).

Nursing and the dying patient.

Studies indicate that contact with the dying patient and death arouse intense emotional turmoil in the caregivers. Anxiety within the nursing profession is recognised as one of the occupational hazards (Menzies 1960, Revans 1966). One of the major stress areas is caring for the dying patient (Birch 1978). In Birch's study of anxiety among student and pupil nurses he found

> "analysis of factors causing stress in the first two years of training indicated that six out of ten of the most stressful situations related to aspects of death and dying --- the level of anxiety during the introductory period was equal to that of surgical patients studied by Franklin and became significantly greater in two years time."

Exposure to death does not relieve but tends to increase anxiety; however, with experience nurses develop coping mechanisms to deal individually with the situation, (Quint 1967, Lester et al. 1974, Denton and Wisenbaker 1977, Stoller 1980). These coping mechanisms which the nurses learn from their colleagues are acquired early in their nursing experience and remain stable throughout their careers (Quint 1967). Though learning to handle the situation, certain types of deaths always prove stressful to nurses eg. the death of a young person, deaths associated with respiratory distress or haemorrhaging and deaths in

environments where this outcome is not anticipated (Lester et al 1974, Strank 1972, Gow and Williams 1977, Shusterman and Sechrest 1973).

It has been suggested that education can in some measure be an effective means of lowering death anxiety and influencing death avoidance behaviour (Lester et al 1974, Sanford and Deloughery 1973, Laube 1977, Yeoworth et al 1974, Bleeker and Pomerantz 1979). These hypotheses were confuted by Hopping (1977). Knutson (1970) also disagreed when he stated that members of the caring team encountered their first death so late in the educational process, and in such a manner that the death had become impersonal. Studies of nurse education curricula indicate that time given to instruction in this area of care is very limited. The nurses are not taught how to meet the dying patients' physical or psychological needs, or to come to terms with the conflicts this generates in them (Boland 1977, Birch 1978, Whitefield 1979).

Before entering hospital nurses might not have had contact with the death scene. Simpson (1975) exposed the limited experience of student nurses prior to commencement of training. He reported that 8% had been present at a death; 12% had experienced a bereavement within the family, 35% had had no opportunity to talk about death at home and 15% had formal discussion on the subject at school. This was less than other health professionals (Knutson 1970). Though not in contact with death, Knutson suggested, nurses imbibe the attitudes of their culture to death and commence their careers with attitudes commensurate with those of society in general.

Avoidance and social isolation of the dying is the general response to the phenomenon of death. Personal contact is feared and face to face encounters are avoided (Kalish 1966). This attitude in Western society is unrelated to sex or ethnic grouping (Pandey 1975). Though there has been an increase in the attention given to the subject in the mass media, death remains a largely taboo subject (Bond 1980).

According to Levine and Scotch (1970) society has developed relatively effective means of managing death and minimising the impact of death on itself by various ritual practices but "it has not been nearly so ingenious in developing devices to cope with the terminal stages".

The avoidance of social contact with the dying which is demonstrated in society is carried over into hospital culture and is reflected in the behaviour of the hospital staff (Bowers 1964, Quint 1967, Keck and Walther 1977).

When faced with death and dying, nurses utilise the defences of not only their culture but also their profession. Menzies (1960) who recognised that 'nurses are confronted with the threat and reality of suffering and death as few people are' (p98), suggested that within hospital the nursing personnel have socially structured defense mechanisms to contain and modify the anxiety and pressure of work. The defence mechanisms used render protection by evasion from the full impact of the anxiety rather than by confronting the anxiety provoking situation and assisting one another come to terms with the problem. In her analysis she suggested that personal contact and involvement with patients is minimised by providing care for patients by task allocation or routinely. This not only dissipates the content time but diffuses the responsibility for care among a number of nurses.

In order to maintain a professional composure when interacting with the dying patient, Quint (1966) argued that nurses learned to protect themselves from feelings of guilt, inadequacy and neglect. The tactics they adopted with the dying patient were determined by their expectations about the certainty and timing of the person's death, by the work requirements and by the social structure of the ward. Nurses avoided learning about the patients personal problems and maintained a relationship on a superficial level. In conversation with the patient they avoided talking openly about the future, offered few details about his signs and symptoms, refused to pick up his invitations to talk by changing the subject or by side-stepping the issue and

maintained a busy air which told the patient they did not have time for questions. By blocking the conversation the nurses were able to maintain their composure. Collective emphasis on recovery also successfully masked the presence of death and protected the staff from the impact of dying. Energy and time were spent on patients who might recover and heroic measures to maintain and prolong life created an atmosphere of accomplishment. These endeavours, Quint (1967) suggested, distanced the nurses from the patient and helped counteract the feelings of helplessness associated with caring for the dying patient. The need for the nurse to maintain composure was paramount and governed her interaction with the patient.

Buckingham (1976) who assumed a pseudo-patient role to study the care of the dying patient in an acute general hospital soon became aware of the lack of contact with the caregivers. He felt that the chief distancing manoeuvre used to avoid nurse-patient contact was 'busy concentration on technical skills'. This ruse can readily be used by senior nurses. Division of nursing labour on the wards and the subsequent matching of technical nursing skills with patients' needs means that most senior nurses are concerned with patients who are undergoing sophisticated treatment (Jones 1975). Thus the care of the dying patient largely by default falls to the more junior members of staff.

Knight and Field (1981) concluded following a period of study in an acute general hospital under the guise of a nursing auxiliary that the junior nurses used the structure and organisation of the ward to avoid threatening situations. Work organisation made it possible for them to be busy doing work elsewhere and thus physically they avoided contact with the dying patient. This also suggested to the patient that she (the nurse) had no time to linger. Moreover as a junior nurse, she could legitimately plead ignorance in communication with the patient by virtue of her low status in the ward hierarchy and refer the patient to more senior personnel.

The avoidance demonstrated by nurses which placed severe limitations on their personal involvement with the patient was, suggested Glaser and Strauss (1968), a necessary coping mechanism which nurses developed to enable them to deal with dying patients. It is made possible by the 'non-accountability of terminal care' (Strauss et al 1964). Physical care and technical procedures are evident and can be noted, but there are no legal requirements for members of the caring team to treat dying patients in a psychologically supportive manner or need for documentation of interactions. In other words, staff in hospital are not held responsible for their conversations in the same way as they are accountable for technical aspects of work.

Though avoidance and distancing might be the response of the nurse to the conflicts and tensions created by the imminent death of a patient, during interactions with the patient, the attitude of the patient to the situation and that of the nurse are interdependent. One of the most useful frameworks within which to conceptualise interactions between nurses and dying patients was developed by Glaser and Strauss (1965) who outlined the 'awareness context' of the interactions. The 'awareness context' is the total combination of what each interactant knows about the identity of the other and his own identity in the eyes of the other. 'Closed awareness' is the situation in which the patient is not aware of his impending death but everyone else is - 'a conspiracy of silence' exists. 'Suspected awareness' is the situation in which the patient suspects what others know and tries to confirm his suspicions. 'Mutual pretence awareness' is the situation in which both parties recognise the patient is dying but each pretend the other doesn't know. 'Open awareness' is the situation in which both staff and patient define the patient is dying, openly acknowledge the other's definition and act relatively openly in response to this knowledge.

In 'closed awareness' and 'mutual pretence awareness' contexts the nurses can function with relative ease, but the 'suspected awareness' and 'open awareness' contexts cause most

problems (Quint 1967). 'Open awareness' is acceptable to nurses as long as the patient shows courage and dignity, does not cause scenes and does not make demands on the nurse, however, since a possible consequence of 'open awareness' is that some patients may behave 'inappropriately'and upset the 'sentimental order' of the ward to avoid this situation nurses prefer to deal with dying patients who are heavily sedated (Glaser and Strauss 1968). In the 'suspected awareness' context when the patient suspects that he is dying and is attempting to confirm his suspicions the nurses feel very vulnerable. This is principally because they do not know how to react to the patient. They lack information about what the doctor has told the patient concerning his condition and they are left to guess from the patient's behaviour (Verwoerdt 1967). Furthermore the nurse is not regarded as the person legitimately responsible to divulge information, as the prerogative of determining how much and when information should be released is that of the doctor (Quint 1967, McIntosh 1977). The nurse's position in this quandary is invidious.

Several investigators have described the high incidence of physical and mental distress of patients who are dying (Hinton 1963, Dewi-Rees 1972, Cartwight 1973, Baines 1978, Woodbine 1982). Appropriate symptomatic treatment can relief physical distress (Calman 1978, Twycross 1978). To relief mental distress demands understanding and an appropriate response to the patient's expressed needs or behaviour (Murray-Parkes 1978) so that the patient might find 'his own way of dying, his own death' (Saunders 1978) or an 'appropriate death' (Weisman 1977). The aim of terminal care being according to Holford (1973) 'to ensure that he (the patient) dies in such a peace of mind, dignity and freedom from suffering as the disease process permits'.

More patients are aware of their diagnosis and prognosis than most people admit. In his definitive study of 120 patients who were dying in the general wards of a teaching hospital

Hinton (1967) wrote

> "Considered as a group, - those patients who remained and died in hospital came to know more and more certainly that death was approaching. In fact, only a quarter of these patients did not speak spontaneously to me at some time of their awareness that death might come soon, and at least a fifth became quite certain they were dying". p. 98

This awareness of the patients has been confirmed by many other studies. (Exton-Smith 1961, Duff and Hollingshead 1968, Garfield 1978, Dewi-Rees 1972, Cartwright 1973). Saunders (1959) from her extensive experience concluded

> "In my experience, I find the truth dawns gradually on many, even most, of the dying even when they do not ask and are not told".

Medical staff do not normally inform patients of their impending death (Oken 1961, Duff and Hollingshead 1968, Cartwright et al 1973, McIntosh 1977, Novack 1979), a policy which is endorsed and copied by nursing staff (McIntosh 1977). That this is the most beneficial approach for either patient or caring staff is in question (Saunders 1978) but it is presently the norm in hospital.

Anxiety pressurises the nurse into distancing herself from the patient. Fear of content of communication has been identified as one cause for this anxiety. The control of the doctor over the nurses with regard to verbal communication with patients is evident, McIntosh (1977) wrote

> "The consultants' jurisdiction over telling was absolute in the hospital context. No one had any right to interfere with what they chose to tell their patients nor did anyone do so, ----. While in hospital, the patient was regarded as the sole responsibility of the consultant, his authority being total in all matters relating to his care. p.40.

The influence of the medical staff on all nurse activities

in hospital is considerable (Revans 1966, Rowbottom 1973). In a seminal study of the effect of staff morale on patient recovery Revans (1964) noted

> "the outside observer who spends many hours among them (the nurses) very soon recognises the immense influence that is exercised on them by the doctors".
> P.75.

Studies describe the responses of medical and nursing staff towards the patients who are dying and outline conceptual frameworks to explain their collective responses. The extent to which the influence of the doctor might affect the nursing of the dying patient - this area which demands 'caring', that recognised as the unique and proper function of the nurse, - is not described in the literature which outlines the management of the patient during the final stages of living.

Chapter 3

Place of Death of Greater Glasgow Health Board Residents, 1980

13,748 of the 1,012,041 residents covered by GGHB died during 1980. 4,447 (32%) of these deaths took place at home, 8,884 (65%) took place in GGHB hospitals and other institutions within the Health Board area and 417 (3%) took place outwith the GGHB area (232 in Lanarkshire hospitals, 102 in Argyll and Clyde hospitals, and a few in hospitals elsewhere). Table 1 shows that these proportions are very similar to those for Scotland as a whole.

TABLE 1

Proportion of Residents of GGHB Area and Scotland as a Whole Dying (a) At Home, and (b) In Hospital and Other Institutions

Residents of	Total Deaths	Deaths at Home		Deaths in Institutions	
		No.	%	No.	%
Scotland	71,299	22,697	31.8	48,602	68.2
GGHB	13,748	4,447	32.4	9,301	67.6

Source: GGHB : *GRO (Scotland) CAMO's tapes
Scotland : GRO (Scotland) Annual Report, 1980.

Table 2 gives the distribution of the 8,884 deaths of GGHB residents in the various hospitals and institutions within the GGHB area by the place of occurrence. 63% (5,566) of these deaths occur within the six major teaching hospitals, 30% (2,672) occur in other hospitals, 3.5% (312) in old persons homes, 2.3% (200) in the two hospices and 0.8% (75) in nursing homes.

* GRO - General Register Office
CAMO - Chief Area Medical Officer

TABLE 2

Numbers of Deaths of Residents of the GGHB Area by Institution of Occurrence

Institution	Number of deaths
Southern General Hospital	1,161
Glasgow Royal Infirmary	1,147
Victoria Infirmary	923
Stobhill Hospital	857
Western Infirmary	796
Gartnavel District General Hospital	682
Mearnskirk Hospital	382
Belvidere Hospital	293
Ruchill Hospital	280
Victoria Geriatric Unit	190
Knightswood Hospital	188
Huntershill Hospital	153
Woodilee Hospital	151
Duke Street Hospital	144
Lightburn Hospital	120
Other Hospitals	2,672
Hospices	200
Nursing Homes	75
Old Peoples' Homes	312
TOTAL	8,884

Source: GRO (Scotland) CAMO's tapes

Table 3 gives the total deaths which took place in each of the six major Glasgow teaching hospitals, and the proportions of these which took place in acute wards of the hospital (general medicine, general surgery, orthopaedic surgery, urology and gynaecology). These numbers include patients resident outwith the GGHB area, and so in general are somewhat higher than the numbers given in Table 2 (although there may be minor differences due to the fact that the sources of information differ between the two tables). The table shows that 3,586 of the 5,932 deaths which occurred in these hospitals occurred in the acute wards (mean 60.5%, range 45 to 75%).

TABLE 3

1980 Deaths: Analysis by Hospital and Related Districts.

	Stobhill	Victoria Infirmary	Royal Infirmary	Gartnavel General	Western Infirmary	Southern General	TOTAL
Total deaths in hospital	902	1,008	1,140	736	786	1,360	5,932
Deaths in acute wards	586	640	717	552	473	618	3,586
% deaths in acute wards	65.0	63.5	62.9	75.0	60.2	45.4	60.5
Total deaths in district	2,379	2,887	2,969	3,245		2,424	13,904
% acute deaths in district	24.6	22.2	24.2	31.6		25.5	25.8

Source: Information Services Division (Scotland) 1.

TABLE 4

Deaths in the Main Acute Specialties of the Six Major Teaching Hospitals: Analysis by Specialty.

Type of Ward	No. of Deaths	Percentage
Surgical	828	23.08
Medical	2,447	68.23
Gynaecological	55	1.53
Urological	119	3.31
Orthopaedic	137	3.82
	3,586	99.97

Table 4 gives the number of deaths by specialty for the 'acute' wards of the six major Glasgow teaching hospitals. The great majority of deaths occurred in general medical wards (68.2% overall, range from 59% at Glasgow Western Infirmary to 72% at Southern General Hospital) and general surgical wards (23.1% overall, range from 17% at Southern General Hospital to 30% at Victoria Infirmary).

Table 5 gives an analysis by age of the patients who died in the acute wards of the six major hospitals. Patients under the age of 20 years accounted for 0.2% of deaths in these wards whereas those in the age groups 20-64 years and 65 years and over accounted for 26.6% and 73.2% of deaths respectively. There was some variation between hospitals. For example, in the medical wards the proportion of deaths in the 20-64 year age group was 27.1% (range 19.4% at Gartnavel DGH to 34.5% at Stobhill Hospital. For the surgical wards the corresponding figure was 27.8% (range 22.5% at Stobhill Hospital to 29.9% at Southern General Hospital).

TABLE 5

Deaths in the Acute Specialties of the Six Major Teaching Hospitals: Analysis by Age Group.

Age at Time of Death	No. of Deaths			Total	Percentage
	Surgical	Medical	Other		
0-19 yrs	2	4	1	7	0.19
20-64 yrs	230 (27.8%)	662 (27.1%)	61 (19.6%)	953	26.60
65 yrs	596 (72.0%)	1,781 (72,8%)	249 (80.1%)	2,626	73.20
	828	2,447	311	3,586	99.99

TABLE 6

Deaths in the Acute Specialties of the Six Major Teaching Hospitals: Analysis by Cause of Death.

Cause of Death	No. of Deaths			Total	Percentage
	Surgical	Medical	Other		
Neoplasm 140-239	398 (48.1)	363 (14.8)	114 (36.7)	875 (24.4)	24.4
Cerebro-vascular Disease 430-438	6 (0.7)	585 (23.9)	4 (1.3)	595 (16.6)	16.59
Ischaemic Heart Disease 410-414	10 (1.2)	421 (17.2)	4 (1.3)	435 (12.1)	12.13
Other	414 (50.0)	1,078 (44.0)	189 (60.8)	1,681 (46.9)	46.87
	828	2,447	311	3,586	99.99

Table 6 gives the principal causes of death for patients in these acute wards. As would be expected the principal causes were malignant disease (24.4%), cerebrovascular disease (16.6%) and ischaemic heart disease (12.1%). However there was variation between specialties. In surgical wards 48% of deaths were attributed to malignant disease, whereas the main causes of death in the medical wards were cerebrovascular disease (24%) and ischaemic heart disease (17%). There were of course differences between hospitals. Thus deaths from malignant disease accounted for only 36% of deaths in the surgical wards of Glasgow Western Infirmary, but for 57% of deaths in the surgical wards of Gartnavel DGH. Similarly deaths from cardiovascular disease accounted for 16% of deaths in the medical wards of Stobhill Hospital, but for 30% of deaths in the medical wards at Gartnavel DGH.

TABLE 7

Deaths in the Acute Specialties of the six Major Teaching Hospitals: Analysis by Duration of Final Stay.

Duration of Stay (days)	No. of Deaths			Total
	Surgical	Medical	Other	
24 hrs	39 (4.7)	295 (12.1)	13 (4.2)	347 (9.7)
1-6	284 (34.3)	1,098 (44.9)	73 (23.5)	1,455 (40.6)
7-14	201 (24.3)	494 (20.2)	77 (24.8)	772 (21.5)
15-28	183 (22.1)	311 (12.7)	69 (22.2)	563 (15.7)
29-42	64 (7.7)	122 (5.0)	34 (10.9)	220 (6.1)
42+	57 (6.9)	127 (5.2)	45 (14.5)	229 (6.4)
	828	2,447	311	3,586

Table 7 provides an analysis of the duration of final stay in acute hospital wards (of the six major teaching hospitals) prior to death. In about 10% of cases duration of stay was less than one day (12% for medical wards, 5% for surgical wards). In a further 41% of cases the length of stay was less than seven days (45% for medical wards, 34% for surgical wards). The considerable variation between hospitals is illustrated in Table 8

TABLE 8

Deaths in the Acute Specialties of the six Major Teaching Hospitals: Analysis by Duration of Final Stay - Ranges for Mean Values Given in Previous Table

Length of Final Stay in Hospital Prior to Death	SURGICAL	MEDICAL
24 hours	2.2 (SH) - 13.5 (GWI)	7.9 (GN) - 16.5 (GWI)
1-6 days	22.9 (GN) - 46.1 (GWI)	39.5 (SGH) - 50.0 (GRI)
7-14 days	16.8 (GWI) - 29.0 (SH)	18.0 (VI) - 21.5 (GN)
15-28 days	17.8 (SGH) - 29.0 (GN)	10.4 (GWI) - 13.9 (GN)
29-42 days	1.1 (GWI) - 13.0 (GN)	3.6 (GWI) - 8.5 (SGH)
42 days+	4.5 (GWI) - 11.4 (GN)	3.6 (VI) - 6.0 (GN)

SH - Stobhill Hospital
GWI - Glasgow Western Infirmary
GN - Gartnavel Hospital
SGH - Southern General Hospital
VI - Victoria Infirmary
GRI - Glasgow Royal Infirmary

Chapter 4

Method of Study

4.1. Selection of hospital and gaining access to the clinical area.

The study was conducted in four of the six large general teaching hospitals in the Greater Glasgow Health Board area. Two hospitals were excluded for the following reasons. In one of the hospitals the researcher had held a senior nursing post for a number of years and was known to the nursing and medical staff. Since non-participant observation was to be the method of data collection, it was felt that activities in the wards of this hospital might change in the presence of the 'recognised' observer. Altschul (1972) writes

> "the investigator's past experience of attempting to act as an observer in a hospital in which she occupied a senior position in the nursing hierarchy, suggested that obstacles in establishing a successful participant's role might be excessive" P 45.

A second hospital had to be excluded as the Divisional Nursing Officer refused access.

The bed capacity of the hospitals ranged from 502 - 796 beds. One hospital had been opened within the last fifteen years, the other three hospitals were built in the Victorian era and had been upgraded periodically since.

Each hospital was recognised as a centre for the teaching of nursing and medical students.

During the initial phase, observations were conducted in thirteen wards - 6 surgical wards, 6 medical wards and 1 specialist ward (i.e. a burns unit). In hospital A five wards were used, in hospital B three wards, in hospital C three wards and in hospital D two wards. (Table 9)

TABLE 9

Wards in which Observations conducted. Phase 1.

Hospital	Surgical Ward	Medical Ward	Specialist Ward
A	2 (Wards 1 & 2)	2 (Wards 3 & 4)	1 (Ward 5)
B	1 (Ward 7)	2 (Wards 6 & 8)	-
C	2 (Wards 9 &11)	1 (Ward 10)	-
D	1 (Ward 13)	1 (Ward 12)	-
Total	6	6	1

During the second phase of the study observations were conducted in four of the wards which had been used in the first phase. One medical ward and one surgical ward in each of two hospitals. (Table 10)

TABLE 10

Wards in which observations conducted. Phase II.

Hospital	Surgical Ward	Medical Ward
B	1 (Ward 7)	1 (Ward 8)
C	1 (Ward 11)	1 (Ward 10)
Total	2	2

Direct contact was made with the District Nursing Officers for permission to have access to the clinical areas. Involvement and discussion with the senior nursing personnel varied. One District Nursing Officer wished to discuss the study and thereafter presented the proposal to the senior nursing staff and medical committee, the other three District Nursing Officers referred the request to the Divisional Nursing Officers of the general divisions of the hospitals. The aim of the research and the period of observation were discussed with the Divisional Nursing Officers of three of the hospitals. In one hospital the writer was referred directly to the Senior Nursing Officers.

In each hospital meetings were arranged with the Senior Nursing Officers during which a broad outline of the research proposal was given and the observer's role discussed. The objective (of the period of observation) was stated as "to observe nurse-patient interaction in acute general wards where there are patients with varied nursing needs and which include a patient who is expected to die within six days". The role of the investigator as a non-participant observer was outlined, with the proviso that should a crisis present e.g. a patient appear to be about to fall out of bed, assistance would be available. Permission for the observer to be present during the ward report sessions and for access to read the nursing kardex and medicine kardex was sought. A lively discussion always ensued. Questions were asked with particular reference to "adding to the nurses' workload". Following assurance that nurses would not be removed from the clinical areas for interview, freedom to observe was granted. The Senior Nursing Officers agreed to identify the wards where the criteria could be met.

At the commencement of observations in three hospitals the Senior Nursing Officers introduced the observer to the nurses in charge. When the Senior Nursing Officer was not on duty the Nursing Officer conducted the writer to the area. In one hospital the researcher was introduced to the ward

sisters by a preliminary telephone call from the Senior Nursing Officer.

In eleven of the thirteen wards the reception was warm and friendly. In two wards, the reception was cool with veiled hostility. For a considerable time discussion took place in one ward on the value of research as a means of identifying the skills of nursing. Eventually the sisters indicated a willingness to permit observations, tea was provided and all concerned could not afterwards have been more helpful. In a second ward the sister was very harassed and certainly did not welcome another encumbrance, however she soon became friendly when the observations did not intrude on or impede her work.

Difficulty was experienced in deciding how much information should be conveyed to the ward staff regarding the research topic, as it was realised that the nurses' interactions with the dying patient might be influenced by her knowledge of the specific area of interest. Ethically it is necessary for the participants to be conversant with their role in the research (Fox 1976). The researcher decided that the nursing staff below the grade of Senior Nursing Officer would not be privy to the particular area of investigation. The research topic was introduced to the nurses as "How nurses and patients interact in the acute hospital ward". This gave knowledge of the activity which was being observed but not of the specific focus of the observations.

When negotiating with the consultants, the approach was to individuals. The aim of the study was identified as "To elicit factors which might influence the nurses during her care of the patient who is dying, including the influence of the doctor, noting his attitude to the patient and his communication with the nurse". Since some consultants were hesitant about the study, it was necessary to give specific details of the subject being considered. This knowledge may have affected the consultant's subsequent activities but relationship with the care staff was of prime importance,

hence frank discussion was necessary to ensure their confidence and trust in the researcher. After the initial hiccoughs, the fullest cooperation and assistance was offered by the medical staff.

4.2 Method

The activities of the nurse can be studied from an operational research perspective by collecting data on which tasks are done, by whom, over what period of time. The value of hard data obtained from this approach is evident, but the 'caring' element of nursing eludes this method, as do the factors which affect the 'caring'. Goddard (1953) stated

> "Any attempt to analyse this type of work (nursing) inevitably results in a cold, calculated list of duties and fails to convey the atmosphere in which these duties were performed".

The 'caring' aspect of nursing practice is intangible. It is part of a dyadic social interaction which is dynamic not static. It is an essential part of nursing which is subject to alteration by social contextual factors. To obtain the necessary information in this area, qualitative rather than quantitative data are essential. (Melia 1981).

As there was no hypothesis from an already formulated theory to be tested, it was decided to rely heavily on the method of study outlined by Glaser and Strauss (1967). During their investigations of the management of death in general hospitals this approach had been used successfully to generate the theory of the awareness context (Glaser and Strauss 1965). To use the study design of developing grounded substantive theory, the problem to be investigated is approached with as few preconceived ideas as possible. Data are collected by fieldwork and analysed simultaneously. Conceptual categories begin to emerge between which relationships gradually become apparent from which hypothesis may be formed. The researcher returns to the natural

habitat of the phenomena being studied to test the hypothesis and gather further evidence to support the developing substantive theory. Central to this method is the gradual development of the conceptual framework, the researcher being guided by the data obtained from persistent fieldwork. Theory was viewed by Glaser and Strauss as a process that is ever developing by comparative analysis, not as a perfectable product. (Glaser and Strauss 1967)

> "Our strategies of comparative analysis for generating theory put a high emphasis on theory as a process: that is, theory as an ever-developing entity, not as a perfect product --------. Theory as process, we believe renders quite well the reality of the social interaction and its structural context". P 32

This approach to research is particularly useful for studying the art of nursing - a social interaction within a social context, which is not amenable to scientific experimental methods. Kratz (1974) used the approach of Grounded Theory when studying the community nursing care of patients who had had a stroke. Melia (1981) in her study of the nurse's concept of her role used a similar approach.

The aim of the present study was twofold

1. To describe the nursing care of the dying patient during the last week of life.

2. To determine factors which might influence the activity of the nurse during her care of the dying patient.

To gain insight into the phenomena and if possible generate explanatory ideas of the causal factors, it was decided to carry out careful, comprehensive observations in a number of clinical areas. This would permit not only a description of the activities at the bedside of the patient, but an explanation of the observed processes by an analysis of comparative observations. Observation, stated Fox (1976)

is

> "particularly appropriate for complex research situations which are best viewed as complete entities and which are difficult to measure either as a whole or separately. -------- there is no better way to obtain data to describe a set of behaviour than to watch the persons behaving." P 211-213

It seemed essential to obtain data that characterised the interaction as it occurred amid the stresses and strains of the ward. This demanded continuous observation to record not only what happened but the context within which the phenomena occurred. Becker and Geer (1957) underlined the importance of observing the incidents which precede and follow an event and suggested

> "It enables one to become aware of the incongruous or unexplained facts, makes one sensitive to the possible implications and connections with other observed facts and pushes one continually to revise and adopt his theoretical orientation and specific problems in the direction of greater relevance to the phenomena under study."

Goddard (1958) stated

> "Experience has shown that a real understanding of the demands made by the range of duties involved in a job is possible only if these duties are studied against a background of the environment and conditions under which the work is performed. For this reason the observation methods is strongly recommended, both for accuracy and for standardized judgment," P 47

Selltiz et al (1965) states that

> "the greatest asset of observational techniques is that they make it possible to record behaviour as it occurs. All too many reseach techniques depend entirely on a people's retrospective or anticipatory reports of their own behaviour. --- remote from the streeses

> and strains that influence what he does or says in the ordinary course of events." P 201

The decision had to be made on the level of participant-observation which was compatible with the objectives of the study. A number of observation techniques involving various levels of participation have been outlined (Gold 1958, Cicourel 1964, Stacey 1969). The variable on the continuum of role activity which extends from passive to active participation is the degree to which the observer participates in the research situation (Cicourel 1964).

Each of the roles outlined by Gold (1958) 1. Complete observer 2. Observer-as-participant 3. Participant-as observer and 4. Complete participant was considered. The more intense the participation the greater the wealth of data, but non-involvement tends to give greater objectivity (Cicourel 1964). In the role of complete participant, the true identity of the worker and the purpose of the study are not revealed to the informants. This tactic has been used in anthropological studies and revealed a wealth of data but assimilation into the group being studied carries the hazard of 'going native'. Buckingham (1976) used this approach in his comparative study of hospice and hospital care, however to his surprise he reported that within 48 hours of his admission as a pseudopatient he was experiencing symptoms of pain, weakness and lassitude. This role was not contemplated. The role of a nurse was considered, but it was apparent this would not be possible, as due to professional experience a lead would inevitably be given on occasion, particularly when with the learner nurses. 'Complete observer' did not seem a feasible role as to be removed from involvement with the informants would reduce the data considerably.

Gold (1958) draws a distinction between the observer-as-participant role and that of the participant-as-observer by indicating the differing emphasis. The observer-as-

participant is 'restricted in his participation' by his over-riding necessity to observe the informants' responses and behaviour whereas the participant-as-observer is 'restricted in his observations' by the over-riding need to maintain participant observation. The former role has the advantage of being 'an outsider' to whom the informants may talk freely, but is disadvantaged by being prevented from gaining knowledge of the total situation, in the latter role there may be an opportunity to gather more extensive in-depth information, but with this goes the risk of involvement.

It was realised that as a nurse there were advantages as one had background knowledge and experience and was already accustomed to the traumatic hospital environment compared to the less inured observer, however one had to be alert to 'familiarity which breeds contempt'. For this reason an observer-as-participant role was decided upon as this would permit the observer to concentrate on the objectivity essential when gathering data.

During the study there was a tendency to vacillate between the observer-as-participant role and the participant-as-observer role; for example, one observed the activities of the caregivers at the bedside of the dying patient and listened to conversation between the medical and nursing staff concerning the dying patients without involvement, whereas at other times one was often involved in conversations with patients, nurses and doctors.

4.3 Acceptance into the ward

The observer passes through various stages before acceptance is achieved (Denzin 1970 P 191-192). The observer-observed relationship problems which have to be contended with during a lengthy period of involvement were not evident to the researcher during this brief period in the wards. The patients' life expectancy limited the time available.

It was essential that the role of the observer should be accepted and rapport established with the staff as quickly as possible. Past experience of gaining entry to the clinical area for the purpose of teaching student and pupil nurses helped guide the investigator in how best to gain acceptance and cause minimal disruption to the ward activities.

A conscious effort was made to be friendly and allay suspicion. In each ward an explanation was given to each nurse. The investigator's presence was said to be "to observe the interaction of the nurse and the patient" and the assurance was given that the exercise was in no way directed towards assessing their level of competence. The need to know the nurses' names for the purpose of differentiating the staff members was explained. Anonymity and confidentiality were promised in the findings. The autonomy of the researcher's role was explained, emphasising that no reporting back or discussion of findings would take place with senior nursing personnel in the hospital. The writer identified herself as a nurse who had not been involved recently in the clinical area.

To maintain good relationships invitations from the sisters to have coffee were accepted, on the understanding that only a brief time was permissible for the investigator in order not to disrupt the observation schedule. Meal breaks were taken with the nurses in the canteen for junior staff rather than with the senior nursing staff. This precedent was established in the first ward and was continued throughout the study.

During casual conversation one could glean a few details pertaining to the ward activities and the nurses' perception of her role. Often the nurses seemed contrained to talk. For example one student nurse expressed deep concern for the patient who was dying and anger towards his relatives, as she felt "they just do not behave properly". The tea break became a debriefing session for the nurse. The student

required help and was looking for guidance. To assist the student understand the family's behaviour yet not alter her present activities references were given for reading. Another incident occurred following the sudden unexpected decline of a mentally retarded patient. All measures to assist towards the recovery of this patient had been invoked. The nurses were concerned for the patient, and talked of the lack of guidance they, the nurses, had with regard to which patients should be resuscitated. They recalled incidents from their own experience and that of their colleagues to illustrate their dilemma. These chats were permitted to take place, as these insights into the nurses' problems were helpful, and helped to develop a rapport with the students.

In each ward the researcher visited every patient and introduced herself as follows: "I am a nurse who is meantime watching other nurses working. You'll see me around for a few days taking notes, but don't worry, I'm not criticising them". Acceptance seemed immediate and friendly. The response generally was "They work hard these girls". Occasionally a patient would express more interest. Questions asked were answered as explicitly as possible without expressing the exact nature of the study. At times, chatting with a patient who was within range of the patient who was dying, permitted an extended period of close observation without disruption. Patients equated the study to "something like time and motion studies". This concept was not expressed by the nurses.

A white laboratory coat bearing a name badge, was worn when in the clinical areas. It was felt this might make one's presence less obvious and be acceptable to the patients who though not immediately involved, should not be threatened by exposure to an uncoded presence.

The junior medical staff were interested and asked pertinent questions. Answers were given which were frank without directly indicating the key area of the study, as they had not been informed that the dying patient was the focus of

attention.

Research demands must take priority, yet the need to be accepted was essential. To remain aloof as a "fly on the wall" the role adopted by Lelean (1973) was thought to be less valuable than to express empathy to the nurses' work situation and thus gain acceptance. On occasion, for example, a telephone ringing for an excessively long time was answered. A 'well' patient's request was relayed to the nurses or a helping hand to lift a patient was given. These gestures were infrequent, hopefully did not change the work pattern extensively, but may have compensated for any disruption due to the observer's presence. 'Flexibility and sensitivity' to the situation as commended by Quint (1967) were paramount and practised in order to maintain relationships so that the required information could be gathered.

It was inevitable that the presence of the observer would be noticed. What stance was to be adopted for maximum surveillance? The physical structure of nine of the thirteen wards was that of an open Florence Nightingale ward sectioned off into areas to accommodate four to six patients in each bay. The nurses' station was either at the ward entrance or in the centre of the ward area. The kitchen and duty room extended off the ward corridor. Toilet facilities and day room areas were at the extreme end of the wards. In the other four wards there were four to eight single rooms and open areas which accommodated four patients. These rooms opened on to a corridor from which the room occupants could be observed. In the centre of the corridor was the nurses' station and duty room. Toilet, bathing, kitchen, sitting room and dressing room facilities were in rooms extending off this corridor. The patients who were dying were nursed in either the open wards or in the single rooms.

In the first ward observations were recorded from a discrete area in the corner of a ward bay. Maintaining an alertness to the activities was on occasion, between spells of no

interaction, difficult. To relieve the situation the investigator began moving to and fro and occasionally chatted with patients within range of the particular patient. This proved less tiring and was later shown to be more acceptable to the nurses. During a lunch break the nurses were asked which they found less threatening. They unanimously agreed that when one walked around "then you are just like everyone else and we don't see you, otherwise we can see you writing things down."

To learn if relevant data was missed by the peripatetic activity, for one hour during a period of observation a nursing colleague recorded data simultaneously. The second participant remained in one discrete position while the writer moved to and fro in the vicinity. Comparison of notes indicated minimal differences in recordings. For this exercise the ward staff were told the second investigator was also a nurse who was 'checking on' the writer's proficiency - a situation accepted as essential and in good humour by all the nurses. Within the nursing hierarchy the situation of being 'checked up on' is often a focus of humour.

The presence of an observer within the ward must inevitably affect the ward dynamics and hence the events to be recorded. Fox (1976) states with regard to observation

> "My own experience with it has convinced me that, while distortion is unquestionably introduced, it does not persist for long periods of time. Therefore, if known observation begins with a period of time for acclimatisation and orientation during which no data are collected, in most instances the research situation reverts to normal" P 212-213.

The researcher's presence seemed to be accepted and ignored within a remarkably short period of time. Antagonism and suspicion were not apparent. In one ward chocolates gifted by a patient were offered with the encouragement "to take your share, before they are all finished", in another area the writer was involved in the intrigue of 'having a cup of

tea without being caught'.

Though one endeavoured to maintain a low profile and merge into the background and was not aware of assisting the nurses, one's presence must have had some impact. Hopefully change, if any, was minimal and not detrimental to either patient or nurse. A sensitivity to the situation and a desire not to add to the stress may have helped maintain a non-obtrusive, somewhat detached, but friendly relationship.

The non-participant observer role was not always easy to maintain. Often it required so little and to give a little would have meant so much to the patient. Twice the observations were discontinued and the observer left the scene. These incidents are identified in the study.

4.4 Data collection

The field work was conducted in two phases. Initially the area was explored, then following analysis of these data, a further period of fieldwork was conducted during which attention was directed towards specific aspects of the field.

Phase I. Observations centred on the activities of the nurses at the bedside of the dying patients.

Phase II. Activities of the senior medical and nursing staff at the bedside of the dying patients were monitored and the information passed between these key participants concerning the dying patients was noted.

Phase I. and II. Throughout both phases a record was kept of the information given by the senior nurses to the junior nursing staff concerning the dying patient and detailed profiles of the dying patients who were central to the

study were drawn up.

Phase I.

Few criteria were set for the data which were to be recorded, as the researcher wished to remain 'open' to all actions, interactions and gestures between the nurses and the dying patients.

Details of the activities observed were recorded as follows

1. What was done for the patient.
2. Who did it
3. Why the contact was initiated
4. How long did the contact last

At no time were activities observed which occurred behind the drawn screens or in a sideroom if the door was closed. It was felt this intrusion might disrupt the care of the patient. The exact nature of these activities was ascertained by asking the nurse, if necessary.

Three variables which influence nursing in the general hospital ward were noted.

1. Resources

Nursing care depends on the resources available at ward level during each shift. A detailed record was kept of the number of nurses on duty, the qualifications of each nurse and the level of training of each student and pupil. The learners do not form part of the stable work force of a ward. As a settling period is necessary for the learner before she can function adequately, the length of time she had worked in the ward was noted and also the position which each nurse occupied in the ward team during each observation period.

2. Ward design

The ward design is recognised as an important variable in the

work pattern of the nurses (Melia 1979). The physical design of the ward was noted, in particular the position of the bed of the patient relative to the other patients and to the ward structure.

3. Staff management

Nursing of patients is influenced by the nursing staff management (Pembrey 1980). The organisation of nursing activities in the general hospital ward is by job or patient assignment. Management by job assignment is when the nursing care is provided by assigning specific tasks to grades of personnel in accordance with their ability to perform them. Patient assignment is when the total nursing needs of each patient, (in which case all the work related to the patient) is assigned to a particular nurse or group of nurses. This variable was noted. The duties allocated to individual nurses were recorded.

Phase II.

During this phase when the consultant was present in the ward, the researcher shadowed the senior nurse. The ward rounds were attended. Invitations to coffee sessions before or after ward rounds were accepted, as during these social interludes various aspects of the patients condition or treatment were discussed.

The interactions between the consultants and senior nurses and the dying patients were observed and a note made of

1. What happened
2. Which aspects of patient need were considered
3. What was discussed with the patient
4. The length of the consultation.

Following the dialogue between the consultant and the senior nurse concerning the patient, the following questions were

considered

1. Did the consultant request information?
2. Did the senior nurse request information?
3. Did the consultant advise the senior nurse?
4. Did the senior nurse advise the consultant?
5. What aspects of patient care were considered?

Phase I and II

Throughout both phases of the study the morning, afternoon and on occasion the evening ward report sessions were attended, the aim being to record the information given to the nursing staff about the dying patient under observation. The report on the patient who was dying was written down verbatim. The day and night report on the dying patients were transcribed in full from the individual patient reports. The individual patient instruction sheets and lists of ward tasks were read and transcribed.

The profile of each dying patient which was drawn up included the patient's age, status in the family, the diagnosis and duration of the illness, the number of admissions to hospital and the length of the present admission, the complications of the illness experienced by the patient and the treatment prescribed. (Appendix 1.) These data were obtained from the medical case records and the medicine kardex. The patient's state of awareness and the ability of the patient to communicate were assessed by the observer.

4.5 Procedure for data capture

Careful consideration was given to the form in which the data would be collected, in particular whether or not observations should be recorded in writing when they occurred or committed to memory and written down at a later date. Strauss et al (1964) stated

> "Most experienced participant observers generally prefer to make only mental notes during observation or interviewing, committing these notes to paper immediately after leaving the situation".

The observer had no experience of observation techniques and was aware that bias might result due to her previous experience as a nurse, and this might increase if the findings were not committed to paper immediately. The time lapse would permit a relationship to be associated with what had happened and why it happened and might inhibit consciously or subconsciously an accurate recording of the minutiae of the interaction, thus masking the true picture. Quint (1967) stated

> "Nurses have been educated to think of problems from a practioner's perspective in which primary values and motivating purposes are quite different from the perspective of the social scientist. ---- nurses tend to think in terms of cause and effect relationships".

She recommended that records of observations are more accurate when they are made as soon as possible following the observations (P 111-112).

Studies involving extensive note-taking in the clinical field have been made (Altschul 1972 and Cormack 1976). They reported that minimal disruption to nurses and patients seemed to occur. The decision therefore was made to take notes during the first phase when interactions between the nurses and the dying patients were monitored. The nurses were informed that this would be seen to occur and invited to express their anxiety if they did feel threatened. They were assured that if anxiety occurred they would be permitted to read the notes taken. This was acceptable to all the staff.

Only one student nurse did accept the offer and ask to see the jottings. No notes were made during the activity sessions observed in the second phase of the study. Later details of the relevant episodes were recorded and a check list used to assist the recall of incidents witnessed. (Appendix 2).

Though the collection of certain data was predetermined an open approach to the problem was maintained. Conscious that nurses tend to see what goes on in hospital in a stereotyped way - "because they view the world through nurses' eyes" (Quint 1967) an effort was made to remain alert to all data pertaining to the patient who was dying and the members of the caring team involved with the patient.

4.6 Observation times

The first phase of fieldwork extended over a ten week period and the second phase over sixteen weeks.

Phase I.

The opportunity to observe was taken up whenever possible. Observations commenced immediately a dying patient was identified by the Senior Nursing Officer. Twenty-three patients were observed during this ten week period. All observations were conducted during the day time commencing at 7.45am. Following the ward report the patient was kept under surveillance for a four hour period. A second four hour observation was continued in the afternoon or evening dependent on the life expectancy of the patient. This timetable was maintained for two to three days. The total observation time was 322 hours 10 minutes. (Table 11)

Phase II

Observations were conducted to coincide with the consultants'

TABLE 11

Details of Observation Periods Phase I

Patient	Observations Commenced Before Death	Observations Discontinued Before Death	Length of Observation Period
A	36 hrs	2 hrs 30 mins	8 hrs 15 mins
B	1 hr 30 mins	at death	1 hr 30 mins
C	48 hrs	21 hrs 30 mins	12 hrs
D	31 hrs 30 mins	30 mins	15 hrs
E	21 days	19 days	11 hrs
F	3 hrs 55 mins	at death	3 hrs 55 mins
G	10 hrs 30 mins	at death	5 hrs 15 mins
H	35 hrs 30 mins	5 hrs	12 hrs 30 mins
I	81 hrs	30 hrs	20 hrs 45 mins
J	20 days	16 days	21 hrs
K	12 days	9 days	16 hrs 30 mins
L	10 days	9 days	12 hrs 30 mins
M	7 days	6 days	12 hrs 30 mins
N	22 hrs	at death	5 hrs
O	29 hrs	at death	14 hrs
P	87 hrs	7 hrs	31 hrs
Q	89 hrs	9 hrs	27 hrs
R	31 hrs	28 hrs	3 hrs
S	5 days	2 days	16 hrs 30 mins
T	92 hrs	36 hrs	13 hrs 30 mins
U	12 days	10 days	16 hrs 30 mins
V	13 days	9 days	21 hrs 30 mins
W	12 days	8 days	21 hrs 30 mins
Total number of observation hours			322 hrs 10 mins

visits to the wards. The morning vigilance was maintained. On occasion when the ward round was conducted in the afternoon period this meeting was attended. Four weeks were spent in each of the four wards. Twenty-seven patients were observed during this phase and ninety-one rounds attended. One hundred and thirty-seven patient consultations were witnessed. (Table 12)

Phase I and II

More than two hundred ward report sessions were attended. The location, specific patient interest and frequency of attendance are described on Table 13.

4.7 Selection of patients

There are no universally accepted criteria to differentiate the patients who will live from those who will die (Thompson 1979), though Murray-Parkes (1972) demonstrated that experienced nurses have a sensitivity in this area. During the first phase each Senior Nursing Officer was asked to identify patients whom she thought would die in six days. The difficulty 'of knowing' were discussed with these senior nurses, but they did agree that they 'usually knew'.

At the commencement of each period of observation the Senior Nursing Officer identified only one patient as dying, in the area for which she was responsible. The opportunity to observe that patient was accepted without question, and observations proceeded when the patients were available. In one hospital conversation with the Roman Catholic priest during his visits to the wards revealed that he was busy. The sacrament of the sick is given not only to patients who are dying but to the seriously ill patient and those who request it. From his chat it was apparent that he had a number of patients in the first category. Following this cue enquiries were made and it was learned that twenty patients had died in the hospital during the fourteen days'

TABLE 12

Number of Ward Rounds/Patient Consultations Observed Phase II

Consultants	Type of Ward	Number of Ward Rounds	Patients	Number of Consultations
W	Surgical	6	$X:B_2:C_2$	13
T	"	15	$Y:A_2$	9
E	"	6	$Z:D_2:E_2$	7
T:E	"	1		
W:T:E	"	2		
B	Medical	6	$F_2:I_2:K_2:L_2$	12
F	"	4	$G_2:M_2$	7
H	"	-	J_2	-
L	"	-	H_2	-
S	"	8	$O_2:P_2:N_2$	10
V	"	8	$S_2:T_2$	14
D	"	8	$N_2:O_2:S_2:T_2$	16
K	"	5	Q_2	1
C	"	5	R_2	1
G	Surgical	2	$U_2:V_2:W_2:X_2$	24
M	"	5	$U_2:V_2:W_2:X_2$	23
G:M	"	10		
	Total	91	Total	137

TABLE 13

Ward reports related to location, specific patient interest and frequency of attendance. Phase I and II

WARD	PATIENTS	NUMBER OF REPORTS ATTENDED
1	A	3
2	B	-
3	C	5
4	D	3
5	E	6
6	F	-
7	G	1
	H	2
	I	5
8	J	5
9	K	4
	L	3
	M	3
	N	1
10	O	3
11	P	6
	Q	6
	R	1
12	S	4
	T	3
	U	4
13	V	5
	W	5
7	X	1
	Y	6
	Z	4
	A_2	6
	B_2	10
	C_2	10

WARD	PATIENTS	NUMBER OF REPORTS ATTENDED
8	D_2	-
	E_2	4
	F_2	4
	G_2	1
	H_2	8
	I_2	4
	J_2	3
	K_2	-
	L_2	6
	M_2	4
10	N_2	2
	O_2	10
	P_2	6
	Q_2	10
	R_2	1
	S_2	6
	T_2	6
11	U_2	6
	V_2	6
	W_2	3
	X_2	12
	Total	217

Average number of reports attended per patient - 4.3

observation period. The Senior Nursing Officer must have selected the patients and the wards in which the observations were to be conducted. Selection may have been according to the Senior Nursing Officer's awareness of the presence of dying patients in the wards for which she was responsible or according to some features of the wards in which she wished the observer to function. It is generally accepted one always wishes to portray the best profile (The Hawthorne Effect). If this bias existed the wards in which the observations occurred would be those where a high standard of nursing care was expected.

During the second phase the patients identified as dying were patients who demonstrated all or some of the following features.

1. He/she suffered from a disease which had a fatal prognosis.
2. His/her physical appearance indicated marked deterioration.
3. His/her condition was not responding to medical therapy.
4. He/she was receiving narcotic drugs regularly.
5. His/her state was referred to by ominous cues during medical-nursing staff interactions.

The observer was responsible for identification of the patients' state during this phase.

Chapter 5

The Study Sample

5.1 The patients observed

Twenty-nine female and twenty one male patients were involved in the study. Their ages ranged from 40 years to 89 years; the mean age was 66.48 years. (Table 14)

TABLE 14

Age of Patients at Death

	40-44 Yrs	45-54 Yrs	55-64 Yrs	65-69 Yrs	70-75 Yrs	75 Yrs +
Male		4	8	3	2	4
Female	2	3	5	6	2	11*
	2	7	13	9	4	15

* One of these patient's recovered

Prognosis on admission

On admission the life expectancy of the patients differed. This is shown on Table 15.

TABLE 15

Life Expectancy of Patients

	ADMITTED 'TO DIE'	NOT EXPECTED 'TO DIE' ON ADMISSION	
		Active medical intervention modified	Active medical intervention maintained
Surgical Unit	11	15*	
Medical Unit	4	15	4
Specialist Unit		1	
	15	31	4

* One of these patients recovered

Fifteen of the patients had been admitted 'to die' as home circumstances could not provide the facilities required in the final stages of living. The other patients though very ill at the time of admission were not expected to die during the period of hospitalisation but the progress of the disease and the inability of the patient to respond to treatment altered the intitial prognosis.

Active medical intervention was initiated for thirty-one patients; however, this was modified when recovery seemed impossible and death inevitable. Four patients did not fall into this category. Two of these patients received aggressive, therapeutic intervention until death; cardiac resuscitation was attempted for one of these patients before death was certified. The deterioration of the other two patients baffled the doctors as they could not determine the diagnosis of the disease, a balance between investigation and alleviation of the symptoms was maintained until death. Forty-nine patients died, one patient recovered and was discharged from the acute ward to a geriatric unit five weeks after the period of crisis.

Previous admission to hospital

Forty of the patients had been in hospital on previous occasions as a direct result of the disease from which they suffered, for ten patients it was their first period of hospitalisation.

Length of hospitalisation

The final period in hospital for the patients ranged from six hours to twenty-four weeks. The average duration was 28.7 days. (Table 16)

TABLE 16

Length of hospitalisation related to life expectancy

	Less than one day	1 - 6 days	1 - 2 weeks	2 - 4 weeks	4 - 6 weeks	6 weeks +
Admitted 'to die'	3	7	2	3		
Medical treatment modified	1	7	2	14	5	2
Active medical treatment maintained		1	1		1	1
	4	15	5	17	6	3

Ten of the fifteen patients (66.6%) who were admitted 'to die' died within six days of admission (three were in hospital for less than twenty-four hours), the other five patients lay for between eight and twenty-three days. The patients who were not initially 'expected to die' tended to have a longer period of hospitalisation. Twenty-three (65.7%) of these patients were in hospital for more than two weeks, only nine (25.7%) of these patients died within six days of admission.

Duration of illness

The known duration of the illnesses from which the patients suffered ranged from two days to eighteen years, more than half of the patients had been ill for less than one year.

Length of illness less than 6 months - 21 patients
Length of illness 6 months to 12 months - 7 patients
Length of illness 13 months to 24 months - 7 patients
Length of illness 25 months to 36 months - 6 patients
Length of illness more than 3 years - 9 patients

Cause of death

The cause of death varied. This is summaried in Table 17 and outlined on Table 18.

TABLE 17

Cause of death related to medical approach

	Neoplasm 140-239	Ischaemic Heart Disease 410-414	Cerebrovascular Disease 430-438	Other
Admitted 'to die'	14			1
Medical treatment modified	16	5	4	6
Medical treatment maintained	2	1	-	1
	32	6	4	8

Malignant neoplasm accounted for the majority of the deaths. Twenty-six patients suffered from metastasis from malignant growths of various origins (five patients had undergone a mastectomy operation, five patients had a bronchial carcinoma, four patients had a gastric carcinoma, six patients had received surgery for a bowel carcinoma, two patients had a carcinoma of the gall-bladder, one patient had a hepatic carcinoma, one patient had a uterine carcinoma, one patient had a prostatic carcinoma and one patient a sarcoma of the femur). Two patients demonstrated the presence of malignant secondary deposits - one patient had a pathological fracture of the humerus and the other patient enlarged cervical glands - but the primary sites of the diseases had not been identified. Lymphoma was the disease suffered by one patient, another patient had a leukaemia and also suffered with a femoral embolism, another patient suffered from myelofibrosis and one patient had a severe anaemia of unknown aetiology.

TABLE 18 : Details of patients - the diagnosis, expectancy of life on admissions to hospital and eventual prognosis, level of consciousness and ability to communicate

Patient	Sex	Age (Years)	Diagnosis	Duration of Illness	Length of present period of Hositalisation	Prognosis related to death	Level of Awareness	Ability to communicate
A	F	52	Metastasis from breast carcinoma	2 years	4 weeks	Unexpected - expected	Semi-conscious	Moaned, responded when spoken
B	F	51	Metastasis from breast carcinoma	16 months	20 hours	- to die	Unconscious	-
C	F	41	Hepatic carcinoma	3 months	4 weeks	- to be prevented	Alert	Able to communicate
D	M	54	Lymphoma	6 months	6 weeks	unexpected - expected	Alert	Difficulty in articulating
E	F	64	Gastric carcinoma	18 months	6 weeks	Unexpected - expected	Alert	Able to communicate
F	M	75	Left ventricular failure	Unknown	4 days	- to be prevented	Conscious - confused	Able to communicate but slightly confused
G	M	63	Perforated duodenal ulcer	15 days	15 days	Unexpected - expected	Semi-conscious	Opened eyes when spoken to
H	F	68	Metastasis from bronchial carcinoma	8 weeks	5 weeks	Unexpected - expected	Alert	Able to communicate
I	M	69	Hepatic carcinoma	12 weeks	13 days	Unexpected - expected	Alert	Able to communicate
J	M	56	Metastasis from bronchial carcinoma	6 months	5 days	- to die	Alert	Able to communicate. Confused on one occasion
K	F	86	Leukaemia. Embolus of (R) leg	36 months	12 days	- to die	Semi-conscious	Drowsy, responded when spoken
L	F	75	Metastasis from breast carcinoma	32 months	2 days	- to die	Alert	Able to communicate
M	F	40	Metastasis from breast carcinoma	18 months	1 day	- to die	Alert	Able to communicate
N	F	69	Carcinoma sigmoid colon	8 weeks	22 hours	- to die	Alert	Able to communicate
O	F	74	Ischaemia heart disease Cerebro-vascular accident	19 days	19 days	Unexpected - expected	Semi-conscious	Responded slightly when spoke
P	F	57	Sarcoma of femur	24 months	21 days	Unexpected - expected	Alert	Able to communicate Occasionally confused
Q	F	76	Pelvic Mass	22 days	6 days	Unexpected - expected	Alert	Able to communicate
R	F	52	Metastasis from breast carcinoma	36 months	2 days	- to die	Alert	Able to communicate
S	F	61	Metastasis from bronchial carcinoma	6 months	4 days	- to die	Semi-conscious	Drowsy, responded when spoken

Patient	Sex	Age (Years)	Diagnosis	Duration of Illness	Length of present period of Hospitalisation	Prognosis related to death	Level of Awareness	Ability to communicate
T	F	68	Infective hepatitis cirrhosis	10 years	4 days	Unexpected - expected	Semi-conscious	Responded by moan when spoken t
U	M	62	Cerebro-vascular accident	14 weeks	14 weeks	Unexpected - expected	Semi-conscious	Responded by opening eyes when spoken to
V	M	60	Melanoma-small bowel obstruction	6 months	2 days	Unexpected - expected	Alert	Able to communicate
W	F	79	Carcinoma of gall-bladder	8 weeks	27 days	Unexpected - expected	Alert	Able to communicate
X	M	64	Cervical metastasis	6 months	6 weeks	Unexpected - expected	Alert	Able to communicate
Y	M	60	Gastric carcinoma	8 weeks	4 weeks	Unexpected - expected	Alert	Able to communicate
Z	M	79	Metastasis from prostate carcinoma	7 years	3 weeks	Unexpected - expected	Alert/drowsy	Able to communicate
A_2	F	64	Gastric carcinoma	18 months	8 days	- to die	Alert	Able to communicate
B_2	M	69	Gastric carcinoma	16 months	23 days	- to die	Alert	Able to communicate
C_2	M	48	Metastasis from bowel carcinoma	19 months	17 days	- to die	Alert	Able to communicate
D_2	F	78	Carcinoma of gall bladder	4 months	36 hours	- to die	Alert	Able to communicate
E_2	F	75	Peripheral vascular disease	3 years	19 days	Unexpected - expected	Semi-conscious	Opened eyes when spoken to
F_2	M	70	Left ventricular failure/chronic obstructive airways disease	18 years	12 days	Unexpected - expected	Semi-conscious	Responded when spoken to
G_2	M	74	Congestive cardiac failure plus renal failure	9 years	6 hours	Unexpected - expected	Conscious - confused	Responded when spoken to
H_2	M	56	Chronic renal failure	10 years	24 weeks	-to be prevented	Semi-conscious	Responded slightly when spoken t
I_2	M	46	Metastasis from bronchial carcinoma	8 months	3 days	- to die	Semi-conscious	Drowsy, responded when spoken to
J_2	M	61	Myelofibrosis	19 months	3 days	unexpected - expected	Alert	Able to communicate
K_2	M	89	Bronchopneumonia	2 days	7 hours	- to die	Unconscious	-
L_2	M	67	Pathological fracture of (R) humerus	9 weeks	8 weeks	Unexpected - expected	Alert	Able to communicate
M_2	M	78	Unidentified anaemia	5 years	18 days	Unexpected - expected	Alert	Able to communicate
N_2	M	50	Subarachnoid haemorrhage	18 days	18 days	Unexpected - expected	Alert	Able to communicate
O_2	F	87	Left ventricular failure/chronic obstructive airways disease	13 years	4 weeks	Unexpected - expected	Unconscious	-

Patient	Sex	Age (Years)	Diagnosis	Duration of Illness	Length of present period of Hospitalisation	Prognosis related to death	Level of Awareness	Ability to communicate
P_2	F	73	Haemetemesis - unknown aetiology	12 weeks	12 days	- to be prevented	Semi-conscious	Drowsy - responded when spoken to
Q_2	F	64	Left ventricular failure/ renal failure	2 years	36 hours	Unexpected - expected	Alert	Able to communicate but drowsy
R_2	F	67	Cerebro-vascular accident	2 days	2 days	Unexpected - expected	Alert	Able to communicate
S_2	F	81	Bronchial carcinoma	5 weeks	19 days	Unexpected - expected	Alert	Able to communicate
T_2	F	76	Left ventricular failure pneumococcal pneumonia	6 weeks	4 weeks	Unexpected - expected	Alert	Able to communicate
U_2	F	65	Metastasis from carcinoma of ascending colon	7 months	15 days	- to die	Unconscious	-
V_2	F	78	Small bowel obstruction - adhesions	43 days	43 days	Unexpected - expected	Alert	Able to communicate
W_2	F	68	Carcinoma of splenic flexure	3 weeks	2 days	Unexpected - expected	Alert	Able to communicate
X_2	F	85	Carcinoma of transverse colon/ right nephrectomy	4 weeks	16 days	Unexpected - expected	Alert	Able to communicate

Four patients suffered pulmonary congestion with related cardiac involvement and two patients had cardiac failure with related renal failure. A cerebro-vascular accident had occurred to three patients, one of whom also had ischaemic heart disease and one patient suffered from a subarachnoid haemorrhage. Hepatic cirrhosis and infective hepatitis was the disease suffered by one patient, chronic renal failure by another patient and bronchopneumonia by a third patient. One patient had undergone surgery for peripheral vascular disease, another patient for a perforated duodenal ulcer and a third patient for small bowel adhesions. The cause of the decline of two patients was uncertain. A tentative diagnosis of hepatic carcinoma had been made for one of these patients, haematemesis had been the initial complaint of the second patient but the underlying illness was not identified.

All but one of the patients who were admitted to die' were afflicted with a malignant disease, the singular patient being an elderly gentleman of eighty-nine years who was suffering from bronchopneumonia and extensive pressure sores. (Table 18)

Each patient suffered from a variety of symptoms (Table 19) some of which seemed to be more distressing to the patients than others. On average each patient had 4.84 symptoms. Pain, dehydration, anorexia, loneliness, dyspnoea and pressure sores were the most common complications.

Nature and frequency of symptoms

The symptoms experienced by the patients are summarised in Table 20.

Pain and thirst were not only the commonest but also the more persistent and distressing symptoms. Thirty-four (68%) of the patients suffered from pain. Only seven patients expressed openly the presence of pain, five of these patients were very distressed and were heard to ask for sedation on more than one occasion. The other patients did not complain or seek attention, but when

TABLE 19

Symptoms experienced by each patient

Patient	Symptoms
A	7 : 9 : 10
B	5
C	1 : 2 : 5: 7 : 8 : 10 : 15
D	1 : 5 : 6 : 7 : 8 : 10 : 15
E	4 : 5 : 7 : 8 : 10 : 14
F	6 : 9 : 11
G	5
H	2 : 5 : 6 : 7 : 9 : 10
I	2 : 6 : 7 : 9
J	2 : 4 : 5 : 7 : 8 : 9 : 10 : 11 : 13
K	5 : 7 : 11 : 15
L	2 : 7 : 10 : 15
M	2 : 6 : 7 : 8 : 10
N	4 : 5 : 6 : 7 : 14 : 15
O	7 : 13 : 15
P	2 : 5 : 6 : 7 : 8 : 9 : 10 : 15
Q	2 : 3 : 5 : 9 : 10 : 15
R	2 : 5 : 6 : 7 : 8 : 10
S	2 : 5 : 7 : 13 : 15
T	2 : 13
U	2 : 12 : 15
V	4 : 7 : 8
W	5 : 10 : 13
X	2 : 7 : 10 : 14
Y	2 : 6 : 9
Z	2 : 6 : 12 : 15
A_2	2 : 4 : 5 : 6 : 7 : 8 : 9 : 10
B_2	2 : 4 : 5 : 7 : 10 : 13
C_2	2 : 4 : 5 : 7 : 8 : 9 : 10
D_2	2 : 5 : 7 : 10
E_2	6

Patient	Symptoms
F_2	2 : 5 : 6 : 7 : 9
G_2	2 : 5 : 6 : 9 : 11
H_2	6 : 7 : 15
I_2	2 : 5 : 7 : 9 : 10
J_2	4 : 6 : 7 : 9 : 10
K_2	5 : 6 : 13 : 15
L_2	7 : 8 : 9 : 10
M_2	2 : 5 : 6 : 7 : 10 : 13
N_2	2 : 5 : 6 : 7 : 8 : 10 : 15
O_2	5 : 12 : 13 : 15
P_2	6 : 10 : 13
Q_2	2 : 6 : 7 : 9 : 10 : 13
R_2	-
S_2	2 : 6 : 7 : 8 : 9 : 10 : 15
T_2	2 : 5 : 6 : 8 : 9 : 10
U_2	5 : 13 : 15
V_2	2 : 5 : 6 : 7 : 8 : 10 : 15
W_2	2 : 6 : 7 : 9
X_2	2 : 4 : 6 : 7 : 9 : 10 : 13 : 15

1	Dysphagia	6	Dyspnoea	11	Confused/disorientated
2	Anorexia	7	Pain	12	Urinary incontinence
3	Nausea	8	Depression	13	Faecal incontinence
4	Vomiting	9	Anxiety	14	Constipation
5	Dehydration	10	Loneliness	15	Pressure sores

TABLE 20

Nature and frequency of symptoms experienced by patients

Symptoms	PATIENTS No.	%
Dysphagia	2	4
Anorexia	30	60
Nausea		
Vomiting	10	20
Dehydration	28	56
Dyspnoea	26	52
Pain	34	68
Depression	15	30
Anxiety	20	40
Loneliness	28	56
Confused/disorientated	4	8
Urinary incontinence	3	6
Faecal incontinence	13	26
Constipation	3	6
Pressure sores	19	28

asked those who were able to communicate spoke of experiencing pain. Seven of the semi-conscious patients moaned and were restless.

Thirst was also a very distressing and severe problem to more than half of the conscious patients. The patients were unable to drink copious quantities of fluid but they desired frequent small drinks. 56% of the patients showed signs of dehydration and it may have been a contributing factor to some of the other complications present, for example the oral hygiene of 82% of the patients was in a poor state.

Over two-thirds of the patients who were conscious had very little appetite and complained of anorexia; about half of these patients were seen to vomit.

Dyspnoea was observed as a complication for twenty-six (52%) patients. It was very severe for thirteen patients. Four patients were troubled by a cough. Restlessness accompanied the dyspnoea. Frequently the upright position could not be maintained to relieve the breathlessness, the patients were often seen to struggle to relieve the distress.

The facial expression, restlessness or comments passed by the patients gave grounds for inferring that twenty-eight (56%) patients were experiencing loneliness and twenty (40%) patients anxiety. Depression was apparent by the conversation of fifteen (30%) patients. Eight patients spoke of a deep yearning "just to get home".

To differentiate whether loneliness, anxiety or depression was the experience of the patients was beyond the scope of the study but the "need for company" to relieve their problem was evident. The patients watched as the nurses and their fellow patients passed their beds, they did not try to attract attention but they responded when spoken to. One patient stated her feelings quite clearly

> - "I'm tired, very tired, but I long for someone to talk to".

Four patients suffered from episodes of confusion or disorientation, these were transient.

The physical appearance of each patient indicated the extreme weakness and lassitude from which the patients all suffered, this and an understanding of the diagnosis left no doubt that each patient was highly dependent and required skilful nursing care.

Stage of awareness

The patients were at various stages of awareness of their environment as is shown on Table 21.

TABLE 21

Stage of awareness related to life expectancy

	Conscious	Semi-conscious	Unconscious
Admitted 'to die'	9	3	3
Medical treatment modified	22	7	2
Medical treatment modified	2	2	
	33	12	5

Thirty-three of the patients were conscious. Twenty-nine of those were mentally alert and able to communicate, twenty-one patients responded readily and were able to converse at length, the other seven patients responded but due to physical weakness were unable to hold prolonged conversations. One patient appeared to be alert but he had difficulty in articulating. Two patients, though conscious, were slightly confused and two patients were disorientated occasionally. The twelve semi-conscious patients seemed aware of their environment, five of the semi-conscious patients were able to recognise the presence of the nursing staff, but they were too drowsy to communicate in more than monosyllables, the other seven patients were unable to respond verbally, but moaned, moved or opened their eyes when addressed. Five patients were unconscious. More than half (60%) of the patients who were admitted 'to die' were alert and more than half of all the patients (58%) retained consciousness until shortly before death.

Technical nursing needs

Technical nursing skills dominated the care needs of eight patients and was required on occasion during the care of the other forty-two patients. The technical nursing skills required are summarised on Table 22.

TABLE 22

Technical nursing skill requirements of the patients

Technical Nursing Skills	PATIENTS	
	No.	%
Intravenous infusion	25	50
Nasogastric tube in situ	7	14
Catheter - Urinary	27	54
Oxygen therapy	11	22
Surgical dressing	13	26
Barrier nursing	1	
TPR recordings	42	84
Blood pressure recordings	24	48
EEG tracings	1	
Chest drainage	1	
Paracentesis abdominis	1	
Peritoneal dialysis	1	
Medication - oral	19	38
- intramuscular	25	50
- intravenous	19	39

The temperature and pulse of almost all (84%) of the patients and the blood pressure of about half (48%) of the patients were recorded. Half (54%) of the patients had a urinary catheter in situ and half (50%) of the patients an intravenous infusion. Seven patients had a naso-gastric tube in place and eleven patients required oxygen therapy. Thirteen (26%) patients required attention to a surgical wound and one patient required the application of a supportive bandage. Of the eight patients who rated highly in their demands for technical nursing care, one patient was 'specialed' as he was receiving hypotensive reversal drugs, two patients had excessive leakage of ascitic fluid following surgery and a fourth patient was receiving medication titrated via intravenous and nasogastric

routes to combat her agitated state. On two occasions one patient was subjected to paracentesis abdominis and one patient had sessions of peritoneal dialysis. One patient had a chest drain in situ and another patient required frequent oro-pharyngeal toilet. Only one patient received no drugs, each of the other forty-nine patients received medication orally, intramuscularly or intravenously. The most common route was parenteral.

When the patients were considered relative to the tasks involved in providing the care they required, the technical nursing skill requirements were few, but the basic nursing skills and the psychosocial nursing skills many. Rated on dependency scales (SHHD Reports 3 and 9) all the patients had high dependency levels, requiring skilful basic nursing care.

Summary

1. One third of the patients who died had been admitted to hospital 'to die'.
2. The final period of hospitalisation, in particular for those patients who were admitted 'to die' was comparatively short.
3. The majority of the patients were alert and able to communicate.
4. Most of the patients who died had few technical nursing needs but were highly dependent and required skilful basic nursing care.

It is contended that the patients observed in this study were fairly representative of patients who die in hospital as the findings are comparable to the figures stated in other studies. (Table 23)

TABLE 23

Studies of nature and frequency of symptoms experienced by terminally ill/dying patients

Symptom	Hinton 1963	Dewi-Rees 1972	Cartwright 1973	Baines 1976	Doyle 1979	Woodbine 1982	Present Study
Dysphagia				16.6%		12%	4%
Anorexia			48%	61.75%		42%	60%
Nausea/ Vomiting	37%	28%	30%	41%	33%	28%	20%
Dehydration							56%
Dyspnoea	18%		48%	41%	32%	29%	52%
Pain	65.7%	54%	66%	66%	76%	34%	68%
Depression	45%	40%	35%		29%	33%	30%
Anxiety	37%	56%			33%	18%	40%
Loneliness					19%		56%
Confused/ Disorientated			36%		17%		8%
Urinary Incontinence			32%	19.5%	13%	12%	6%
Faecal Incontinence	)	32%	28%		21%		26%
Constipation	)		28%	45%	67%	22%	6%
Pressure sores			16%	21.5%	12%		28%

In 1961, Exton-Smith reported 25.5% of the patients died during the first six days in hospital, Dewi-Rees (1972) found the percentage was 50% and Levy and Sclare (1976) in a Glasgow study reported a similar figure i.e. 50%. In the present study 38% of the patients died within six days of their admission to hospital.

Witzel (1975) following a study of the conscious levels of patients before death reported "60% of one hundred and ten dying patients were well orientated in time and space twenty-four hours before death and 26% fifteen minutes before death". In this study 58% of the patients were alert and able to communicate.

In different studies of the terminally-ill patient and the dying patient (Hinton 1963, Dewi-Rees 1972, Cartwright 1973, Baines 1978, Doyle 1979, Woodbine 1982) the nature and frequency of symptoms have been assessed. Different approaches have been used in the assessments but their collective findings indicate there is a degree of correlation with the symptoms experienced by the patients in the present study.

5.2 Location of patients

The patients were observed in different units. The number of patients observed in each unit differed. This is shown on Table 24. Twenty-six patients were observed in surgical wards, twenty-three patients in medical wards and one patient in a 'specialist' unit. In two surgical wards eleven patients and seven patients respectively were observed and in two medical wards nine patients and eight patients respectively. In the remaining nine wards the number was less. In one surgical ward four patients were observed, in one medical ward three patients, in another

TABLE 24

Hospital and type of ward in which dying patients were observed. Phase I and II

Hospital	Number of Wards	Surgical Wards	Medical Wards	Specialist Wards	Number of patients	Patients in Surgical Wards	Patients in Medical Wards	Patients in Specialist Wards
A	5	2	2	1	5	2	2	1
B	3	1	2	-	21	11	10	-
C	3	2	1	-	19	11	8	-
D	2	1	1	-	5	2	3	-
	13	6	6	1	50	26	23	1

surgical ward two patients and in the remaining six wards - three medical, two surgical and one specialist ward - one patient.

Facilities available to the patients and their relatives or close friends varied. In three of the thirteen wards there were no single rooms, in the remaining wards though individual accommodation was available, few of the dying patients were afforded this privacy. Twenty-nine patients died in an open Florence Nightingale ward, screens sheltered the majority of these patients. Two patients died in four-bedded rooms and the remaining eighteen patients died in single rooms. Three of the latter patients were moved into the single rooms shortly before death occurred, i.e. within the last four hours. (Table 25)

5.3 Nurses observed

A total of one hundred and ninety-three members of the nursing staff were observed. There were forty-six qualified nurses (i.e. sixteen sisters/ charge nurses, twenty-five staff nurses, five enrolled nurses), one hundred and twenty-six learners (one hundred and three student nurses, twenty-three pupil nurses) and twenty-one nursing auxiliaries.

The sisters and charge nurses had varied lengths of experience in senior nursing roles, this ranges from two to thirty years. Fourteen sisters and two charge nurses were observed. The staff nurses had been in post for between three months and two years.

There were variations in the stages of learning and experience of the learner nurses. This ranged from learners with two months clinical experience to learners who had passed the State Final Examination and were gaining

TABLE 25

Number of patients who died in various areas, relative to accommodation available

Ward	Design of Ward	Number of dying patients	Number of patients who died in		
			Siderooms	4 Bedded bays	Open Wards
1	Open ward and S/R	1	1	-	-
2	Open ward and S/R	1	1	-	-
3	Open ward	1	-	-	1
4	Open ward	1	-	-	1
5	4 bedded bays and S/R	1	1	-	-
6	Open ward and S/R	1	-	-	1
7	Open ward and S/R	11	10	1	-
8	Open ward and S/R	9	-	-	9 *
9	Open ward and S/R	4	1	-	3
10	Open ward	8	-	-	8
11	Open ward and S/R	7	-	-	7
12	4 bedded bays and S/R	3	2	1	-
13	4 bedded bays and S/R	2	2	-	-
	Total	50	18	2	30

S/R - Side room available

* - One of these patients recovered

pre-registration experience. As the learners are peripatetic, the student and pupil nurses had differing lengths of experience in the specific clinical areas eg. in one ward three student nurses had been allocated to the ward to commence their clinical experience and were observed during their first period of duty in that area, whereas in another ward student nurses were observed during their final period of duty, having been in the area for six weeks. Two student nurses were encountered in different areas during the observation time in the hospital.

The number of staff on duty varied and the ratio of qualified nurses to learner nurses differed considerably. In one ward on two occasions no trained nurses were present, whereas in another three areas three qualified nurses were on duty during the observation period. During most periods either one or two qualified nurses were present. (Table 26)

The position of the nurses in the ward team fluctuated according to the qualifications of the staff on duty. The tasks, therefore, for which the nurses were responsible varied from one span of duty to another.

Work was organised by task allocation in eleven of the thirteen wards and by patient allocation in two wards.

5.4 Doctors observed

Fourteen consultants were involved, in Hospital B three surgeons and four physicians and in Hospital C, two surgeons and five physicians. Two of the consultants had been appointed within the previous twelve months, the other twelve consultants had been in post for a number of years and one was expected to retire soon. A number of other grades of medical staff - senior registrars, registrars, senior house officers and resident doctors - were present in the wards, their interactions with the patients and the senior nurses were

Distribution of the nurses in the wards during periods of observation Phase I

Ward		Sister	Staff Nurses	Enrolled Nurses	Students	Pupils	Nursing Auxiliary
1	Staff complement	1	2	-	7	2	2
	1st observation	-	1	-	5	-	2
	2nd observation	-	1	-	1	2	-
2	Staff complement	1	1	1	5	-	-
	1st observation	1	1	1	2	-	-
3	Staff complement	1	2	-	6	2	-
	1st observation	-	1	-	3	1	-
	2nd observation	-	2	-	4	1	-
	3rd observation	1	-	-	2	1	-
4	Staff complement	1	1	-	9	2	-
	1st observation	-	1	-	4	-	-
	2nd observation	-	-	-	3	-	-
	3rd observation	-	-	-	4	1	-
5	Staff complement	2	2	3	7	1	2
	1st observation	1	1	1	2	1	-
	2nd observation	1	1	-	2	-	1
	3rd observation	1	1	-	4	-	-
6	Staff complement	1	1	-	8	-	2
	1st observation	1	1	-	6	-	-
	2nd observation	-	1	-	4	-	-
7	Staff complement	1	4	-	8	5	1
	1st observation	1	1	-	3	2	1
	2nd observation	-	2	-	4	1	1
	3rd observation	1	-	-	3	2	-
	4th observation	-	2	-	3	3	-
	5th observation	-	2	-	4	3	-
8	Staff complement	2	2	1	7	2	3
	1st observation	1	2	-	2	2	-
	2nd observation	1	1	-	2	1	1
	3rd observation	1	2	-	3	1	1
	4th observation	-	2	-	4	1	1
	5th observation	1	-	1	4	-	1
9	Staff complement	1	2	-	10	-	2
	1st observation	-	1	-	4	-	1
	2nd observation	1	-	-	5	-	-
	3rd observation	-	1	-	2	-	1
	4th observation	-	1	-	4	-	1
10	Staff complement	3	1	1	12	3	1
	1st observation	1	-	-	4	2	1
	2nd observation	2	-	-	8	2	-
	3rd observation	2	-	-	7	2	-
11	Staff complement	1	2	1	9	-	2
	1st observation	-	1	-	4	-	1
	2nd observation	1	1	-	3	-	1
	3rd observation	-	1	1	2	-	2
	4th observation	1	-	-	4	-	-
	5th observation	1	-	1	3	-	1
12	Staff complement	1	2	-	4	4	2
	1st observation	-	1	-	2	2	-
	2nd observation	-	1	-	1	3	-
	3rd observation	1	-	-	1	-	3
13	Staff complement	1	1	1	6	4	2
	1st observation	-	1	-	4	2	1
	2nd observation	-	1	-	3	2	-
	3rd observation	1	1	-	4	2	-
	4th observation	1	-	-	3	2	1
	5th observation	1	1	-	2	2	1
	6th observation	1	-	1	3	2	-

noted, however the study concentrated on the communication between the consultants and the senior nurses, as the consultant is recognised to be responsible for the patient when in hospital. (Central Health Services Council and Ministry of Health 1963).

Since the wards were served by more than one consultant and at least four qualified nurses a number of permutations of consultants and qualified nurses were observed. Table 27

In Hospital B, each surgeon interacted with seven senior nurses and each physician with six senior nurses, the surgical nursing staff interacted with three surgeons and the medical nursing staff with four physicians. In Hospital C, each surgeon interacted with four senior nurses and each physician with five senior nurses, the surgical nursing staff interacted with two surgeons and the medical nursing staff with five physicians.

TABLE 27

Consultant - senior nurse partnerships

Hospital	Consultants	Sister/Charge nurses	Staff nurses	Ward	Type of Ward
B	W	M : J : K : L	A : P : N	A	Surgical
	T	M : J : K : L	A : P : N	A	Surgical
	E	M : J : K : L	A : P : N	A	Surgical
	B	F : C	Q : R : S : I	B	Medical
	F	F : C	Q : R : S : I	B	Medical
	H	F : C	Q : R : S : I	B	Medical
	L	F : C	Q : R : S : I	B	Medical
C	G	H	T : O : D	C	Surgical
	M	H	T : O : D	C	Surgical
	S	B : G	E : V : W	D	Medical
	V	B : G	E : V : W	D	Medical
	D	B : G	E : V : W	D	Medical
	K	B : G	E : V : W	D	Medical
	C	B : G	E : V : W	D	Medical

Chapter 6

The Study - Phase I

6.1 Nurse - patient interactions

On commencing observations in the clinical field, the immediate impression was that the nurses moved constantly to and fro in the ward. The encounters between nurse and patient were numerous and brief, there was minimal sustained contact. The nurses flitted in and out of the patients' environment, lingering rarely for any length of time; their activities resembled that of butterflies alighting briefly on flowers, there was no resting or waiting. Ceaseless activity pervaded the general ward environment.

Five hundred and seventeen nurse-patient encounters occurred during the observation period of 322 hours 10 minutes. Twenty-three patients were involved. (Table 28)

The length of observation time was a factor in the number of patient encounters witnessed, but the majority of the patients were visited by a nurse one to two times every hour. This bore no relationship to the length of the visit.

A breakdown of nurse visits related to the state of awareness of the patients is shown on Table 29.

TABLE 29

Average number of visits per hour:
Analysis by state of awareness of patient

State of Patients	No. of Patients	Average No. of visits per hour		
		2 - 3	1 - 2	Less than 1
Alert	15 *	5	8	1
Semi-conscious	7	2	2	3
Unconscious	1		1	
	23	7	11	4

* One patient was confused and had a nurse in attendance constantly

TABLE 28

Number of nurse-patient contacts and duration of observation times

	Ward	Patients	No. of Contacts	Period of Observation
	1	A	18	8 hours 15 minutes
	2	B	2	1 hour 30 minutes
	3	C	24	12 hours
	4	D	23	15 hours
	5	E	11	11 hours
	6	F		3 hours 55 minutes
	7	G	7	5 hours 15 minutes
	7	H	37	12 hours 30 minutes
	7	I	54	20 hours 45 minutes
	8	J	50	21 hours
	9	K	19	16 hours 30 minutes
	9	L	12	12 hours 30 minutes
	9	M	18	12 hours 30 minutes
	9	N	5	5 hours
	10	O	29	14 hours
	11	P	70	31 hours
	11	Q	37	27 hours
	11	R	5	3 hours
	12	S	13	16 hours 30 minutes
	12	T	5	13 hours 30 minutes
	12	U	8	16 hours 30 minutes
	13	V	39	21 hours 30 minutes
	13	W	31	21 hours 30 minutes
TOTAL	13	23	517	322 hours 10 minutes

The alert patients received more visits per hour than the semi-conscious patients. The patient who received the greater number of visits (Patient H) was an alert lady who lay in a side room. She commanded the attention of the nurses by ringing her call-bell at frequent intervals; this patient averaged 2.96 visits per hour. By contrast, Patient T received only 0.37 visits hourly. The patient also lay in a side room, but she was unconscious and due to her potentially infective condition was barrier nursed.

Nurse visits related to life expectancy of patients

When the life expectancy of the patients and the course of medical intervention was considered, the patients who were 'admitted to die' received fewer visits than those patients who, on admission, were 'not expected to die'. This is shown on Table 30.

TABLE 30

Average number of visits per hour: analysis by 'life expectancy' of patient

Life Expectancy	No. of Patients	Average No. of visits per hour		
		2 - 3	1 - 2	Less than 1
Admitted to die	8	1	5	2
Medical treatment modified	13	5	6	2
Active medical treatment maintained	2	1 +	(one patient with nurse in attendance constantly)	
	23	7	11	4

Of the two patients who received active medical intervention until death one was 'specialed' i.e. the patient had a nurse in attendance continually, the other patient averaged more than two visits hourly.

Nurse visits related to ward organisation

Three of the four patients who were observed in the wards where patient assignment was practised, received on average more than two visits hourly, while only four out of the nineteen patients received this number of contacts in task allocation ward organisation. Table 31

TABLE 31

Average number of visits per hour analysis by ward organisation

Ward Organisation	No. of Patients	Average No. of visits per hour		
		2 - 3	1 - 2	Less than 1
Patient allocation	4	3	1	-
Task allocation	19*	4	10	4

* Nurse in attendance constantly

One of the four patients nursed in the patient assignment ward organisation was semi-conscious. This patient (Patient O) received on average 2.07 visits per hour as indicated below. Table 32. This was considerably more than the other five semi-conscious patients.

TABLE 32

Average number of visits per hour to semi-conscious patients

PATIENTS	A	O	K	G	S	U	T
Average number of visits per hour	2.18	2.07	1.5	1.31	.78	.48	.37

The semi-conscious patient (Patient A) who received on average more visits per hour moaned loudly, her distress could be heard throughout the ward.

Nurse visits related to bed position

No relationship was found between the number of visits the patient received and the position of the patient in the ward i.e. whether the patient was nursed in an open ward or in a side room, or between the type of ward in which the patient was nursed, i.e. a medical or surgical ward.

6.2 Analysis of nurse-patient interactions

'Basic nursing' and 'technical nursing' are terms used to categorise the activities of the nurse (Goddard 1953 p.27-28). 'Basic nursing' is used to describe "those nursing duties having their origin in the physical needs of the patient". Basic nursing focusses on the promotion and maintenance of physical comfort. Patient needs vary. Basic care is directed to meet the 'person' needs of the patient and includes the following tasks - bathing, care of oral hygiene, care of pressure areas, toileting, change of position, providing fluids, providing nutrients. Some basic care is complex requiring the skills of a highly trained nurse.

'Technical nursing' describes the care given in the treament of the disease. Technical nursing tasks relate to therapy and tomonitoring the progress through treatment. The following tasks are included - recording the temperature, pulse and respiration rates, recording blood pressure, administration of medicines, administration of oxygen, care of intravenous infusion, care of wounds, nasogastric aspiration, oropharyngeal suction.

A third category - communicating - was added to 'basic' and 'technical' for this study. Early in the observation period, it became apparent that during the nursing of the patient who

was dying, the nurses frequented the bedside to ascertain if the patient 'was still there'. These contacts might be verbal or tactile. No discrete nursing task was performed. In this category were included those encounters when a conversation did take place between the nurse and the patient and when 'to communicate' was the purpose of the nurse's presence at the bedside.

The activities of the nurse were not always observed at first hand because observations were not made when care was given in privacy, that is behind screens or in a single room. However, since the writer was present during report sessions and had noted the allocation of duties and the tasks to be performed at specific times, the nurse responsible for these activities and the activity itself could be identified.

For example the task of bedbathing was identified as the nursing activity from this observation.

9.00 a.m.	Nursing C and Nurse E entered the room with bed bathing trolley. Door closed.
9.20 a.m.	Nurse A entered.
9.30 a.m.	Nurse C, E and A left the room with the trolley. Patient now propped on her left side, her hair has been combed. Clean linen is on the bed, nightdress unchanged. Her eyes are closed. She is breathing deeply, the moaning has ceased. Door left open.

Tasks as witnessed and reported varied in content and duration.

For example

1. Two nurses said one patient had had a 'bed bath'

following a nine minute encounter. In contrast another two nurses following a period of forty-five minutes attributed a 'bed bath' to care which left the patient looking fresh, well groomed, shaved and with fresh linen on the bed.

2. One patient was given *Brompton's mixture during a ten second encounter, another episode during which medicine was administered to a patient involved the nurse for ten minutes.

All tasks 'said to be done' by the nurses were not recorded as being done in the study. Instances were observed when medicines dispensed were not received by the patients and, tasks were ticked or the task list indicating that the task had been done when, in fact, the patients had not received the specific attention in the appropriate time interval.

For example

> Patient J was not bathed on three consecutive mornings. Each day a tick was placed against the patient's name on the task list implying that he had received this attention.

6.3 Content of the interaction between the nurse and the patient.

Of the three hundred and forty-four tasks performed, two hundred and seventeen (63%) were classified as basic nursing and one hundred and twenty-seven (37%) pertained to technical nursing. One hundred and sixty-seven times

* A mixture of morphine and diamorphine and cocaine in chloroform water.

the nurses visited the patients 'to communicate'. (Table 33)

If the accepted standard of basic care (SHHD Reports 3 and 9) requires daily attention to personal hygiene, i.e. a bed bath daily, 2-4 hourly care of oral hygiene, 4 hourly care of pressure areas, 2 hourly change of position, 1-2 hourly provision of fluids and 4 hourly provision of nutrients, it was evident that a number of nursing tasks associated with basic care were not accomplished for all patients every day.

There were some omissions of care which contrasted with other observed incidents when care of a high standard was delivered.

Basic nursing

Bedbathing

Twenty patients received attention to their personal hygiene, but nightwear was stained and remained unchanged for twelve patients. Three patients were observed not to have a bed bath when this was scheduled.

Example 1

Mr F was a 56 year old former hospital porter who had been 'admitted to die'. He suffered with metastasis from a bronchial carcinoma, some of the lesions were evident as skeletal secondaries had developed in the skull. The patient was pale and emaciated; though very weak he was alert.

This patient received no care, i.e. bathing, attention to his oral hygiene or pressure areas, during the first two days of observation. He looked dishevelled, neglected and

TABLE 33

Tasks performed for each patient

Tasks Performed	Number of times for each patient																						Tota
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	
Basic nursing care																							
Bathing/bedbathing	1	1*	1*	1	2*	-	-	1	2*	1	2	2	2	1	1*	4	3	-	3	3	3	2	3	
Care of oral hygiene	-	-	1*	3	-	1	-	1	1	-	2	-	-	-	1	1	2	-	-	-	-	-	1	
Care of pressure areas	2	-	1*	2	1	2	1	2	2*	-	3*	2*	2*	-	3*	4	5	-	1	-	1	-	2	
Toileting	-	-	2	2	-	1	-	2	-	4	-	-	4*	1	-	3	-	-	1	-	-	6	-	
Changing of position	2*	-	1*	2	1	2*	-	5	1	8*	1	-	-	1*	2*	1	-	1	-	-	-	-	-	
Providing of fluids	1	-	4*	2	1	4	-	2	6*	3	2	-	-	-	2	7*	11*	-	-	1*	-	-	7	
Providing nutrients	-	-	2	-	-	-	-	2	-	5*	-	2*	1	-	-	3*	1*	1	1*	-	3*	-	-	217
Technical nursing care																								
Recording TPR	1	-	1	4	-	6	2	3	2	2	-	-	-	-	1	2	5*	-	1	1	1	3	3*	
Recording blood pressure	-	-	-	3	-	6	2	3	2	-	-	-	-	-	-	1	1	-	1	1	-	-	-	
Administration of medicines	3	-	3*	1	2*	-	-	-	4	5*	1	2	-	-	2	10*	2	1	-	-	-	1	-	
Administration of oxygen	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Care of intravenous infusion	-	-	-	1	-	1	1	1	-	-	-	-	-	-	2*	3	1	-	-	-	-	4*	-	
Care of wound	-	-	-	-	-	-	-	-	5*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Nasogastric aspiration	-	-	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Oropharyngeal suction	-	-	-	-	-	-	-	-	1*	-	-	-	-	-	-	-	2	-	-	-	-	7	-	127
Communicating	9*	1*	9*	5	4*	-	1*	14*	21	18*	4*	2*	6*	-	11*	31*	4*	-	3*	-	-	12*	12*	167

* Qualified nurse involved

miserable and seemed to be aware of his unkempt, unshaved appearance as he was seen to smooth his hair with his hand and to feel his rough skin. Finally, 'by accident', he was able to have a bath on the third morning, when he himself wandered to the bathroom. He was found there by the observer, sitting by the side of a bath of water, talking to a junior nurse. The writer expressed pleasure for him by saying "Oh good, you'll enjoy this." "I'd love it" he answered. "Can he have a big bath?" the junior nurse asked. "Please" said the patient. "You should ask sister" suggested the writer. "But haven't you had your bath Mr F?" asked the nurse. "No, it's days since I've had a wash and I feel grubby." answered Mr F. The junior nurse obtained permission and assisted this patient with his care. This patient's name was on the 'bathing list' each day but it was scored off on three consecutive occasions by the nurses responsible for the task, which denoted the task had been done, though he received no attention.

Similar neglect was witnessed during the care of another patient.

Example 2

Mrs S was a 52 years old mother of eight children (aged between 12 years and 27 years) who looked very ill. Following a mastectomy operation secondary spread involving the liver had developed causing gross distention of the abdomen. The patient was icteric, her conjunctiva were very swollen and she had icteric tears. She was very alert but breathless. She did not complain but when asked spoke of a vague abdominal ache which "will not go away". This patient, who too had been 'admitted to die', in like manner received no care from the nurses delegated to attend to her personal hygiene. She had brie attention during the morning from one nursing auxiliary who responded when she required a commode. No care was given to her personal hygiene, appearance, oral hygiene, pressure areas

or eyes. On the lists of tasks to be done a tick appeared against her name to signify she had had this care. In the nursing kardex details were written down denoting attention had been given, all of which in fact was inaccurate.

In contrast, some nurses were seen to attend to the dying patients' grooming and appearance with meticulous care. Though these patients were debilitated and looked haggard, after the time and care given by the nurses they appeared fresh, relaxed and presentable.

Oral Hygiene

Nurses were rarely seen to attend to this need. Inadequate attention to oral hygiene could not be ignored by the observer when in close contact with the patients. Dentures were most often in a dish on the locker.

Example 1

Mr T, who was 54 years of age and was the father of two teenage children, had the appearance of a 70 year old man. His body was wasted, his hair gone, and his appearance icteric. He had received cytotoxic therapy but the regime of treatment had fluctuated from an active to a passive approach as signs of intestinal obstruction had developed. This patient was alert and seemed very depressed. When asked "How are you?" he did not answer but meaningfully shook his head. He was unable to articulate due to a very dry mouth which was caked with sordes. Candida were present. This patient was eventually given attention by a junior nurse when she returned from 'days off'. Thereafter he had attention twice before his death. Her efforts gave a modicum of relief and helped relieve the foetid breath, but the condition was such that the deep cracks bled as she lightly swabbed his coated tongue.

Care of pressure areas

Attention to the pressure areas and assisting with a change in position was given during the 'routine ward round'. If the patients' relatives were in attendance the nurses seemed loath to interrupt and passed the patients' beds but invariably they returned to give care after the relatives had left. Of all the tasks this procedure was performed most frequently. (Table 33) The nurses commented when the skin remained intact and were obviously proud of their endeavours and their achievement with regard to this aspect of patient care.

Providing fluids

Thirst was experienced by eight patients; it seemed to be severe. The nurses became aware of the problem for two of the patients and kept these patients supplied with fragments of ice or iced water. On other occasions there was no relief given and the weak cry for assistance from the patients went unnoticed.

Example 1

One patient called out after a long struggle, "Nurse, a glass of cold water please. I'm not asking much. Will you not give me just a glass of <u>cold</u> water." A nurse responded, went to the bedside and asked "What is that you want Mrs -?." "Just a glass of water" said the patient. Iced water was provided which the patient drained immediately. This was the second day this patient had expressed her dire thirst. Previously she had beseeched a number of passers-by to help her.

Extract from the data (1)

1.40 p.m. Patient asleep.

1.50 p.m. Nurse K wakened patient to record T. and P. Chat briefly. Patient asked as nurse left "Can I have a drink of water?" I'll be back in a few minutes" she answered and left the bedside. (1½ minutes)

2.15 p.m. As a porter passed, the patient called out "Eh mister - some water please." He shrugged his shoulders, smiled and passed on.

2.20 p.m. Doctor passed. "Doctor, water please." He looked over, approached nurse F who was attending another patient, returned to the patient and said "It's coming." Patient watches, waits, she looks distressed.

2.25 p.m. Called out desperately - "Listen, a glass of water please, all I want is water, I'm choking for water." Nurse L approached, offered the patient a drink. She took the glass and slowly sipped the water.

That evening this patient tried to throw a lemonade bottle through a glass partition and caused a disturbance in the ward. The nurses were surprised and said that this was out of character for this patient whom they had come to know over a period of time, but the thirst and despair were very apparent during the four hours of observation prior to the incident.

Fluids were available as a glass was placed on every locker. Often, however, the patients were unable to get a drink either because the locker was out of reach or they were physically unable to drink unaided. Seven patients were

seen to struggle to quench their thirst and eventually to abandon their efforts.

Example 2

Miss J was a 41 year old lady who had always been at home with her family. She had severe congenital physical deformities - a kyphosis and a barrel chest. Her present illness was undiagnosed though it was felt she was suffering from hepatic carcinoma which was causing gross abdominal distention. This patient looked ill and was often distressed. She suffered with severe dyspnoea and complained of persistent pain. She did not settle for long periods of time, was often restless, and seemed to be unable to find a comfortable position. She was very alert and watched the ward activities silently.

Extract from the data (2)

5.05 p.m. Nurse G roused the patient and gave her Brompton's mixture 5 mls. "Janet, here's your medicine" she said. The patient took the medicine. Nurse left the bedside. (10 secs)

5.25 p.m. A supper tray was taken to the bedside. Nurse C and Nurse G lifted the patient into a sitting position, with her legs dangling over the side of the bed. They left. She fell back as she was unsupported by pillows. (10 secs)

5.42 p.m. The maid approached and asked "Like some tea, just milk in it?" Answer "No sugar." - "OK". A cup of tea was placed on the tray and the patient struggled up to drink the tea.

She was unable to drink and support herself simultaneously. She fell back. Nurse G from the foot of the bed asked "What did you have to drink?" No response. She marked up the fluid chart. The patient had eaten nothing and had no drink.

5.45 p.m. Nurse F, when passing, looked over to Miss J who had flopped back in bed, but passed on. No contact.

5.46 p.m. She tried to get up for a drink. Unsuccessful.

6.05 p.m. The patient rolled over, drew up her legs, and tried to cover herself with a sheet. Nurse C looked over as she passed. No contact.

6.12 p.m. Nurse F removed the supper tray, food untouched. No contact.

6.30 p.m. The patient called Nurse F as she passed. Nurses F and G attended to the patient, gave pressure area care, a change of position and a mouth wash. (12 mins)

6.50 p.m. The maid brought in fresh water and poured out a drink. A straw was placed in the glass, and it was placed on the locker. No contact.

7.00 p.m. - 8.15 p.m. Visitors.

8.15 p.m. Nurse C asked "Janet tea of coffee?" She answered - I've got juice." (10 secs) Patient now tried to raise herself to reach her locker which was outwith her reach. She struggled intermittently then fell back.

9.10 p.m. Miss J moaned as Nurse C passed by when collecting cups. Nurse C did not respond. Her restlessness continued as she tried to reach

her drink.

9.30 p.m. Nurse C passed by. The patient called. The nurse responded and went to her bedside. "What's wrong?" nurse asked. The patient indicated she wanted her juice. Nurse C handed the patient the glass and left. (5 secs)

The patient attempted to drink but could not keep her head up to do so. She struggled for a few minutes but was unsuccessful and lay back. She could neither drink the juice nor lay the glass down as the locker was badly positioned. She looked once more in the direction of the observer. The decision was made to discontinue the observations and assist the patient.

Providing Nutrients

It seemed that no consideration was given to the existence of anorexia or nausea of the patients. The diet provided was similar to that presented to the average hospital patient. A slice of corned beef, a leaf of lettuce and half a tomato was presented to one patient for supper. She tried to eat but was unable to feed herself, and lay back exhausted. Another patient tried a little food then rang her bell and told the nurses it was too salty. She received no replacement. Most often the trays were removed with the food untouched.

In contrast, one dying patient expressed the desire for ice cream during the middle of the afternoon. Immediately the nurse went to the hospital kitchen, which was at a distance from the ward, returning with the ice cream which she spooned to the patient. The same patient at lunch had received no assistance.

The nurses were frequently seen sitting and assisting the 'well' patients with their meals. These patients were encouraged to eat, but the dying patient was not offered the same service.

Technical nursing

The demands on the technical skills of the nurses were few. The recording of the patients' temperature and pulse rates and blood pressure levels accounted for fifty-eight (45%) of the technical nursing skills; the administration of medicines for thirty-seven (29%; the care of wound sites for five (4%). (Table 33)

Administration of medicines

Medicines were administered most often for relief of pain and included both scheduled and non-scheduled drugs. The drugs most frequently used to relieve pain were Bromptons Mixture, D F 118 tablets and Diamorphine Sulphate.

All dispensing of medicines was not recorded, as incidents were observed when medicines were left on the patients' lockers by the nurses, no contact being made with the patients.

Example 1

Four medicine glasses lay on patient D's locker top (two containing six tablets in each and one with a white mixture) which was an accumulation of medicines dispensed over an eight hour period. The patient was unable to reach for the tablets or pour out a drink with which to swallow his medication.

Extract from the data (3)

5.09 p.m. Nurse F (a first year student nurse) approached

Mr T. "What would you like to drink? Water with a straw? You will need to take your tablets. Alright?" She went off to the kitchen and returned with a glass of water and a straw. This was laid on the locker as she left to attend to another patient. She called to Mr T "I'll be back Mr T." Nurse D (a third year student nurse) was standing at the foot of the bed watching Nurse F and as she left she dispensed a further six tablets for the patient and left them in a glass on the locker. No contact. She moved away. The patient had at hand his medicines for 8 a.m., 2 p.m., and 6 p.m., all outwith his reach. In his condition he seemed unable either to take or swallow the tablets.

5.17 p.m. Nurse F returned to Mr T and sat on his bed. "Now we'll try to get these tablets down. You'll have to take your tablets. We'll start with these ones first. Stick out your tongue, now take a big drink, swallow". The patient obliged by responding to her instructions, but he could not swallow. She was interrupted by Nurse D and left the bedside. ($1\frac{1}{2}$ mins)

5.21 p.m. Nurse F returned to Mr T. The tablets were still in his mouth. "Can you not swallow them? Spit them out." The patient opened his mouth which enabled the nurse to retrieve the tablets. She left and reported to Nurse D at the Nurses Station.

5.55 p.m. Following discussion with the senior nurse and the registrar, Nurse F returned to the patient. With assistance the patient took his medicine dissolved in water. He was able

to swallow but with difficulty. She took time and cajoled him along. This met with success.

Often the medicine was given to the patient with little explanation.

Example 1.

One patient - patient C - was given 5 mls of Brompton's Mixture during a ten second encounter. The nurse's comment to the patient was "OK".

Or the explanation was peremptory.

Example 1.

Extract from the data (4)

3.00 p.m. Nurse E approached one patient - patient P - to give a Diamorphine injection. "Don't want that, I've got no pain" said Mrs P. "But this is to prevent you having pain" assured the nurse. Sister joined the nurse and the patient was given injection.

Medication was given on a strict 'routine' regime, only occasionally did this change. The following incident was observed.

Extract from the data (5)

6.20 p.m. Sister and student nurse J drew back the screens from the patient they had been attending. Mrs E (the dying patient) called out "Two tablets, Sister, please." Sister went to the bedside and explained she

was now having the tablets every 2 hours instead of every 4 hours. The dosage had been increased. She promised the patient would receive them at 8.00 p.m. The patient appeared more distressed. Sister continued "I said you would get them at 8.00 p.m. Is your husband coming up tonight?" (This patient's husband was rarely known to visit; this fact distressed the patient.) Two student nurses approached the bed and asked Mrs E which side she would like to lie on. They drew the screens. She asked for a bedpan. Instructions were heard as the patient was given physical care. Another two student nurses went behind the screens. Mrs E was asked "Are you sore?" "Aye" she replied. The nurses, including Sister, discussed who should go for supper. Laughter. Three nurses left leaving Sister and one student with the patient. "We'll put a pillow at your back and change your sheet" was heard. "No the noo" answered Mrs E. "It just takes a minute" Sister said. The sheet was changed. The patient seemed distressed as moaning was heard. "Not feeling too good tonight?" asked Sister. "No" responded the patient. "Is that comfortable?" "Sick bowl" was the answer. "You keep us busy here. Take deep breaths. Do you want a sheet and a blanket? How's that?" "Two pain killers" said Mrs E. "I promised you at eight, alright?" answered Sister sharply. The screens were drawn back. The patient was lying on her right side, supported by pillows, with her vomit basin at hand. Sister commented to her, "Think you were attached to it. Well, cough, that

chest's moist." Sister moved off to another patient. The student nurse went out of the ward. Sister left the ward and waved to Mrs E as she passed. The patient looked at the clock. Ten minutes later the patient was moaning. The vomit basin was still at hand though not used. She again looked at the clock.

6.55 p.m. Sister re-appeared. She looked over at Mrs E as she passed. Mrs E watched Sister and again looked at the clock. As Sister left the ward she called over "How are you? Chest sounds better." Mrs E did not answer. Sister left. The patient again looked at the clock.

This patient had been admitted to hospital due to a burn injury which had occurred while she was in an inebriate state. She told the observer "I get drunk to get rid of the pain." The patient suffered from a gastric carcinoma.

By contrast nurses were seen to do what they could to relieve patients. In one area when the pain of a patient - Patient O - was unrelieved by her sedation, Sister promptly repeated the dosage. In another area, when a patient was distressed and suffering discomfort, Sister and four student nurses tried to ease the patient by immersing the patient in a bath of warm water. The patient requested this care. With alacrity the nurses responded showing every desire to help. The ward routine was disrupted for 30 minutes, at a most inopportune time as the visiting hour was at hand. It was no easy task as the patient was heavy, but the efforts of the nurses did give a modicum degree of relief to the patient, who died 48 hours later.

Communication

The incidents classified as 'communicating' were frequently very brief, little more than a token of concern, or gestures acknowledging the patient's existence. One hundred and eighteen times (70.6%) the nurses were observed at the bedside of the dying patient 'checking up on' the patient by looking, touching, or asking rhetorically "Alright?" or "OK?" On forty-nine (29.4%) occasions there was a dyadic interaction.

The following 90 minutes period of observation illustrates the typical nurse/patient interaction.

Extract from the data (6)

10.20 a.m.* Nurse E popped in to the side room for seconds. Looks. (15 secs) Nurse B glances in when passing. The patient can be heard half-way down the open ward. She appears distressed as her right arm is waving in the air.

10.37 a.m.* Nurse E popped in for 30 secs. Touched the patient's hand and spoke to her. Patient quietened.

10.39 a.m. Nurse F entered to record the patient's TPR, looked at the patient and said "Are you OK?" No answer. The moaning recommenced. (1½ mins)

10.40 a.m. Maid dusted the room.

10.47 a.m. Nurse B glanced in when passing.

11.02 a.m. Nurse E glanced in when passing.

11.04 a.m.* Nurse E entered the room, took the patient's hand. Nurse looked concerned, left the room after 30 seconds.

11.08 a.m. Spasmodic moaning and restlessness continued.

11.13 a.m. Nurses C, D and E entered. Door closed. Nurses left the room at 11.17 a.m. Patient's position changed.

11.22 a.m. Priest entered; left one minute later.

11.23 a.m. Patient now alone with door closed.

11.50 a.m. * Nurses G and H entered. Patient moaning and her arm is moving. They looked and left. (5 secs)

11.55 a.m. * Nurse E went in, touched the patient's arm, left the room. (10 secs) Nurse B and resident doctor glance in when passing.

11.56 a.m. * Nurse C entered the room, held the patient's hand, spoke to her. The patient quietened. Nurse C mopped the patient's brow and hands with a moistened cloth. She talked to the patient quietly. (4 mins)
Nurse C reported to Nurse A. Decision taken to give the patient Brompton's Mixture 10 mls. 12.10 p.m.

* Incidents were identified as communicating

Verbal communication occurred between the nurse and the patient during nursing activities. For twelve patients who were nursed in the open ward this conversation could be overheard and noted. Eleven of these patients were conscious. Listening to the communication with the other eleven patients, one of whom was unconscious and six semi-conscious, was not possible as they were in single rooms. The communication was sparse. Frequently the patients were asked "How are you?" The answers were brief and often indicated pain. Further conversation was dominated by the nurses as they instructed the patients or cajoled them to cooperate during the

procedures.

Sometime an attitude of concern was discerned. Two junior nurses attending a very debilitated patient, who could barely talk, were overheard guiding him in tender tones.

Extract from the data (7)

7.50 a.m. Nurses F and H took a bath trolley to the bedside and drew the screens. Nurse H spoke kindly - "Straighten your legs Mr T. Does that feel dry? Just going to give your legs a wash. Is that alright Mr T? Some area down here painful? I'll let doctor know. On your side to wash your back; won't be long now, then we'll change your sheet."

During the procedure Nurse H answered the telephone. She returned to the patient's bedside: "That's your Aunt on the 'phone asking if you're feeling a bit better. Would you like your gown on? There's the buzzer - OK Mr T? If you need the toilet buzz. Alright? Try a wee drink, swallow, swallow."

8.35 a.m. The screens were drawn back. The patient was lying in the semi-recumbent position supported by pillows. Clean linen was on the bed. He looked groomed. His mouth, though still dry, had been attended to.

In contrast this extract describes the content and context of a conversation during the care of another patient.

Extract from the data (8)

8.30 a.m. Nurses M and C took a bed bathing trolley to

the bedside and with "Going to give you a wee wash, Mrs E." the screens were drawn. "Oh my God, not a bath!" answered the patient. "No, a wee wash. Are you going to try and cough that up?" Patient tried. "Did you sleep well?" - "Aye" - "Good". Sister C entered. Instructions about dressing to be attended to given. Sister left. The patient asked "Am I needing my dressing done again today?" - "No" - "Oh good". Nurses gossip together. As the procedure of bed bathing progressed the patient was given brief instructions on appropriate movement - "Turn" - "Over" - then "Would you like your hair washed?" - "No! - No! Not today" - "Oh! OK! OK! Just let's know when you feel like it - hand here, we're going to lift." The patient cried out "Stop roaring like a bull" said the nurses. Sister C appeared. "What's sore?" - "It's my back passage, Sister" - "OK" - Sister left.

8.50 a.m. The screens were drawn back, the patient was propped up, smoking a cigarette, her hair was dishevelled, but her nightdress was clean. Clean linen was on the bed.

Communication contacts with the patients differed between patients, between nurses and from one observation to another.

Example 1

Mr J was a 69 years old intelligent patient whose condition dramatically and unexpectedly deteriorated following surgery. Pre-operatively this patient had established excellent relationships with the staff as he had been up and about in the

ward bantering with both fellow patients and staff. On the first afternoon he was cooperative, had a feeling of well-being and did not seem to be suffering pain; 48 hours later he was complaining, slightly aggressive and viewed the future with foreboding.

Extract from the data (9)

1st observation period 1 - 4.30 p.m.

1.00 p.m. Sister in to explain to the patient that he would have an intravenous infusion recommenced. (2 mins)

1.05 p.m. Nurse R attended oral hygiene. (2 mins)

1.30 p.m. Intravenous infusion commenced by doctor. Staff Nurse D in attendance. Patient's wound dressed. (15 mins)

1.55 p.m. Nurses I and Q attend to patient's pressure areas. (15 mins)

2.20 p.m. Nurse M and R bandage arm to splint. Chat. (2 mins)

2.21 p.m. Staff Nurse D offered the patient sedation explaining "You can have it before the pain gets too bad." The patient didn't want his sedation at that point. (5 mins)
Nurse R entered the room - light chat about her deafness and recorded the patient's blood pressure. (2 mins)
Nurse T entered and lightly comments "Hello Alfred, how are you doing? Alright?"
Superficial chat continued. (2 mins)

2.25 p.m. Staff Nurse D returns with sedation. (1½ mins)
On leaving she commented to the observer "He says he is like a pin cushion. He is an awfully nice patient."

2.55 p.m. His wife, who is severely crippled, and his son arrive and enter the room.

3.00 p.m. X-ray girls arrive. The relatives leave the room saying "Hope we get longer for this!"

3.00 p.m. Sister came along and chatted to the relatives, then went into the patient's room. (2 mins)

3.07 p.m. Relatives returned to the room.

3.35 p.m. The Consultant passing the room, entered, waited briefly 30 seconds and was heard to say to the son "I'll see you before you go."
Two minutes later the son went to the Consultant's room.

Three minutes later he returned to his father.

3.40 p.m. Nurse M entered the room with fluids and chatted to the patient and his relatives. (1 min)

3.43 p.m. Relatives left.

3.45 p.m. Nurse Q entered with fresh sputum carton. Brief chat. (15 secs)

3.46 p.m. Nurse M popped in. Brief chat. (15 secs)

4.20 p.m. Nurses M and H attended to the patient's dressing.

48 hours later 1 - 4.30 p.m.

Extract from the data (10)

1.20 p.m. Staff Nurse C been in to check situation. (1 min)

2.08 p.m. Nurse O in to give patient a drink. (15 secs)

2.10 p.m. Nurse W in with sputum carton. (5 secs)

2.18 p.m. Staff Nurse C looks in when passing. No contact.

2.30 p.m. Relatives appeared in the corridor. Two Staff Nurses looked at them coming - no contact made or welcome to them. The relatives went into the

room; son came out and asked for coffee for his mother. Staff Nurse disappeared - brought back two cups which she handed to the relatives, then left the room.

2.44 p.m. Ward clerkess popped in. (5 secs)

2.50 p.m. Relatives leave, no contact with nurses at all. No effort made to help the crippled lady to chair or lift. (Why? There are so many on duty.)

3.05 p.m. Nurse L in to attend to oropharyngeal suction and oral hygiene. (15 mins)

3.17 p.m. Sister enters room. Left after 3 minutes.

3.33 p.m. Nurse L popped in. (2 secs)

3.50 p.m. Son returned and entered the room.

4.00 p.m. Nurse O in to try to give patient fluids (15 secs)

4.10 p.m. Sister passed, pops in. (2 secs)

4.12 p.m. Nurses C and P attended to pressure areas. (15 mins)

The difference in the length of contact time and number of visits to the bedside by the nurses during the two observation periods was noticeable as shown below

Observation time	Contact time	Number of visits
1st period 3½ hrs	60 mins	14
2nd period 3½ hrs	19 mins 31 secs	9

Studies of communication in nursing have brought sharply into focus the brevity of conversation and the control over the communication by the nurses when talking to patients (Bond 1979, Clark 1981). This pattern was evident during the study.

6.4 The nurses involved in the interactions.

Nursing care was provided predominantly by the student and pupil nurses from the junior grades of nurse training. The dying patients were given care by the trained staff on a continuum extending from no involvement to participation equal to that of the learners and in some wards proportionally more. Qualified nurses participated in one hundred and forty-four (28.1%) of the five hundred and eleven interactions. (Table 34)

In the work force the ratio of qualified to unqualified nursing staff was 1:3, but this was not reflected in the proportion of time spent with each patient by the grades of nurses. This is shown on Table 35. When the average was taken of the number of minutes per hour the dying patient was observed with a nurse in attendance, the majority of the patients had the presence of a qualified nurse for a fraction of a minute every hour.

The greatest proportion of the encounters between the qualified nurses and the patients was categorised as 'communicating' (Table 34). This was observed, on most occasions, to be for the purpose of 'checking up' on the patient. Few sustained conversations were observed.

Five patients were identified as receiving more of the time of the trained nurses. These patients were C, E, I, O and P.

Patient C was alert, had some breathing difficulties and some pain. There was no equipment involved which might have demanded the senior nurses' expertise. She was one of the least physically dependent of the very ill patients observed. The differentiating feature was that

TABLE 34: Tasks performed by qualified nurses

Patient	Tasks performed for each patient	Total number of tasks performed by trained nurse	Number of times trained nurse involved in basic skills	Number of times trained nurse involved in communicating	Number of times trained nurse involved in technical skills
A	19	2	1	1	-
B	2	2	1	1	-
C	25	11	5	5	1
D	26	-	-	-	-
E	11	5	1	3	1
F	24	1	1	-	-
G	7	1	-	1	-
H	36	7	-	7	-
I	49	17	3	10	4
J	46	14	5	8	1
K	15	6	2	4	-
L	10	5	3	2	-
M	15	7	5	2	-
N	3	1	1	-	-
O	25	14	5	8	1
P	70	21	3	13	5
Q	37	5	3	1	1
R	3	-	-	-	-
S	11	3	1	2	-
T	6	1	1	-	-
U	8	1	1	-	-
V	35	10	-	8	2
W	28	10	-	8	2
Total	511	144	42	84	18
Total number of times skills provided for all patients			217	167	127

TABLE 35

Interaction time of qualified nurses and student/pupil nurses with patients

Patient	Time with qualified nurses			Time with Learners			Ratio of time with qualified/ unqualified nurses
	Hours	Mins.	Secs.	Hours	Mins.	Secs.	
A		10	5		54	15	1 : 5
B		9	1		9	0	1 : 1
C		32	21		39	16	1 : 1
D		nil		1	49	0	-
E		35	5	1	27	0	1 : 3
F		30	0	3	55	0	1 : 8
G		3	10		16	45	1 : 5
H		3	49	2	30	15	1 : 40
I	4	40	45	4	57	0	1 : 1
J		9	19		45	3	1 : 5
K		7	47	1	44	0	1 : 14
L		6	5	1	55	0	1 : 19
M		8	5	1	32	0	1 : 11
N		3	30	1	2	0	1 : 21
O		43	11	2	12	58	1 : 2
P	4	28	4	7	21	45	1 : 2
Q		28	17	3	56	49	1 : 8
R		nil			4	36	-
S		39	32	2	24	35	1 : 5
T		1	30	2	14	0	1 : 89
U		20	30	2	3	0	1 : 6
V		18	10	2	15	17	1 : 9
W		33	35	4	29	6	1 : 9
Total	14	51	51	50	37	40	

the diagnosis was uncertain, whereas the diseases of the other patients had been delineated.

Patient E demanded attention as she was distressed by pain. This patient had been identified as 'difficult'. One of her encounters with the trained nursing staff has been outlined on pages 92-94.

Patient I was nursed in a ward where patient allocation was practised. This patient had a naso-gastric tube in situ, was receiving parenteral feeding, and his wound required constant attention due to persistent loss of ascitic fluid. The consultant's concern and interest was also apparent by his frequent visits.

Patient O was semi-conscious with minimal technical nursing needs. Allocation of nurse duties was also by patient allocation in the ward in which she was nursed. The high dependency of this patient was recognised and skills provided to give the nursing care, as a qualified nurse was delegated to care for this patient during allocation of duties.

Patient P commanded the attention of the qualified nurses eventually by her disturbed behaviour. At the beginning of the observation period she received minimal contact. For two days she was very distressed and had not been able to settle. On the third day when the doctors' round commenced, two nurses tried to calm the patient so that the usual ward quietness which accompanied this procedure could be maintained. Finally, the medical staff had to give attention to the ward furore which they were trying to ignore; the patient had thrown a tumbler which smashed at the feet of one of the

consultants. This patient received intravenous and intramuscular medication. A nasogastric tube was inserted and an intravenous line established for continuous medication. The patient quietened with the sedation. The therapy commenced and continued involved technical nursing skills.

Sixteen patients had minimal contact, time or care from the trained members of the nursing staff and two patients, patients D and R, had no contact though both of these patients required skilful care. The condition of patient D had been outlined on page 84 and patient R on page 83.

Certain nurses, qualified and unqualified were observed to have a greater number of encounters and longer contact with the patients than their colleagues. These nurses demonstrated specific qualities or characteristics which identified them as 'caring' persons. They attended to the patients persistently and gave care which was outwith the ward routine, addressed the patients by name and acknowledged that a response might be possible by waiting in expectancy for an answer. They gave attention to the appearance, clothing and environment of the patients and respected the idiosyncracies of the patients. Telephone messages received were conveyed to the patients and a letter or get well card received was read to the patients. They touched the patients when talking to him/her; they approached the relatives and talked to them unsolicited. Thirty (15.5%) of the 193 nurses observed showed these characteristics of 'caring'. This was in contrast to the behaviour of their colleagues who appeared to treat the patients as 'socially dead'. (Glaser and Strauss 1972)

This pattern of nurse-patient interaction demonstrated by this select group of nurses remained constant from one spell of duty to another. Ward environment did not seem to affect the approach, e.g. one student who demonstrated this 'caring' was observed in two clinical areas. In the different wards her attitude remained unchanged; during her spell of duty in one ward and her initial spell of duty in the second area, she had the longest interaction time in comparison with her

colleagues in both areas. Change of environment and patient did not alter her frequent attendances and approach to the patients who were dying. A second student nurse, who was also observed in two wards, also demonstrated that her behaviour remained unchanged. By contrast she indicated no involvement with the dying patient in either ward.

These 'caring' nurses had varied qualifications and were at differing stages of training.

The observations of the morning care of patient D on the two consecutive mornings prior to his death illustrates the activities of a 'caring' nurse and the change in patient care which resulted when a 'caring' nurse was on duty. Nurse F, a first stage student nurse, was identified as the 'caring' nurse.

First morning observations : 7.30 a.m. - 1.00 p.m.

Nurses on duty : Nurse A - Staff Nurse
Nurse C - Pre-registration student nurse
Nurse E - 1st stage student nurse
Nurse G - 1st stage student nurse
Nurse L - Psychiatric secondment student nurse

Extract from data (11)

8.00 a.m. Nurses C, E, G and L commenced bed bathing patients and making empty beds.

Patient watched activity. No contact. He has slipped down the bed. Looked very uncomfortable and had some difficulty with breathing.

9.20 a.m. Nurse A approached. Left tablets on the patient's locker. He looked. No communication.

9.50 a.m. Nurse A commenced the ward round with doctors; they chatted together at the foot of the bed. Patient looked. No contact. They moved on. (10 secs)

9.52 a.m. First contact with the patient. Nurse C approached and asked "How are you?" No answer. Nurse G approached; together they lifted the patient up the bed into a semi-recumbent position and left the bedside. (13 secs)

10.00 a.m. Teas were brought into the ward. Patient watched. He was not offered tea - oral fluids were permitted. He raised his hand. No contact.

10.15 a.m. Nurse G took the patient's TPR. No communication. (1 min)

10.20 a.m. Patient became restless, slipped down the bed and drew his legs up. Nurses C and L were working at the nurses' station. No note was made of the patient's restlessness. He looked towards them.

10.37 a.m. Nurse L collected a chart from the bed. No contact with the patient. He watched.

10.44 a.m. The patient was approached by Nurse C who asked "Would you like to sit up a bit?" He answered "No". She tried to persuade him to be lifted up - "It would help your chest". He answered again "No". (7 secs)

10.45 a.m. Nurse A watched from nurses' station as patient moved a little in bed. He pushed the bedclothes down.

11.00 a.m. Nurse C approached patient again and tried to persuade him to drink. "Alright? Want a wee drop water now? Dry?" She went off and returned with a glass to water. He would not drink. (15 secs)

11.05 a.m. Nurse G tidied the locker. Patient watched. No contact.

11.20 a.m. The patient was lying on his back. Medicine dispensed at 9.20 a.m. lay on locker top untouched. He had had no attention, had watched movement of nurses and doctors to and fro, was still restless.

He seemed unable to speak, or drink, due to the condition of his mouth. Nurse E approached, bent down and talked to patient. She repositioned the patient's legs, left and returned with the commode. Snippets of conversation were heard. "You feel better when up? You will have to take these tablets." Commode removed. Patient was now in the semi-recumbent position. (5 mins)

11.40 a.m. Nurse G approached patient and said "You must cough." She left the bedside. (5 secs) No further contact.

12 noon Observation discontinued.

Throughout this time this patient watched the nurses' movements continually. When they approached his bed he watched, but few established eye contact with him. He moved his legs up and down, made weak movements to attract attention. He did not respond to the brief interactions, but did respond to Nurse E who bent down and stood waiting for an answer. The patient was too weak to assert himself but did seem aware of his miserable condition and his lack of care. This was apparent in the evening when Nurse F gave him the attention he required and assisted him to drink and take his medication. Though not able to converse at length, he communicated his satisfaction by gestures, expression and the occasional word.

Second morning observations : 7.30 a.m. - 1.00 p.m.

Nurses on duty : Nurse D - Pre-registration student nurse
Nurse H - 2nd stage student nurse
Nurse F - 1st stage student nurse
Nurse G - 1st stage student nurse
Nurse K - 2nd year pupil nurse

Extract from data (12)

7.40 a.m. Nurses F and H took a bathing trolley to the

bedside and drew the screens. Nurses could be heard talking to patient and explaining their actions to him throughout the procedure. His responses were muffled. When the screens were drawn back the patient was lying supported by three pillows. He looked fresh, had been shaved, was dressed in a clean nightshirt and had fresh linen on his bed. His oral hygiene had been attended to, though his mouth was still dry. (35 mins)

8.45 a.m. Nurse D laid tablets in a glass on the patient's locker. No comment or contact with the patient.

9.05 a.m. Nurse F approached the patient and asked if he would like a drink. She noticed his tablets, crushed them down and aided him to swallow, having obtained a straw to aid the process. The patient did not respond immediately but in time took his mixture. He did not talk. (5 mins)

9.10 a.m. Nurse D accompanied two doctors on the ward round. At the patient's bedside, on hearing from the Resident that the patient had been given Diamorphine, the Registrar commented "That's a good idea". He then approached the patient and said "Going to give you an injection to slow your breathing down and make you a bit more comfortable. Alright?" No response. The group moved on. (1 min)

9.20 a.m. I V Diamorphine Sulphate 10 mgms administered via infusion in situ. No communication with patient.

9.22 a.m. Nurse F approached the bedside. "I'm putting the bed side up." She looked at the patient. No response. (2 mins)

9.25 a.m. Nurse G recorded the patient's TP and BP, leaving the bed with the sides down. (1½ mins)

9.40 a.m. Patient's relatives appeared at the ward doorway. Nurse F approached them and invited them to sit in the corridor. Nurses F and G drew the screens and

and took in the back trolley. Instructions were given to the patient as they attended to his pressure areas. Screens removed. Patient's position changed. He looked comfortable. He has been given fluids. (10 mins)

9.50 a.m. Nurse F invited the relatives to bedside.

10.20 a.m. Relatives approached by the maid and offered tea. They refused.

10.55 am. Relatives left the bedside.

11.10 a.m. Nurse F approached patient, bent down and talked to the patient. He moved his head in response. She touched his hand, then left.

11.30 a.m. Nurse F approached and looked at the patient who was lying quietly. No contact.

12 noon Nurse F answered an enquiry for Mr T on the telephone. She approached him and said "Mr T - that's your brother John on the 'phone for you. Stick out your tongue for me. A wee drink? Not possible? Mr T - can you hear me?" (1 min)

12.15 p.m. A bouquet arrived for the patient. Nurse F read the card to the patient, arranged the flowers and placed the vase on his bed table. The patient did not respond. (2 mins)

12.30 p.m. Nurses F and G drew the screens around the patient. When the screens were drawn back the patient had been turned. He looked fresh. His mouth had been attended to and a swab with ice was laid on his lips. Nurse G recorded the patient's TP and BP (35 mins)

1.05 p.m. Observations discontinued.

The patient died 2½ hours later.

The care the patient received on the second morning which was instigated by Nurse F stood in sharp contrast to the

neglect of the previous day as indicated below.

Nurse involvement and time taken in patient care

Observation time	Nurse	Qualifications	Total time with patient	No. of visits
1st morning $4\frac{1}{2}$ hours	A	Staff nurse	0	0
	C	Pre-reg. student nurse	35 secs	3
	E	1st stage student nurse	5 mins	1
	G	1st stage student nurse	1 min 5 secs	2
	L	Psych. student nurse	0	0
			TOTAL TIME: 6 mins 40 secs.	
2nd morning $4\frac{1}{2}$ hours	D	Pre-reg. student nurse	1 min	1
	G	2nd stage student nurse	$46\frac{1}{2}$ mins	3
	F	1st stage student nurse	91 mins	9
	H	1st stage student nurse	35 mins	1
	K	2nd year pupil nurse	0	0
			TOTAL TIME: 1 hr 32 mins 30 secs.	

The needs of the patients were recognised by the 'caring' nurses and nursing care, tailored to meet the demands, provided. Nurse E, a part-time staff nurse, was identified as the 'caring' nurse in the following observation period of patient I.

Observation time : 7.45 a.m. - 1.00 p.m.

Nurses on duty : Nurse D - Staff nurse
Nurse E - Part-time staff nurse
Nurse H - Student nurse
Nurse I - Student nurse
Nurse L - Student nurse
Nurse Q - Pupil nurse
Nurse U - Student nurse sent temporarily to assist in the ward
Nursing auxiliary - T

The patient, Mr J, looked anxious, distressed and aggressive. When asked "How are you?" he answered "Terrible!" "What's wrong?" he was asked. "Pain" he replied, "they said they would come, but I don't know what's happening - three of them - it's my back - all over. Since half past seven." "What like a night did you have?" he was asked. "Alright until half past three, but it's so noisy since then, have no water." Doctor passed and could be seen by the patient. He called out "Hello doctor!" The doctor did not hear. The patient continued, "This is the worst period. It's the pain. Can't move. They've put the drip up but it's so slow."

Extract from data (13)

8.05 a.m. The patient called out to Nurse L as she passed in the corridor. She looked in and left to contact staff nurse D. Both entered the room, lifted the patient up the bed. He complained of pain, saying the night nurses had promised something but he had not received it. They left, promising help. (30 secs)

8.26 a.m. Part-time staff nurse E entered. "How are you?" she asked. "Something for the pain" he replied. "I've been waiting since half past seven. Something for the pain. My mouth's dry. It's awful!" "Alright" she replied, "Staff nurse D will come with something." She went off to get the keys. (30 secs)

8.30 a.m. Doctor entered the room to take a blood sample. "Hello doctor" said the patient "something for the pain. They've promised but nothing's coming." "Oh" replied the doctor "I'll go and hurry them up." "They said they would come, but no one comes" the patient said. (3 mins)
Staff nurse E entered the room and gave the patient sedation then left quickly to attend to an

emergency. (25 secs)

8.37 a.m. Maid entered the room. "How are you, not too good?" she asked. His smile was friendly and he answered "A bit better now." "Such is life" said the maid "we've got to take it as it comes. It's like the weather, can't change it." "Aye!" he replied. His distress and aggression were gone now. (30 secs)

8.39 a.m. Another maid popped in to tidy his locker. There was chat, and banter about her having removed his orange juice and leaving him with no fluid.

8.45 a.m. Staff nurse E returned. She had been involved in the comparatively sudden death of another patient. "Shall I leave you and come back, or do you want something just now?" she asked. "Scotties - how long shall I sleep for?" he asked. "Have a wee sleep. Let yourself relax" said staff nurse "I'll see to the others. I'll leave you for an hour. Here's your buzzer. Drink that up, then off to sleep." He took the drink offered to him. Nurse then left the room, closed the door and drew the curtains. (3 mins)

9.00 a.m. Staff nurse E opened the door, looked in, then closed it again.

Staff nurse E and Auxiliary T had been allocated to care for Mr J and three other patients during the morning shift. She instructed the maids - "Don't go into Room 18."

9.20 a.m. Staff nurse D went in. (1 min)

On coming out she said "He's not so bright this morning - I think he is going downhill - just like her next door. Have you seen her?"

9.29 a.m. Nursing Officer went in briefly. (30 secs) She approached Nurse D - "Sorry to trouble you, but I think Mr J is leaking." A discussion ensued over the problems of his wound care.

10.15 a.m. The Consultant and his retinue (6 doctors), also Staff nurse D, enter the room. The patient and doctor chat about his wound and infusion. Instructions are given relative to the patient's treatment. (2 mins)

10.20 a.m. Staff nurse E went into the room, then left to receive guidance on the care to be given. She approached Mr .. in the corridor to ask advice about the dressing, then discussed other problems of the patient. He gave her full responsibility for doing what she felt was best, having told her how much of the drain to shorten.

10.30 a.m. Staff nurse E and Auxiliary T entered the room with a bathing trolley. (1 hour 20 mins) During this time of care he was bathed . shaved, mouth care given, wound dressed.

11.30 a.m. Staff nurse D popped in for 30 secs.

Staff nurse E chatted on leaving the patient, explaining she had left the patient at 9.30 a.m." .. even though he was wet, he was so sore, he needed to rest."

12.20 p.m. Staff nurse E went in to give the patient a drink. They chatted. (2 mins)

12.25 p.m. The writer approached the patient - "How are you getting on?" "Just been told very well by the staff. Going to change this line after lunch" he said pointing to the infusion.
The patient settled down and closed his eyes.

12.45 p.m. Staff nurse E popped in. Patient asleep. (2 secs)

The dying patients, when given attention, received care most often from junior nurses or 'caring' nurses.

Goddard (1963) found that ward sisters and staff nurses were primarily concerned with ward management. This left the care to the student nurses who functioned with minimal supervision or instruction.

> "45% of the sisters working day is spent actually giving basic and technical care to her patients"

These findings were supported by the Committee on Senior Nursing Staff Structure (1966) who reported that

> "only a quarter of the Ward Sister's time was spent on nursing duties" P 33

The percentage of time given to the dying patients by the qualified nurses in this study was less than the percentage of time given to general patients as identified by these cited studies.

6.5 By whom was the interaction initiated?

The interactions between the nurse and the patient were classified as having been initiated by the nurse, the patient or by the ward routine. (Table 36)

The interactions which were the result of the nurse performing her allocated duties were designated 'routine'. Two hundred and fifty-four times (49%) of the nurse-patient interactions were established within the framework of the ward routine.

TABLE 36

Number of interactions commenced due to the ward routine, the patient and the nurse

Patient	No. of Interactions	Ward Routine	Initiated by Patient	Initiated by Nurse
A	18	4	5	9
B	2	2	-	-
C	24	13	4	7
D	23	8	1	14
E	11	8	1	2
F	Continuous attention			
G	7	5	-	2
H	37	12	11	14
I	54	22	1	31
J	50	19	9	22
K	19	14	-	5
L	12	8	3	1
M	18	8	6	4
N	5	3	2	-
O	29	9	2	18
P	70	28	21	21
Q	37	28	5	4
R	5	4	-	1
S	13	9	-	4
T	5	5	-	-
U	8	8	-	-
V	39	22	9	8
W	31	15	2	14
TOTAL	517	254	82	181

During these contacts the patient received physical care, outwith this framework the patient was rarely observed to receive this care as contacts initiated by the nurse resulted invariably in brief communications.

Interactions resulting from a patient's request were classified as initiated by the patient. This occurred eighty-two times (15.8%). The patients were very weak, tired and often seemed unable to communicate sufficiently to attract the attention of the staff. Rather than call out the patients became restless, tried to beckon, or watched the nurses moving to and fro with a look which seemed to long for attention. This gaze of anticipation was observed frequently when it was apparent that the patients had been unsuccessful in attracting attention by his or her weak call or gesture. The patients were unable to compete with the aggressive ward environment and succumbed in the struggle to gain the nurses' attention. Three times the patients were assisted in their efforts to receive attention by their fellow patients. The nurses responded immediately they were told - "Nurse, I think ---- wants you".

A study of the type of patients the nurses enjoy caring for most (Stockwell 1972) portrayed the popular patient as one who could communicate readily, was able to laugh and joke, was determined to get well and cooperated with the staff to achieve this goal. The patients who were dying did not have these characteristics; they did not grumble or complain as did the unpopular patient but were passive and uncomplaining.

Example 1

Mrs S was an alert, elderly lady who had not previously been in hospital as a patient. Her illness had developed suddenly: her physical deterioration was rapid. Surgery which had been contemplated was abandoned due to her weak condition and a chest infection which had developed. She was flushed, was perspiring freely, and had rapid moist respirations. A nasogastric tube and intravenous infusion were in situ.

Observation period : 1.00 p.m. - 5.00 p.m.

Extract from data (14)

1.10 p.m. Patient lies asking quietly for a drink. No one hears. She moans a little; calls a little louder; coughs. No response.

1.20 p.m. Begins to call "Nurse! Nurse!" - begins groaning a little more loudly. She watches the nurses go by. No one responded.

1.40 p.m. Tries to lift her head: waves her arm: groans slightly. Nurse D, passing with the back trolley, responds to her groan. Patient asked if the infusion was still functioning and for a drink of water. Given a sip. (1 min)

1.50 p.m. Seemed a bit more settled. Lies quietly.

2.00 p.m. Nurse G aspirated the naso-gastric tube. Patient awake. No verbal contact with the patient. (2 mins)

2.05 p.m. Nurse E approached the patient - "Just me .. tablets for you." She encouraged her to swallow two tablets "Can't manage? - pass them out again". She tried kindly, to get her to drink: the

patient had problems swallowing and drinking. Turned the pillow. Left. (3 mins)

2.30 p.m. Called out "Drink please!". No response. Nurses D and G passed back and forwards and do not seem to hear her. She watched their movements.

2.40 p.m. Groaning increased a little; nurses looked from the nurses' station. No response. Patient moved her arm as if to beckon them. No response.

3.00 p.m. Moans slightly. Watched nurses pass. No response from nurses.

3.15 p.m. Pushed the bedclothes down, tries to move her legs, calls "Drink, please" Nurses looked as they passed her bed. Patient looked at the nurses. No response from nurses.

3.45 p.m. Distress is still present. Patient groaning occasionally; quietly asked for a drink. No response from Nurse G as she passed. Patient closed her eyes.

4.10 p.m. Patient moans slightly, opens her eyes, but no one was there.

4.40 p.m. Nurses D and F go to the bedside with the back trolley. Instructions given as they do the procedure. Patient groaned a bit as if in pain when moved. She has been turned. Pillow slip changed as it was badly stained. (7 mins)

5.00 p.m. Observations discontinued.

This patient required frequent attention but seemed wearied and tired of the casual ineffective response or contact with the nurses in response to her call, restlessness and enquiring looks.

Not only were the patients unable to attract attention but they were unable to establish meaningful contacts to get attention to meet their needs.

Example I

Mrs F was a 57 year old mother of a family of four, who were in their early twenties. She suffered from a sarcoma of femur which had previously responded to treatment. Hospitalisation had been recommended as the patient was experiencing difficulty in walking. During her period of three weeks' hospitalisation her condition gradually deteriorated. The family (her husband, 'John'; two sons and two daughters) were attentive and visited regularly. When the observations commenced the patient was agitated and at times noisy, calling for 'John'; there were times when she appeared to hallucinate but long intervals when she was very coherent.

Extract from data (15)

7.30 a.m. Patient looks drowsy. Lies quietly, watching nurses. Her mouth is parched.

8.10 a.m. Patient rattled the cot-sides which are in position. She seems agitated: called Sister over: distressed by catheter which has been passed. Sister tried to reassure her she will not 'wet the bed'. (25 secs)

8.15 a.m. Nursing Officer approached. "Good morning, how are you?" She passed on. (7 secs)

8.16 a.m. Called Nurse B over who was dispensing medicines. Nurse B responded, "I'm coming!" She approached with tablets, chatted kindly to patient, and coaxed her to take tablets. Problem swallowing - "Is it away? Let me see!" Nurse takes time to give tablets - one at a time with a drink to follow.

Nurse is interrupted to assist in another area of the ward. She returned to patient and continued to coax her to swallow tablets: Patient now upset and starts to cry. Nurse N joins; together they try to settle the patient. "Don't worry, it's alright" they said. Patient tries to vomit. (5 mins 40 secs)

Both nurses leave the bedside. Nurse N returned with a vomit basin, handed it to the patient and left. Patient continues to weep silently. She holds her dentures in her hand. She gains control, looks around, no one present. She called out "John!" She weeps again, lies back and moves her hands in the air. She then calmed down and watched the ward activities.

8.35 a.m. Nurse N tidied patient's locker. "Would you like a wee drink?" Fetched a glass of iced water. (55 secs)

8.40 a.m. Nurse B returned, checked there were no tablets in the patient's mouth. (5 secs)

9.00 a.m. Ward round. Group approach bed, discuss patient's problem at the foot of the bed. Patient calls out "I need the toilet and I can't go!" No response from the group. Without speaking to the patient they move on. (2½ mins)

9.15 a.m. Patient called to nurse A. She stopped. Patient complained of catheter. "It's OK!" said nurse. She moved on. (15 secs)

9.20 a.m. Patient called to doctor as he passed. He responded "How are you Mrs F?" She started to speak ... he moved away and said "I'll come back later." (5 secs)

9.40 a.m. Called to nurse A. No response.

9. 42 a.m Maid passes - patient called out. "Alright Mrs F" she replied and passed on.

9.45 a.m. Patient weeps. (She is distressed, looks bewildered: sitting in bed, the cotsides in position, no one taking her on)

9.55 a.m. Sister approached and chatted quietly with the patient. Patient settled. (5 mins)

10.15 a.m. She lies watching the ward activities.

10.30 a.m. Nurses M and N approach; offer her a drink of water. Screens drawn. Patient has been 'bathed' and is now sitting by the side of her bed in an armchair. (20 mins)

11.30 a.m. Asks for toilet. Nurses K and N take commode to bedside. Nurse K waits with the patient. (9 mins)
Patient given a newspaper.

11.50 a.m. Calls to nurse M as she passes. Nurse responds. She asks to be returned to bed as her leg is "awfully sore". "OK!" replied nurse, and left. (15 secs)

12 noon Patient tries to rise out of her chair to reach her bed. Nurse B approached and suggested "Sit back in your chair." Patient moaned loudly. "Shush!" said nurse and left. (5 secs)

12.10 p.m. "Nurse!" called the patient. No response.

12.15 p.m. Nurse K laid soup before the patient, saying "You'll get me into trouble if you don't take your soup!" Leaves the bedside. (5 secs)

12.16 p.m. Nurse N calls as she passes, "Take your soup!"

12.17 p.m. Nurse N returns. "Won't you have soup?" "No!" replied patient. (5 secs)

12.20 p.m. Nurse N returns. "Steak pie Mrs F?" "Yes" replied the patient.

12.30 p.m. Patient weeps; called "John!". Approached by nurses N and M. Nurse M stays; talks to her; she calms patient. Weeping stops. (3 mins)

12.35 p.m. Meat course untouched. Nurse E offers "Ice-cream and jelly?". Patient refused. (10 secs) Patient called again - "John!". Nurse N approached the patient joined by nurse M. Together they reassure the patient - "John is just coming". (10 secs)

1.00 p.m. Again patient called "John!" Nurse M approached again; explained John was busy but he would come. (1 min)

1.05 p.m. Nurse offered patient tablets. She refused. (10 secs)

1.10 p.m. Patient called out "Help, John!". Sister responded, spoke quietly to patient. Patient expressed a desire for toilet. Commode provided. Nurse M helped and stayed with patient. Reseated in chair. (3 mins)

1.20 p.m. Patient tries to rise out of her chair. Nurse E called over - "What are you doing, trying to get out of the chair?" - she doesn't stop to assist her.

1.40 p.m. Nurses M and E approach and assist patient into

her bed. Little chat; instructions on her movements to cooperate. (8 mins)

2.00 p.m. Observations discontinued.

One patient was observed struggling for two hours to attract attention. During this time the observer was aware of being involved in the look for help. Finally, the writer approached the patient, gave assistance and apologised for not having responded sooner. "It's alright - you have your work to do" she answered. This patient's uncomplaining demeanour was characteristic of the dying patients. The requests from the patients were invariably for 'a drink', 'the toilet' or 'something for pain'. They sought attention in a weak manner. If unattended the dying patients appeared to resign themselves to the situation and said nothing.

On occasion it was not possible to discern if the patient or the nurse had initiated the interaction. This was particularly difficult during the observation of the semi-conscious patients who moaned. Some nurses did not respond to the sound whereas other nurses did attend to the patients. As the writer could not elicit if the contact was due to the patient or to the nurse's volition it was decided to identify the nurse as responsible for establishing these contacts. All interactions which were not considered to have been commenced as a result of ward routine, or at the patient's request, were classified as initiated by the nurse. This accounted for 181 (35%) of the interactions observed. These unsolicited interactions were initiated mostly by the 'caring' nurses (15.5% of the nurses observed). The other nurses rarely attend to the patients of their own accord, but gave care identified with the ward routine or in response to the patients' requests.

6.6 The length of the interaction

The length of the nurse-patient interaction was variable, but in most instances was short. At times the nurses were observed in the presence of patients without establishing contact.

Example 1

11.02 a.m. Nurse G approached the bedside of a patient with a glass of ice cubes. She placed the glass on the bed table and left. No chat or eye contact.

The patient lifted the glass and tried to place the ice cubes in her glass of orange juice. As the pieces were too large she could not dislodge the ice. After a few attempts she abandoned her efforts.

Frequently the patient's contact with the nurses was a series of brief interludes during which time no care was given and no dyadic interaction was established.

Example 1

Mr F was sitting up in bed observing the ward activities.

Extract from data (16)

8.22 a.m. Sister passed his bed with the medicine trolley. Patient looked but was not spoken to. He looked again and said "Good morning!" Sister responded from the next bed.

He spoke again but received no answer. She called to the staff nurse who was near at hand. The

patient responded. "No, it's not you I'm speaking to, it's staff nurse" replied Sister. He looked and said no more.

8.30 a.m. Patient called to staff nurse three times. She was standing at the nurses' station. No response. Sister replied from her stance by the medicine trolley. She approached the patient and he asked for water. She left the bedside and instructed a maid to give the patient water. On receiving the water he said "Thank you!" to the maid. She replied "Just call if you want more." he added juice and drank the fluid.

8.37 a.m. Sister approached with his medication - Morphine sulphate 20 mgms. The patient asked "What's that for?" "The pain" was her answer.

Conversation continued which was not overheard. (1½ mins)

8.48 a.m. Patient called "Sister!" She responded. Conversation was not overheard. (20 secs)

8.50 a.m. Patient called the maid. She responded and gave him more water. (10 secs)

Patient wound up his watch.

9.00 a.m. Nurses responsible for bed-bathing the patients on the left side of the ward where he lay, passed his bed and attended to the next patient.

9.20 a.m. Consultant, senior registrar and Sister looked and passed his bed. Muttered speech from the consultant as he averted his head from the patient. No contact. Patient looked.

9.25 a.m. Staff nurse approached the patient in the next bed to Mr F. "Have you got a paper?" She went off and returned with a newspaper. No contact with Mr F. He asked the patient on his other side, who was already reading a newspaper "Is that today's paper?" A nodded response.

A note was added to the notes at this point .. 'this patient would seem to be in Coventry; the rejection and isolation is remarkable'.

9.40 a.m. The tea trolley was brought into the ward by the maid. She spoke to all the patients and asked them what they wanted. She passed Mr F's bed. No contact. He called out. The nursing auxiliary answered. The patient asked for a cup of tea and a glass of milk. The nursing auxiliary went after the maid and returned with tea but was "Sorry - there isn't enough milk!" He asked for more water. The nursing auxiliary went to the kitchen and returned with iced water. She asked "Have you had a wee wash this morning?"

"No"

She gave him a comb and he tidied his hair. She left again and returned with a glass of milk which she encouraged him to drink. (1½ mins)

Maid tidied his locker. No contact.

9.55 a.m. He lay watching the ward activities; occasionally he sipped water. No contacts.

10.30 a.m. Nurse P, as she passed his bed, was called over by the patient. "What's that you're saying?" she asked. Patient's response not heard. "That's what we're here for" said nurse and she walked away. (4 secs)

10.40 a.m. Nurse M recorded the patient's TPR . They chatted briefly. (1½ mins)

10.50 a.m. Consultant's ward round: "How are you?"

"OK!"

"No pain? Just let us know and we can give you something" said the consultant. (30 secs)

11.15 a.m. Patient called to the nursing auxiliary. He wanted more water. She responded again with iced water. (15 secs)

Maid set up his table. He looked. No contact.

11.40 a.m. Nurse S asked to replenish his water. She provided fresh water. Little contact. (10 secs)

11.59 a.m. Nurse H is called over as she passed. Brief chat. (30 secs)

12 noon Nurse H asked if he wanted soup.

"Please"

The soup was laid on his tray. He took a little. (2 secs)

12.10 a.m. Staff nurse offered the patient "Roast beef?"

"Yes, please" he answered. It was placed before the patient.
He didn't manage to eat any. (2 secs)

Maid collected his plate. No contact. He looked.

12.15 p.m. Staff nurse offered the patient "Jelly and ice cream?"

He accepted. She laid it on his tray.

Nurse S approached the bed and gave him a spoon.

He was able to take a little. (5 secs)

12.40 p.m. The patient called the writer to his bedside. He began totalk of what he had done with his life .. not always as kind as he may have been but had no regrets - wouldn't change much, but some things .. "Life is like a breath of fresh air; gone like that!" He snapped his fingers to illustrate its brevity. He spoke of the world being for young people. He felt the lumps on his skull (skeletal metastasis) and said "I think they are getting larger."

He chatted for about ten minutes; obviously what he had desired to do throughout the morning, but no contact was established for him to unburden his thoughts.

12.55 p.m. Nurse P approached the patient and gave him his Morphine sulphate 20 mgms.

"Here's your tablets" she said and left the bedside. (5 secs)

1.00 p.m. Observations discontinued.

By contrast, a few nurse-patient encounters were prolonged, two nurses were in attendance on a patient in another area for 1 hour 20 minutes, during which time the patient received the care he required and afterwards expressed his satisfaction by saying "Top marks to these girls".

Of the five hundred and seventeen encounters observed between the nurse and the patients who were dying, one hundred and forty-three (27.6%) were of 3 minutes duration or longer,

three hundred and seventy-four contacts (72.3%) were of less than 3 minutes duration.

The length of contacts the patients experienced, differentiating between contacts established to provide physical care and encounters during which 'communicating' appeared to be the purpose of the encounter, are outlined in Table 37.

The contact time involved in providing different aspects of nursing care varied both within and between the major categories. Basic or technical nursing care varied in duration from 10 seconds to 1 hour 20 minutes. One hundred and twelve of the three hundred and forty-nine encounters (32%) during which physical care was provided lasted for 5 minutes or longer, the remaining two hundred and thirty-seven encounters (67.9%) for less than 5 minutes. Of the one hundred and sixty-eight nurse-patient encounters identified as 'communicating' one hundred and nineteen encounters (70.8%) lasted for less than 1 minute (the average length of time 11 seconds) and forty-nine encounters (29%) for more than 1 minute. Only sixteen interactions (9.5%) were observed when the nurse spoke to the patients for more than 3 minutes.

The brevity of the nurses' visits gave the patients few opportunities to establish a relationship with the nurses. The more aggressive the patient the longer the interaction time, though one quiet, elderly lady, who was identified as 'popular' by the nurses, attracted the staff to spend time with her. Ten (43%) patients chatted readily with the observer and expressed an appreciation of the chat in terms "It's been nice chatting to you" which seemed to underline the lack of communication experienced by the patients. Five patients (21%) responded freely but were breathless and tired easily. The remaining eight patients were semi-conscious or unconscious.

The total time the patients had the company of a nurse was meagre, as is shown in Table 38.

TABLE 37

Number of interactions to give care of 5 minutes duration plus or minus and to communicate for 1 minute duration plus or minus

tient	Length of Observation	No of Contacts	No of Contacts for Care 5 min +	No of Contacts for Care 5 min -	No of Contacts to Communicate 1 min +	No of Contacts to communicete 1 min -
A	8 hrs 15 mins	18	4	5	3	6
B	1 hr 30 mins	2	1	-	-	1
C	12 hrs 0 mins	24	2	13	1	8
D	15 hrs 0 mins	23	5	13	1	4
E	11 hrs 0 mins	11	4	3	1	3
F	3 hrs 55 mins	Continuous attention		-	-	-
G	5 hrs 15 mins	7	1	5	-	1
H	12 hrs 30 mins	37	6	17	4	10
I	20 hrs 45 mins	54	12	21	7	14
J	21 hrs 0 mins	50	2	30	4	14
K	16 hrs 30 mins	19	3	12	1	3
L	12 hrs 30 mins	12	2	8	1	1
M	12 hrs 30 mins	18	2	10	1	5
N	5 hrs 0 mins	5	3	2	-	-
O	14 hrs 0 mins	29	5	13	-	11
P	31 hrs 0 mins	70	16	23	15	16
Q	27 hrs 0 mins	37	9	24	-	4
R	3 hrs 0 mins	5	-	4	-	1
S	16 hrs 30 mins	13	7	3	1	2
T	13 hrs 30 mins	5	3	2	-	-
U	16 hrs 30 mins	8	7	1	-	-
V	21 hrs 30 mins	39	8	19	3	9
W	21 hrs 30 mins	31	10	9	6	6
	TOTAL	517	112	237	49	119

TABLE 38

Percentage of time patients observed to have a nurse in attendance

Patient	Time observed	Time nurses with patients	% of time nurse with patients
A	8 hrs 15 mins	1 hr 2 mins	12.5%
B	1 hr 30 mins	0 hrs 9 mins	10.0%
C	12 hrs 0 mins	0 hrs 41 mins	5.6%
D	15 hrs 0 mins	1 hr 49 mins	12.1%
E	11 hrs 0 mins	1 hr 27 mins	13.1%
F	3 hrs 55 mins	3 hrs 55 mins	100.0%
G	5 hrs 15 mins	0 hrs 16 mins	5.0%
H	12 hrs 30 mins	2 hrs 34 mins	20.5%
I	20 hrs 45 mins	5 hrs 0 mins	24.0%
J	21 hrs 0 mins	0 hrs 50 mins	3.9%
K	16 hrs 30 mins	1 hr 45 mins	10.6%
L	12 hrs 30 mins	1 hr 55 mins	15.3%
M	12 hrs 30 mins	1 hr 32 mins	12.2%
N	5 hrs 0 mins	1 hr 2 mins	20.6%
O	14 hrs 0 mins	2 hrs 33 mins	10.6%
P	31 hrs 0 mins	8 hrs 43 mins	28.0%
Q	27 hrs 0 mins	2 hrs 55 mins	10.8%
R	3 hrs 0 mins	0 hrs 4 mins	2.2%
S	16 hrs 30 mins	2 hrs 26 mins	14.7%
T	13 hrs 30 mins	2 hrs 14 mins	16.5%
U	16 hrs 30 mins	2 hrs 3 mins	12.4%
V	21 hrs 30 mins	2 hrs 15 mins	10.4%
W	21 hrs 30 mins	4 hrs 29 mins	21.1%

One patient - patient F - was never alone as he was 'specialed', a service requested by the medical staff. This patient had a nurse in attendance until his death. Two patients (patients I and P) received attention for 24% and 28% of the time respectively, both of these patients were alert and had not been expected 'to die' on admission, though the prognosis had altered during the period of hospitalisation. Seventeen patients had less than 20% of nurse attendance time and for two patients it was less than 5.0%. (Tables 39 and 40)

In the two wards where the nurse work was organised by patient allocation, the nurses involved with two of the four dying patients were qualified or senior nurses and the time spent giving care to the dying patient were equal to the time these nurses gave to the other ward patients for whom they were responsible.

The dying patients were often alone. Those who were conscious looked lonely; they had minimal contact with the nursing staff, sparse contact with the doctors and little contact with relatives who were restricted to one hour daily in some wards. This restriction was lifted when the deaths of twelve patients became imminent. Details of the length of time the patients had the company of a nurse, doctor, relative or friend are shown on Table 41.

TABLE 39

Percentage of time nurse in attendance, analysis by patient's state of awareness

State of Awareness	No. of Patients	PERCENTAGE OF TIME				
		Less than 5%	5% - 10%	10% - 15%	15% - 30%	30%+
Alert	15	2	1	5	6	1
Semi-conscious	7	-	1	5	1	-
Unconscious	1	-	-	1	-	-
		2	2	11	7	1

TABLE 40

Percentage of time nurse in attendance, analysis by patient's prognosis

Prognosis	No. of Patients	PERCENTAGE OF TIME				
		Less than 5%	5% - 10%	10% - 15%	15% - 30%	30% +
Admitted 'to die'	8	2	-	4	2	-
Medical treatment modified	13	-	1	7	5	-
Active medical treatment maintained	2	-	1	-	-	1
		2	2	11	7	1

TABLE 41 : Contact times of members of caring team and relatives with the patient

Patient	Time with Nurses	Time with Doctors	Time with Relatives	Time Alone	% of Time Alone Durir Observation Period
A	1 hr 2 mins 30 secs	Nil	1 hr	6 hrs 12 mins 40 secs	75%
B	- hr 9 mins 1 sec	Nil	Nil	1 hr 20 mins 59 secs	89%
C	- hr 41 mins 37 secs	6 mins 30 secs	1 hr 10 mins	10 hrs 4 mins 53 secs	84%
D	1 hr 49 mins	1 min	1 hr 5 mins	12 hrs 5 mins	81%
E	1 hr 27 mins 35 secs	- min 10 secs	Nil	9 hrs 32 mins 25 secs	87%
F	3 hrs 55 mins	47 mins	- hr 15 mins	Nil	Nil
G	- hr 16 mins 55 secs	Nil	Nil	4 hrs 58 mins 5 secs	95%
H	2 hrs 34 mins	3 mins 20 secs	1 hr 20 mins	8 hrs 35 mins 40 secs	69%
I	5 hrs - mins 45 secs	28 mins 30 secs	1 hr 58 mins	13 hrs 46 mins 15 secs	66%
J	- hr 50 mins 12 secs	7 mins 30 secs	1 hr 5 mins	19 hrs 2 mins 18 secs	91%
K	1 hr 45 mins 33 secs	3 mins 15 secs	- hr 38 mins	14 hrs 6 mins 27 secs	85%
L	1 hr 55 mins 57 secs	5 mins	- hr 5 mins	10 hrs 29 mins 3 secs	84%
M	1 hr 32 mins 35 secs	1 min 10 secs	- hr 5 mins	10 hrs 32 mins 25 secs	87%
N	1 hr 2 mins 15 secs	18 mins 30 secs	- hr 5 mins	3 hrs 50 mins 15 secs	77%
O	2 hrs 33 mins 58 secs	5 mins	- hr 38 mins	10 hrs 48 mins 2 secs	78%
P	8 hrs 43 mins 39 secs	59 mins 35 secs	8 hrs 20 mins	13 hrs 56 mins 21 secs	45%
Q	2 hrs 55 mins 56 secs	6 mins 30 secs	1 hr	23 hrs 4 mins 4 secs	85%
R	- hr 4 mins 11 secs	2 mins	Nil	2 hrs 55 mins 49 secs	97%
S	2 hrs 26 mins 23 secs	19 mins 30 secs	1 hr 30 mins	13 hrs 30 mins 7 secs	82%
T	2 hrs 14 mins 30 secs	1 min 30 secs	Nil	11 hrs 15 mins 30 secs	83%
U	2 hrs 3 mins 30 secs	- min 30 secs	Nil	14 hrs 27 mins 30 secs	88%
V	2 hrs 15 mins 27 secs	19 mins 40 secs	- hr 45 mins	18 hrs 26 mins 53 secs	86%
W	4 hrs 33 mins 35 secs	3 mins 5 secs	1 hr 40 mins	15 hrs 16 mins 25 secs	71%

NB - Visits by nurses, doctors and relatives on occasion overlapped - this accounts for apparent discrepancies in "Time Alone" column

As the time of death approached the patient's isolation increased.

Example 1

Mrs M was unconscious and did not respond to touch or speech. She was very pale, thin and dehydrated; her eyes deeply sunk in their sockets. Her breathing was rapid and noisy, but regular.

Extract from data (17)

8.20 a.m. The patient was moved into the side room by Sister and nurse B. No contact.

8.32 a.m. Nurse B and nurse C entered the room with the bed bathing trolley. Screens drawn. The nurses left the room nine minutes later. Door left open.

9.10 a.m. Maid entered the room and mopped the floor briefly.

9.16 a.m. Sister entered the room and checked the chart at the foot of the bed. She glanced at the patient as she left.

* 9.20 a.m. Patient's breathing ceased.

9.25 a.m. Nurse A glanced in as she passed; she continued out of the ward.

9.30 a.m. Nurse C glanced in as she was passing. No contact.

9.40 a.m. Sister, nurse B, the registrar and house doctor entered the room, talked to one another when in the room. Left the room two minutes later.

9.45 a.m. Sister entered the room to change the infusion unit. As she was about to leave, having completed this task, she looked at the patient,

appeared startled, drew the screens, left the room shutting the door, and called the doctor.

9.50 a.m. Death was certified and recorded as having occurred at 9.45 a.m.

This was the second time a patient had died unnoticed. On the previous occasion the patient lay for 15 minutes. Her pillowslip was marked by a dark stain due to regurgitation which occurred at the time of death. The patient's husband came to visit and was observed asking for permission to enter the ward from the nursing staff. He entered the open Florence Nightingale Ward unaccompanied to visit his wife, who lay in the centre of the ward. At this point, the non-participant role of the observer was abandoned and the elderly gentleman diverted. When he was later told by the Sister of his wife's death, he expressed a preference not to see her body and left the unit accompanied by a friend.

These brief periods of observation on day duty indicate that the patients were isolated for long periods of time. The nurses did not linger by the bedside of the dying patients. Nurses were involved for 3% - 34% of the patient's day. The patients were alone 66% - 97% of the time.

Observations were not conducted during the night period. In the morning the verbal report from the night staff was listened to and the nursing kardex read. From these sources it was learned that five of the patients had fallen out of bed during the night. Four of these patients (Patients J, M, R and S) had been "admitted to die"; this accounted for 50% of the eight patients "admitted to die". These patients were not observed to be confused during the day observation periods, which suggests that the loneliness experienced during the day, was replicated during the night watch.

6.7 Summary

Data collected from the first phase of fieldwork indicated that the nursing care of the patient who was dying was less than adequate.

The findings are summarised as follows

1. The patients were alone 70%-90% of the time.
2. Nurse-patient interactions were numerous and brief.
3. Patients were attended most frequently by junior nurses.
4. Senior nurses were involved when active medical intervention was maintained.
5. Nurse-patient interactions were governed by the ward routine.
6. Patients in patient assignment ward organisation received more contact and nursing care from qualified nurses than in task allocation ward organisation.
7. Certain nurses a) spent time with the patients.
   b) indicated an awareness of the patients' presence, they
      1. talked with the patient
      2. waited for an answer
      3. touched the patient
      4. established eye contact
      5. gave heed to the idiosyncracies of the patient
      6. gave care not identified as routine
8. Patient needs demanded basic and psychosocial nursing skills. Few technical nursing skills were required.
9. Care given was predominantly basic/non-technical nursing.

10. 65% of the patients were conscious and aware of the environment.

11. Patients were unable to attract attention.

12. Patients 'admitted to die' received fewer visits and less nursing care than patients admitted initially with a positive prognosis.

13. Doctor-patient interaction time was minimal.

14. Patient-relatives/friend contact time was minimal.

The pattern of care the dying patient received remained consistent from one period of observation to another, and varied little from one patient to another, unless the dying patient was demanding or a 'caring' nurse was present.

The picture was similar in eleven of the thirteen wards. In the remaining two wards slight variations could be detected. In these wards qualified or senior nurses frequently provided care, more interactions were initiated by the nurse and the care given focussed on the patients' needs. The wards were in different hospitals. One was a medical ward and one a surgical ward. In these two units nursing work was organised by 'patient assignment' whereas in the other eleven wards 'job assignment' work organisation was practised.

The minimal nurse-patient interaction time was replicated by the medical staff, whose visits to the patients were also brief. Between senior nurse-patient interaction and the consultant-patient interaction an interesting relationship was detected. If the consultant demonstrated interest in the patient, the senior nurse maintained a watching brief on the patient and was involved in the nursing care. If the senior doctor withdrew from the patient the senior nurse likewise spent little time with the patient. Care was then relegated

to the junior nurse or 'caring' nurse.

The following incidents reflect this doctor-nurse bond:-

a. The clinicians indicated concern for patient C who was dying from a disorder which could not be determined. This was evident as they spent time with this patient and were heard to discuss the dilemma at the nurses station. This patient received attention from the senior nurses, though there was no technical equipment in use which would necessitate this expertise.

b. Intensive medical therapy was initiated in an effort to reverse the hypotensive state of Patient F. The senior registrar, senior house doctor and resident doctor visited the patient's bedside at regular intervals to monitor the progress of the patient and regulate the drugs given. This patient had a third stage student nurse continually in attendance. She was relieved for tea-break by a student of similar grade. The patient was conscious but slightly confused. He was receiving oxygen therapy and intravenous fluids. His condition was monitored by continual electrocardiograph tracings and pulse and blood pressure recordings at fifteen minute intervals.

c. Following surgery the condition of Patient I became critical. The operation was exploratory as palliation of the disease was not possible. This patient was alert. He had a close relationship with the consultant which was apparent by the frequent visits made by the consultant to his bedside. The management of this patient was discussed between the surgeon and the staff nurse who personally attended to the care of the patient.

d. The disturbed mental state of Patient P necessitated skilful medication. The consultant personally gave the initial medication and established a regime of management for

the patient. The control of the patient was maintained by drugs administered by nasogastric and intravenous routes. The sister and staff nurses attended to the administration of medication and spent long periods of time observing the patient.

The bond between the doctor and the senior nurse extended beyond comparable lengths of interaction time. The influence of the consultant infiltrated the nursing care of the patients. Often the senior nurse mimicked the activities of the consultant. She identified with the care, control and communication patterns established by the consultant.

One means of providing relief for the patient is by the use of drugs. The prescription and hence administration of the medicine is controlled by the doctor. Despite the moans of one patient a consultant advised the staff nurse "Better keep off sedation in case anything happens". A 'caring' nurse consistently reported the patient's discomfort to the staff nurse but the staff nurse followed the consultant's instructions, thus indicating the influence the doctor had on one tool available to the nurse to provide comfort for the patient.

In another unit one patient became very distressed. To restrain this patient the consultant prescribed sedation titrated to maintain a state of drowsiness. The nurses copied this pattern of behaviour; they physically restrained the patient by bandaging her hands in a boxing glove manner. This tethering by drugs and bandages was maintained till her death which, though peaceful, prevented communication, verbal or tactile between the patient and her family. The consultant's advice to the team was "You'll have to sock her". His metaphor was performed literally.

In the specialist unit (the "burns" unit) the consultant recommended activity to prevent deformities. All the

patients in the ward were cajoled and jockeyed along. The patient who was dying was cared for in a similar vein. She was lightheartedly encouraged to respond to the nursing care. Priority was given by both doctor and nurse to the healing of the injury which had necessitated her admission to hospital. Little concern was directed towards the needs associated with the process of dying.

A conversation overheard between one patient and a ward sister underlined her affiliation with the consultants care and his control of the patient's comfort. The "doctor's orders" was the cliché she used to explain to the patient why she withheld sedation.

Communication, another essential tool in the nursing care of the dying patient was controlled by the doctor. During conversation with one patient the consultant withheld the truth from the patient regarding her prognosis saying "Don't worry, we will do our best for you, you'll be fine". Later that day sister was overheard saying in similar vein "Now you'll be fine, don't worry". The tactics initiated by the consultant were continued, the patient was given no opportunity to communicate with the doctor or the senior nurse, though to the junior nurses she continued to give cues indicating her distress. This was apparent to the junior nurses who spoke of her awareness when she responded to their suggestion of attention to her hair "Yes, if my hair is permed this time it will be permanent" or again when she answered on receiving a telephone message "Yes thanks, they are just 'phoning to see if I'm still here". This deceptive approach was established by the consultants in their interactions with ten patients. The senior nurses were not disconcerted when they maintained this bluff but the junior nurses were distressed when they deceived the patients.

This relationship between senior nursing and medical staff is

subtle. It can be overt but is often covert. In the second phase, the study focussed on the relationship between the senior medical and nursing staff.

Chapter 7

The Study - Phase 2

The management of the patient demands medical and nursing skills, the input of which should be balanced. The doctor's expertise is directed towards diagnosis, prognosis and treatment of the disease, that of the nurse to care for the person. The goal to be achieved for the patient - recovery or 'a peaceful death' is shared by both professionals. However, it is contended that if this balance in the care of the dying patient is disturbed the care of the patient becomes less than adequate.

It is hypothesised that the balance is disturbed during the management of the dying patient in the acute general hospital because the medical practitioner has a pervasive influence on the activity of the nurse.

i.e. the characteristics of behaviour of the consultant are imprinted on the senior nurse - the senior nurse models her attitude on that of the consultant.

It is further hypothesised that the more the nurse is influenced by the doctor

1. the more the nurse is an adjunct to the doctor.
2. the more communication between the doctor and the nurse is dominated by medical ideology.
3. the less nursing care is provided by the nurse.
4. the less guidance on nursing care is given to the junior nurses.

During this phase the senior medical and nursing staff were observed during their interactions with the dying patient and the communication between these two key figures was monitored.

In particular

1. the attitude of the consultant towards the dying patient.
2. the attitude of the senior nurse towards the dying patient.
3. the content of communication between the consultant and the senior nurse concerning the dying patient

was noted to detect if a relationship did exist between the behaviour of the consultant and that of the senior nurse.

Observations were conducted in the two wards where nursing focussed on the patients i.e. the two wards where patient assignment work organisation was practised and in two wards, where nursing was by task allocation. To control one variable only two hospitals were used. (Table 10)

7.1 The ward round

Most patient consultations and discussions between the senior medical and nursing staff took place during the 'ward rounds'.

The 'ward rounds' are meetings convened when members of the clinical team can exchange information and determine further treatment for the patients. During these group sessions the patients are visited by the consultant accompanied by junior medical staff and the nurse in charge. The junior doctor reports on the details of the clinical history, the findings of the clinical examination and the results from laboratory investigations. The consultant listens to the resume, when necessary examines the patient, then outlines further investigations required and decides on the subsequent management of the patient. The nurse accompanying the doctor acts in a supportive role; she assists the patient during the physical examination and reports on the patient's needs, his progress and his response to treatment. She listens to

and participates in the discussions of the patient's management and notes decisions made concerning the patient's treatment which necessitate a nursing input.

Ninety-one ward rounds were attended. Forty ward rounds in hospital B and fifty-one in hospital C. Forty-four of these ward rounds were in medical areas and forty-seven in surgical area. (Table 42)

The format of the procession was stereotyped. The group commenced at the first bed on the left-hand side of an open Florence Nightingale ward and moved from bed to bed in a clockwise direction. The condition of each patient was considered and the discussion pertaining to that patient closed before the consultant and his retinue moved to the next bed. In units where the patients were nursed in single rooms or four-bedded bays the clinical team moved from one room to the next in an established circuit. This pattern was not altered unless there was a crisis. This was witnessed once when, after the specific incident had passed, the normal format and circuit was resumed at the point where the break had been made. If the senior nurses were interrupted by the junior members of staff seeking guidance on various problems, they rarely disengaged themselves to attend to these requests but gave holding orders, then attended to the task when the visit was completed. The consultants deflected interruptions also. If the senior nurses were interrupted too often the consultants indicated displeasure.

TABLE 42

Ward rounds attended

	Hospital B		Hospital C	
	Ward 7 Surgical Unit	Ward 8 Medical Unit	Ward 10 Medical Unit	Ward 11 Surgical Unit
Number of ward rounds attended	30	10	34	17
Total	40		51	

The sessions commenced at a predetermined time which was built into the ward routine. The precise time was adhered to by most of the consultants in two of the four units observed. In ward 8 of Hospital B it commenced daily at 9.30 a.m. and in ward 11 of Hospital C at 8.30 a.m. If the consultants were not available their place was taken by the next in command. Two of the four consultants in ward 8 did not adhere to the pattern - they entered the ward at random - but "usually in the morning" was the time of their visit identified by the Sister. In the third unit - ward 10 a medical unit of Hospital C - the patients were visited twice weekly by the consultants responsible for their treatments. The Sister was able to identify the morning or afternoon when she anticipated the ward rounds of three of the five consultants but the time of the visits was uncertain. The ward visits of the other two consultants in the unit were erratic, though the senior nurse expected these physicians on specific days frequently they did not keep to the schedule - "They just sort of wander in at any time ... between clinics and private patients," explained Sister. In the absence of a daily

visit by the consultant the registrar reviewed each patient; once a week the resident doctor fulfilled this responsibility. In the fourth unit - ward 7 a surgical unit in Hospital B - there was considerable ambiguity; the Sister eventually detailed the times when one consultant visited his patients and another time when the doctors congregated to do the 'big round', she indicated that the senior doctors had scheduled times for their appearance but they came "when they were able". In this ward they or their registrars visited their appropriate patients daily without establishing the accepted format of 'doing a ward round'. Informal communication occurred sporadically throughout the day in this unit.

The appearance of the consultants in Wards 8, 10 and 11 heralded the commencement of the ward round, the junior medical staff assembled and the group waited for the senior nurse to attend before consultations commenced. The two consultants in ward 8 who had no pre-arranged time for visiting the patients were never seen to invite or wait for a nurse to attend. In ward 7 where a more informal approach to the visits existed, the consultant who held a regular time for his ward round waited for the nurse in charge to join the group, the second consultant stood waiting while the registrar gathered together the other participants, the third consultant sought out and approached the nurse to announce his intentions.

The duration of the consultants' ward visits varied. This was dependent on the number of patients visited, the problems encountered and the decisions to be made, the consultant's particular style and the presence of extra participants, i.e. medical students and postgraduate medical students. Three physicians and one surgeon held lengthy deliverations on the progress and treatment of the patients, their consultations lasted in total 30 minutes to 2 hours, three surgeons and two

physicians reached their decisions more quickly their visits lasted 15 - 30 minutes, one surgeon and four physicians visited briefly, the duration 15 minutes or less.

The senior nurses prepared for the ward rounds. Three of the nine senior nurses (sisters and charge nurses) arranged their work schedule so that they were always free and able to attend, five senior nurses set aside any task in which they were engaged to accompany the doctors, one sister acknowledged the doctor's presence in the ward, accompanied him when it was expedient for her, but at no time was she seen to interrupt her immediate involvement with a patient to be present. The staff nurses when 'acting up' for the Sister/charge nurse always made themselves available and waited for the senior doctor's appearance with anticipation. In preparation the senior nurses in wards 8, 10 and 11 jotted in a notebook specific details which they wished to report and certain facts which they anticipated the doctors might wish to know, a space was allocated in the book to each patient where the nurse documented aspects of the prescribed treatment which required a nursing input.

The number of participants on the ward rounds ranged from 2 to 13. (Table 43)

TABLE 43

Number of persons in attendance during ward rounds

No. of persons attending	No. of Ward Rounds	% of ward rounds
2 - 3	18	19.78%
4 - 5	42	46.1%
6 - 7	20	21.9%
8 - 9	6	6.5%
More than 6 persons	5	5.4%
	91	99.68%

The average number in attendance in the medical ward was 4.08 persons and in the surgical ward 6.02 persons. Integration of the teams during a number of the visits in the surgical unit was reflected in the increase in the number attending. The surgeons were inclined to group together to discuss and exchange ideas on the medical management of each consultant's patients. The physicians did not overlap to advise on the treatment of the patients 'belonging to' the other consultants. Each physician visited his specific patients. 8.8% of the visits (8 times) were made by the consultants and the senior nurses alone, 11% of the visits (10 times) the resident doctor attended also, on the remaining 79.9% of the visits (73 times) other members of the medical, nursing and paramedical staff were present e.g. senior registrars, registrars, postgraduate medical students, medical students, dietitians and pre-registration nursing students.

Most issues pertinent to the nurses' involvement were discussed during the ward rounds conducted by the small intimate group consisting of the consultant, the senior nurse with or without the resident doctor. The objective of the visit was clear notably to discuss each patient's needs and decide on treatment. Communication between the consultant and the senior nurse diminished as the number of participants increased. When more persons were involved the aim of the ward round was blurred by extraneous factors related to those in attendance; if medical students attended the consultant taught the students, if medical colleagues were present discussion on the disease manifestations and possible treatments ensued, past cases were recalled and a general exchange to upgrade and renew theoretical knowledge occurred. The focus of the visit altered from care of the patient to management of the disease.

7.2 Pattern of dying patient consultations

The consultants were responsible for different patients, each of whom had individual and diverse problems, requiring varying degrees of medical therapy. Despite these patient variables the individual consultants demonstrated a standard characteristic approach with regard to:

1. contact with the dying patient
2. the focus on the patient consultations.

Contact with the dying patients

The time spent with the dying patients and the approach to them adopted by the consultants varied.

Time with the patients

The contact time between the consultants and the dying patients was on a continuum ranging from no contact to 6 minutes.

Five consultants conducted protracted consultations during each visit. Time was taken with the dying patients. The average length of their visits to the patients bedside was $3\frac{1}{2}$ minutes. (Table 44)

TABLE 44

Average length of time of consultations with dying patients: analysis by individual consultants

	Average Consultant Time					
	0-30 Secs	31-60 Secs	1-2 Mins	2-3 Mins	3-4 Mins	Not Recorded
Consultants	T:B:K: C	F:G:M	—	W:S	V:D:E	H:L

Example

Patient S lay weakened by disease, her condition had stabilised for a brief period after admission but her decline was occurring gradually. Six visits of one consultant to the bedside of this patient were observed, the average length of these visits was 4½ minutes. Each time he listened to the senior nurse outline her observations of the physical and mental state of the patient. He read the charts which detailed the patient's temperature, pulse, blood pressure and fluid balance and checked on the contents in the urinary drainage apparatus. The consultant completed a physical examination of the patient and spoke compassionately to her during the visit. The changes in the patient's condition and proposed alterations in treatment were discussed at length with the senior nurse and attending junior medical staff. He deliberated on the medication which would be most beneficial to provide relief for the patient and consulted the patient to ascertain whether the pain persisted.

The consultations of seven consultants were very brief, varying in time from no contact to less than 60 seconds. The average length of patient consultations was 0.35 of a second.

Example

Emergency surgery was performed shortly after patient was admitted. Her condition improved slowly and steadily but 26 days later she developed complications which required further surgical intervention. The patient rallied a little after the operation but her condition remained grave. Each day the consultant visited, the first visit lasted 1½ minutes, subsequent visits were of less than 1 minute's duration. On the first post-operative day he asked the nurse for details of the temperature, pulse and blood pressure recordings, the fluid balance and the colostomy output. He examined the patient,

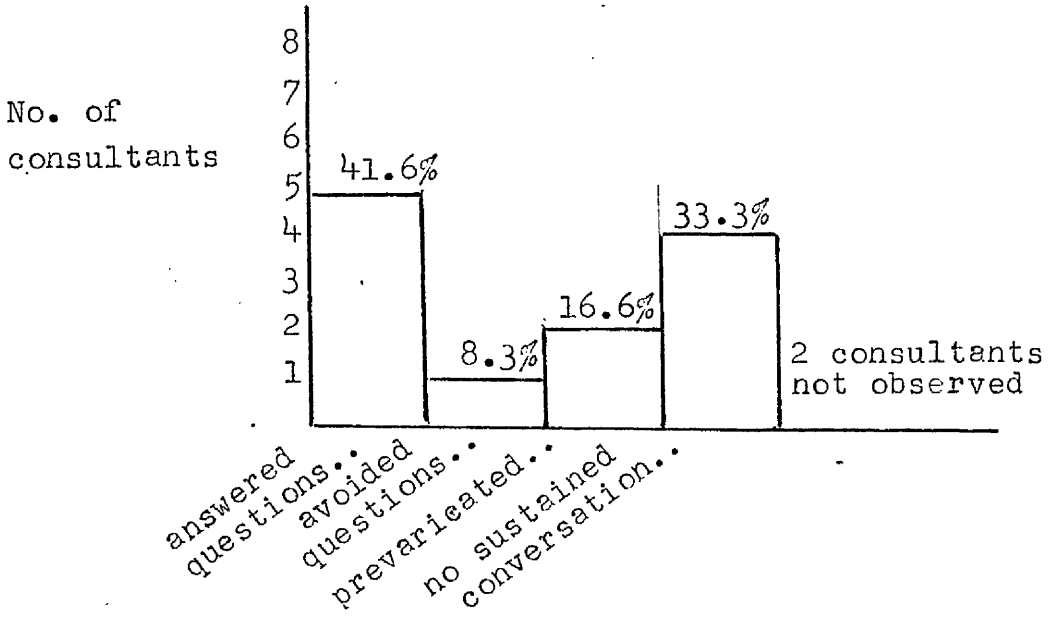
requested a chest X-ray and directed the nurse to collect a specimen of urine and sputum for culture, he reduced the sedation adding "treat it gently here." Each following day the patient's condition was reviewed briefly, the charts outlining the temperature, pulse and blood pressure recordings and fluid balance were read and sometimes instructions on medicine given. Contact with the patient was limited to "Fine?" or "OK!"

Approach to the patient

The consultants differed in their approach and in their dialogue with the patients. (Figure 1)

FIGURE 1

Pattern of communication of consultants



Five consultants (S:V:D:E:G) endeavoured to develop a rapport with all the patients; they took time, made contact with the patients when possible, listened intently, responded to the patient's defined problems and questions, and outlined to the patients the treatment which had been prescribed. Though

physical weakness inhibited prolonged conversations the consultants lingered at the bedside and gave the patients an opportunity to discuss any aspect of care or treatment. During conversation they bent down and tried to make eye contact with the patients. Two consultants sat on the patient's bed and held the patient's hand. On one occasion a consultant was observed mopping the patient's brow. These consultants demonstrated a 'caring' approach similar to the 'caring' nurses in phase 1.

Example 1

Mrs M was alert but drowsy. The consultant sat on the bed to talk with the patient, enquired how she was feeling, listened to her mumbled response, then outlined the treatment prescribed. The patient asked "How am I doing?" "You're a problem. Don't give up, things are not too good but we'll see if the new drug will help. Hold on," he answered quietly.

At another bedside, following a similar approach, another consultant advised the patient "We will do what we can. Try not to worry, if you have any pain please tell us and we will give you something. Just let the nurses nurse you."

Seven consultants (W:T:M:B:F:K:C) during consultations, stood invariably at a distance from the patients, i.e. at the foot of the bed or at the medical case notes trolley. There was minimal or no tactile contact. Conversation with the patients was limited. One of these seven consultants avoided the patients' questions, two consultants prevaricated and four consultants talked to but did not establish a dialogue with the patients.

The consultant (W) who deflected questions spoke to the patients and enquired after their welfare, but as the patients responded he turned away and addressed himself to the other members of the team present. He ignored cues given by the patients which gave

an inclination of the patient's awareness. The avoidance was obvious. The patients were aware of his behaviour.

Example 1

Mr Y had developed metastasis following surgery for gastric carcinoma 16 months previously. He was admitted for investigatory procedures to confirm the recurrence and spread of the malignancy. The life expectancy of the patient was very limited but, though very ill, he was alert. This patient had been in a hospice for a brief period of time but had been able to go home. He was now in the final stages of living. During conversation with the observer he compared the care in the two areas - "They were professional there - don't misunderstand me," he said. "The nurses?" he was asked. "Both the doctors and the nurses." "Can you explain what you mean?" "Well, when they ask you a question here, they don't wait - they don't ask you, they ask the other doctors. No one asks me!"

At the ward round the following day the consultant who was responsible for this patient's treatment entered the room accompanied by the registrar, the resident doctor, two medical students and the nurse in charge.

"How is the pain, staff nurse?" he asked. She reported that she felt that the drug prescribed was effective. The patient disagreed and said that he was awake and conscious of pain but had been lying with his eyes closed. The consultant suggested that to lie with his eyes closed was a good idea and inferred the patient had been sleeping. Mr Y demurred. "Fine!" said the consultant, indicating he was satisfied with the medication he had prescribed. "Did you find out what was causing it?" asked the patient. "It's a puzzle," answered the consultant, "Keep your pecker up, we can give you something for pain. Fine now." Aside, to the doctors in attendance, the consultant spoke of the findings during the endoscopy

examination.

Two days later the consultant, attended by the registrar, junior doctor and the senior nurse, entered the room.

"How are you? What about the pain?" he asked the patient. Involving the patient in the conversation with the other members of the care team, the consultant discussed the patient's ability to eat, his urinary output, his sleep pattern, and the pain still present. He suggested that the patient return to the hospice where he had been previously. "I bid you all a last good-bye!" interjected the patient. No one responded. The consultant instructed the registrar to contact the hospice. Discussion ensued between the doctors on the biopsy report. The consultant then addressed the patient and asked, "Would you like a Guinness?" He refused. "Be a devil!" encouraged the consultant. "I'm too old for that" replied the patient. There was a slight pause, then the patient said again, "I bid you all a last good-bye!" "You're doing fine!" said the consultant, and he left the room followed by the retinue.

Later the observer entered the room where the patient lay alone. "It's good to see you. I'm glad you came in" he said. During conversation, he confided "That's a terminal hospital. You know what I mean by that!"

The following day, at the patient's bedside the consultant discussed the result of the registrar's contact with the hospice. This was not satisfactory. He decided to negotiate for the patient's transfer himself. The consultant told the patient of these endeavours. The nurse was asked about the pain the patient was experiencing. She told of the ineffective results and of the patient's pain. The patient asked "Can I smoke?" (This was forbidden in the ward area of the unit.) "Definitely!" replied the consultant. No further conversation occurred and the group left the patient.

Two days later Mr Y was lying quietly. The day previously he had suffered extensively. Prior to the doctors visit the writer approached him. "How are you?"
"Oh, better today. Yesterday was terrible. I seem to have lost it completely."
"Why?"
"Oh, I don't know, it was terrible."
"But you're better today?"
"Oh yes, it's fine now."
"I see you're for a bath."
"Is that so?"
"Well, the trolley's here. Do you manage to get up?"
"No, that's the problem. It's my leg," he said, pointing to his right leg. "They don't understand! It's sciatica, there's nothing to see, they've X-rayed and there's nothing, but boy do I feel it! It's there alright. I get awful angry - awful angry sometimes. Mr .. coming I see!"
I'm going to ask what they found after the examination. You've got to ask."
"Yes, you ask Mr .. when he is in."
"Well, how are you?" the consultant asked as he entered the room.
"He's fine," said the nurse in attendance, "we increased the Temgesic to 10 mgms three hourly and that helped yesterday, also he's getting MST."

The doctors discussed again negotiations for a bed in the hospice. The consultant turned to the patient and said
"You're fine now?"
"Yes" answered the patient.
"We're just waiting for ..." said the consultant (naming the hospice).
"Yes, I want to see the World Cup," replied the patient.
"Oh!" laughed the group lightly in response, and left the room.

The interactions between the patient and the doctor continued in similar vein during his time in hospital. The patient

gradually weakened physically but he remained mentally alert. He was transferred to the hospice 14 days later. He died two days following his admission there.

The two consultants (T.M) stood briefly at the bedside. The conversations with the patients were controlled; they gave the patients no opportunity to ask any questions. A description of the disease was given to the patient which was convincing but fabricated. The patients could not dare to question what they had been told as to do so would have been to question the authenticity of the story and to doubt the wisdom of the consultant. The consultants spoke with assurance and optimism.

Example 1

Mr D had been told he had multiple ulcers following surgery which revealed an inoperable gastric carcinoma. The consultant, the registrar, the junior doctor and sister entered the room. The registrar opened the dialogue. "Mr D is getting mmm-" he mumbled. "Everything should go here, yes, fine Mr D," said the consultant. He looked at the charts at the foot of the bed. "That's grand. OK!" He patted the patient on the shoulder and left the room, promptly followed by the group. (45 secs)

Example 2

Mrs M was a very distressed patient. She had had surgery for gastric carcinoma 18 months previously and was now in the terminal stage of life. She was thin, very pale, dehydrated and cachexic. Due to abdominal distention, resulting from abdominal metastasis, she had difficulty finding a comfortable position and was breathless. She complained of abdominal pain and was frequently seen to vomit small quantities of fluid. The consultant visited daily during her final period in hospital. At each visit he palpated her abdomen lightly and

inspected the wound site. Part of a suture from surgery 18 months previously protruded slightly from the surface. This he concentrated on at each visit and gave instructions to the nurses in attendance to "cut off that bit of hay". At each visit the format of the consultation was the same: the visit brief, the inspection of the abdomen routine, the presence of the stitch the focal point of conversation. This alert lady was very distressed; during her discomfort she longed for the stitch to be removed to relieve what she was led to understand was the source of her distress.

"I'm just waiting to see Mr .. to see if he can help," she said one day, in her extreme discomfort. "He never comes near; unfortunately when he does come near I can't express myself. I seem to be repeating myself over and over again. I don't know what's wrong. If only I knew!"

When the consultant visited, he inspected the wound, checked the patient's abdomen and said "Fine?" The patient tried to express herself and answered "OK just now, but awful just before." He looked again at her wound, patted her on the shoulder and said "You'll have to eat up and build yourself up," then left the bedside. The patient looked and said no more. She died two days later.

Example 3

The consultant held the patient's hand as he listened to the problem. "Is it cancer I've got?" asked the patient, who had paraplegia due to bony metastasis following a mastectomy operation 14 months previously. "You've got bony changes following your op, but you've done well to date, haven't you?"
"Mmm" she replied.
"Well, fine, we'll give you treatment and tablets."
"It's just I got a fright when the doctor said yesterday "....."
(a radiotherapy unit).
"Fine!" replied the consultant, and he left the bedside.

"Funny how folks get names associated with hospitals. It happens all the time" the consultant remarked as he joined the team.

Four consultants (B:F:K:C) did not converse with the dying patients. After a perfunctory glance and opening question "How are you?", they listened to the response then, without comment, they turned from the patients to communicate with the team members in attendance.

Example 1

Miss G, 54 years old, who lay dying from breast metastasis was semi-conscious. She seemed to have considerable discomfort, as she moaned loudly. This patient was observed by the consultant from the doorway of the ward. He commented to the staff nurse "She's going downhill, the relatives aware of her condition?"
Answer - "Yes, they know."
"When is the niece coming from America?"
"Coming today."
"Better keep off the sedation in case anything happens," he responded, and left the ward. The patient continued in distress. She died 6 hours later.

The length of the patient consultation and the approach of the consultant to the patient was dependent on the consultant rather than the state of awareness or the prognosis of the patient. The five consultants who established contact and a relationship with the patients maintained this approach when treatment was modified and dying was conceded. They also established prolonged contact with the patients who were 'admitted to die'.

Example 1

Each day the condition of patient R was discussed by a member of the senior medical staff and the senior nurse. This was

either by the consultant during his visits or in his absence by the senior registrar. The unconscious patient's physical appearance was considered, the state of her pressure areas, mouth and eyes were reviewed, the signs of deterioration in the patient's condition were noted. The subsequent care was discussed in detail and the determination that no active therapy was valid, was reaffirmed clearly. This activity was observed during the five consultations of this patient.

The other consultants who distanced themselves from the patients withdrew more when active medical therapy was scaled down and death became imminent. On a number of occasions they by-passed the dying patient's bed without comment.

Example 1

The visits of one consultant to the bedside of patient Z were observed on the two consecutive days before she died. This patient's bed was screened off from the view of the other patients. On the first occasion the ward round conducted by the consultant passed the bed. No-one entered the screened off area, neither consultant nor senior nurse commented on the presence of the patient. On the second day the patient's breathing was noisy due to bronchial secretions and could be heard outwith the immediate environment. When the ward round two consultants, two registrars, the resident doctor and the sister) approached the area, one consultant entered the screened off area unaccompanied; he walked half-way up the side of the bed, stood and looked briefly at the unconscious patient then left the secluded area and rejoined his colleagues. No comment was made by the consultant, the senior nurse, or any member of the team. The group moved on to review the patient in the next bed. Patient Z died 24 hours later.

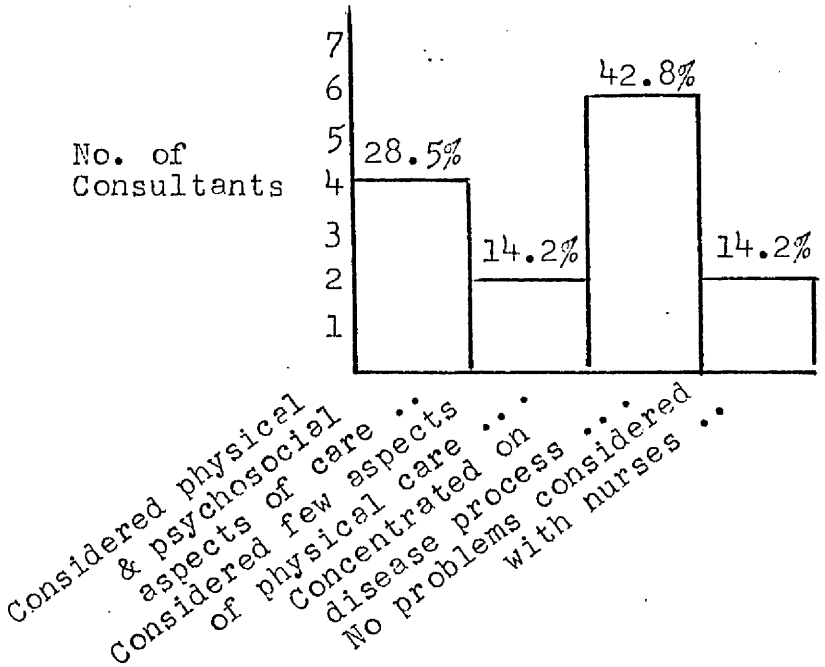
The content of the contact of two consultants (H:L) with the patients was not recorded, as these consultants were not accompanied by a senior nurse during patient consultations.

Focus of patient consultations

The content of the deliberations by the consultant concerning the patients differed, indicating a trend towards care of the "person" or an emphasis on the management of the 'disease'. (Figure 2)

FIGURE 2

Number of consultants: analysis by topics considered during patient consultations attended by senior nurses.



Indices to gauge the orientation of the consultations were:

1. Care of the 'person'
   a. consideration of physical state -
      relief of symptoms
      patient's ability to eat, to drink,
      to move, to pass urine, to defaecate.

b. consideration of emotional state -

relief of symptoms (emotional/ psychological problems)
patients ability to communicate, to perceive his state.

c. consideration of social state -

patients contact with family/friends

2. Management of the 'disease'

a. consideration of the disease and its manifestations

b. consideration of temperature, pulse and blood pressure readings, laboratory reports.

Four consultants (S:V:D:E) had a balanced approach; they gave consideration to the physical and some psychosocial aspects of care. The disease, its development and the treatment was considered and decisions made relative to the quality of life which would be achieved for the patient. Problems which might be encountered during the nursing care were considered. These consultants demonstrated a holistic approach to the care of the dying patient.

The management of the disease and its related symptoms featured principally in the consultations conducted by two consultants (W:G). Few references were made to the care of the 'person'.

Concentration on the disease process to the exclusion of the 'person' of the patient was evident during the consultations conducted by the remaining six consultants (T:M:B:F:K:C). This emphasis persisted after aggressive medical therapy was withdrawn. These consultants looked for and commented on physical signs associated with the progression of the disease, e.g. the increasing distension of the abdomen and evidence of petechiæ due to hepatic failure; the extensive involvement of lymphatic tissue due to carcinoma metastasis. Little attention was given to the physical aspects of care apart

from medication for pain. No reference was made to the patient's psychosocial needs.

The consultants who demonstrated a holistic approach to the patients maintained this attitude until the patients' death; the other consultants who concentrated on the disease indicated less involvement when aggressive medical intervention was withdrawn.

7.3. Pattern of consultant-senior nurse communication

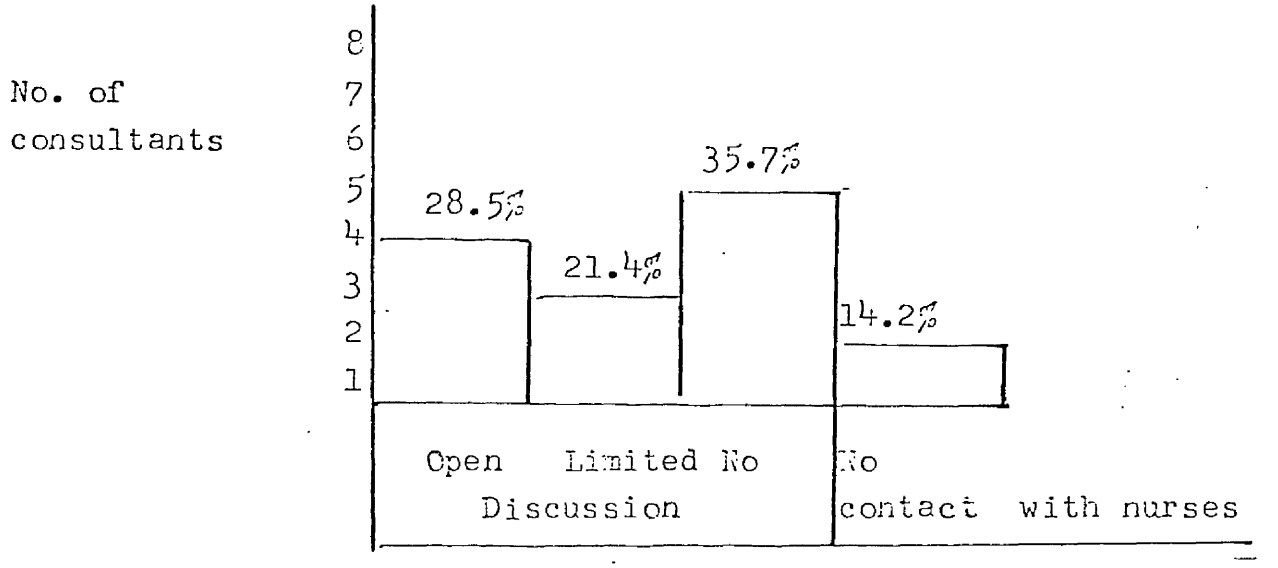
The consultants initiated 98% of the consultant-senior nurse verbal communications and took precedence in the discussions which occurred at the bedside of each patient. The contribution of the senior nurse was varied but was frequently minimal.

In certain teams discussion developed at each bedside during which all caregivers participated. Medical and nursing aspects of the patients' care were considered. The participation of the medical and nursing staff was balanced. In other teams the senior medical staff dominated the scene, discussed disease pathologies and treatments and excluded the nurses from these discussions. Figure 3.

Four consultants (S:V:D:E) spoke to the senior nurses at the bedside of each patient, consulted them regarding the patients' state, listened to their resume of the patients' daily progress or deterioration, noted the findings and asked for elaboration on salient features.

FIGURE 3

Pattern of communication between senior medical and nursing staff



They asked open-ended questions regularly

e.g. "How is Mrs --?"

"Sister what is the saga here?"

"How is she?"

"Any problems here?"

welcomed comments on the senior nurses' assessment of the situation and did not discard any observation as trivial. Decisions on the management of the patients were made in collaboration with the senior nursing staff.

Three consultants (W:G:T) involved the nurses frequently, where appropriate the nurses were asked to detail their observations on the physical manifestations of the disease and the response of the body to treatment. Discussions developed rarely. These consultants were inclined to pose direct questions, the nurses were not asked for their opinions on the patients' progress or encouraged to ask questions irrelevent to the physical components of care. There was no dialogue regarding the subsequent care of the patients.

Four consultants (B:M:K:C) spoke infrequently to the nurses. During episodes when the nurses were involved they were asked direct questions relating to the patients' physical state which merited factual answers, they were not encouraged to give a value judgment on the condition of the patients. No discussion developed. Instructions relating to patient care, when given, were brief and pedantic.

One consultant (F) involved the nurses rarely. Four ward rounds were attended with this consultant, he was observed to speak to the senior nurse once on each occasion. The questions were direct. The answers acknowledged. No discussion ensued.

The senior nurses did not participate during the consultant-patient consultations of two consultants (H:L), the junior medical staff were in attendance. These consultants were not heard asking the senior nurses to contribute before or after the visits. Guidance on the medical treatment initiated filtered back to the senior nurses via the junior doctors.

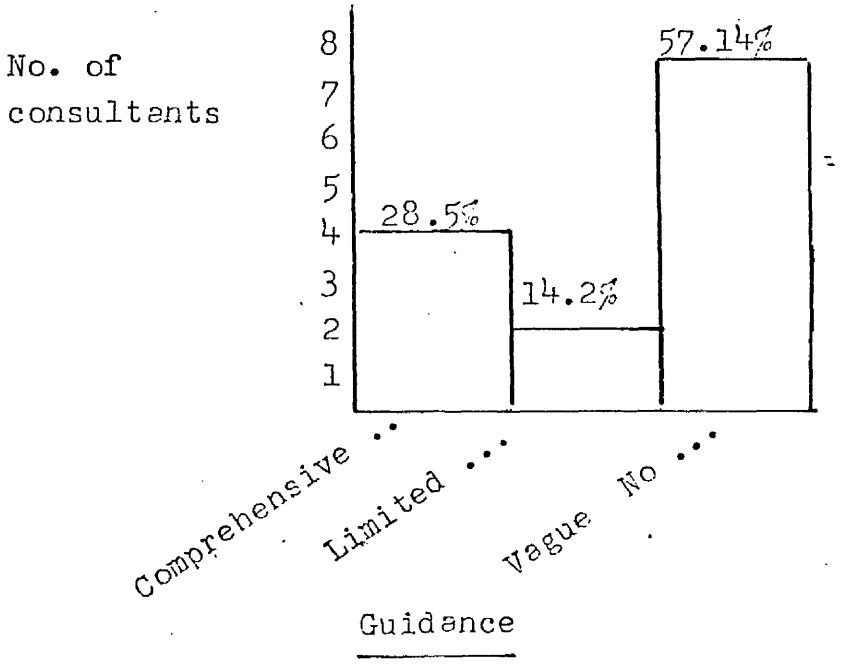
Communication with the nurses took the form of criticism on a few occasions. Four consultants (S:V:D:E) discussed nursing problems with the nurses and offered suggestions but were never heard passing adverse comments on any aspects of care. The other consultants (W:T:B:F:K:C:G:M) censured a few nursing activities. The nurses on all occasions demurred, did not retaliate but jeered later with their nursing colleagues or junior doctors over the unfavourable remarks.

Guidance given to senior nurses

The advice given by the consultants to the senior nurses on the dying patients' welfare and subsequent care varied. (Figure 4)

FIGURE 4

Type of guidance given by consultants to senior nurses



Four consultants (S:V:D:E) outlined a comprehensive policy of care, two consultants (W:G) gave limited guidance and the other consultants gave vague and in some instances no guidance. Often the nurses had to gather the relevant information they required by listening to the discourse between the consultant and the attending medical staff. Hospital jargon punctuated the communication between the consultants and those in attendance during patient consultations.

Aspects of care considered

Guidance on physical care and symptomatic relief was very limited. Directives on psychosocial care were rare and on spiritual care was non-existent.

Four consultants (S:V:D:E) conducted comprehensive consultations, during which consideration was given to physical and a few psychosocial aspects of care. Medical and some nursing problems were looked at and decisions were then made after deliberation and discussion, in collaboration with the senior nurses. Precise guidance was given on the medical treatment required and a policy of care was outlined. The findings and recommendations were documented in the medical case records by three of the consultants. The comprehensive patient centred plan of care was reviewed at the next visit and subsequent problems dealt with. There was no ambiguity, the senior nurses were involved at each bedside and were informed of the line of action to be taken with each patient. These consultants demonstrated a sensitivity to the nursing problems as they listened and gave support. Problems great and small received the same understanding and response. Following these consultations the senior nurses had liberty to plan the nursing care of the patients according to their professional judgment. The prescription for pain relief medication was flexible and gave the nurses licence to administer the appropriate drug at their discretion.

"You'll know best, just give it when she needs it" suggested

one consultant after the senior nurse reported on the distress of one patient. This comment followed an examination of the patient and conversation with the patient and discussion within the team; a number of appropriate remedies were considered before the appropriate medicine was prescribed.

Two consultants (W:G) initiated discussions with the nurses at the bedside of most of the dying patients, but medical aspects of the care of patients dominated the conversation and consideration of the related nursing problems was limited. Following consultations they did not summarise their findings and prescribed treatments, a written record was not made of each consultation. The instructions given to the nurses were often vague and open to interpretation and in the form of cliché, e.g. "Watch her"; "Fine, keep it up"; "Seems no change". When the nurses outlined a problem they listened but their understanding and support were not guaranteed.

Example 1

Patient V persistently turned night into day. This caused distress to both staff and patients. At the bedside when the consultant asked "Well, how is Mrs -," the senior nurse replied "Yes, she's been awake all night and so has everyone else!" The consultant discussed the pros and cons of the various medications with his colleagues, decided to withdraw all medication, then turned to the senior nurse and suggested the patient be moved into a side room. The nurse replied that this was impractical as the patient required constant attention. The consultant listened but said no more; he had made the decision.

The dying patient consultations of six consultants (T:K:C:B:F:M) were brief and perfunctory, lasting less than one minute. If discussions did follow these hasty patient consultations the orientation was towards the disease, its aetiology and manifestations. No policy of care was discussed or outlined. The nurses were rarely invited to contribute; they were

infrequently addressed directly. The majority stood by silently. As the consultant conferred with his medical colleagues the senior nurses listened in order to glean the relevant information on aspects of the management of the patients which necessitated a nursing input. Instructions when given to the nurses were very brief and curt, e.g. "Continue with the IV"; "Watch that mouth!"; "Keep an eye on her output"; "I'll see the relatives". If these consultants were asked by the senior nurses to revise medication prescribed and instigate further therapy for the patients who complained of peristent pain or for those who were confused, they did not accede to the request, they did not seem to appreciate the nurse's dilemma and did not demonstrate a readiness to discuss the reasons for her concern. They permitted no licence but insisted that the nurses abide by their dictates.

Example 1

At Mrs S's bedside the consultant was concerned because the patient was very drowsy. He recommended that all sedation should be withdrawn. "But she's striking out at the nurses" sister replied. "I'd rather she was doing that than under like this," answered the consultant as he deleted the prescription for sedative drugs.

Example 2

At another bedside the senior nurse requested a change of medication which had been prescribed for the patient as "the relief is not adequate." The consultant disagreed, and would not agree to alter the original medication. The nurse conceded but her manner indicated her disagreement.

Sometimes the latter group of consultants (T:K:G:B:F:M) did not enter the presence of the patient during the ward round. This was observed on ten of the ninety-one visits. No comment was made regarding the patient who was dying behind

the screens. On other occasions during the ward round a brief discussion relating to the welfare of the patients took place at the doorway of the side room where the patient lay, at the nurses' station, or at the foot of the patient's bed. The diagnosis of these patients was confirmed; further intervention relating to the specific technical skills of the consultant was not involved. Sedative drugs had been prescribed. The consultant verified with the junior doctors that he had no further role to play then moved on.

On six occasions these consultants did not enter the ward, but in the duty room asked the nurses to "bring them up to date" with the patients. Having been informed of the situation they gave no directives but said "Oh, I'll leave them to your tender care" or "Fine, it's over to you" and left.

The dying patients attended by the two consultants (H:L) who were not heard to communicate with the senior nurses, were highly dependent on both medical and nursing skills. The senior nurses confirmed that there was no contact outwith the observation periods. The information on medical aspects of care came indirectly by the junior medical staff i.e. the registrar or resident doctor.

The fragmentation, lack of discussion, and no definition of policy of care within ten of the fourteen teams, led to confusion in the management of the dying patient. Incidents were observed which were a result of disjointed communication.

Example 1

The disease of one patient was investigated relentlessly by one senior registrar. At the ward round the consultant looked at the patient then decided "She's had a fair crack of the whip. I think we should just keep her comfortable". The senior nurse listened without comment. No record was made in the patient's case notes. The following day at 2.15 p.m. a porter came to the ward with a trolley to take

the dying patient to an ambulance which was waiting to transport the patient to another hospital for further investigation. The nurse in charge conferred with her colleagues, decided that the test which had been arranged two weeks previously was now unwarranted, and since the patient was dying was unnecessary. She contacted the senior registrar for confirmation. He disagreed and insisted the investigation should proceed as he wanted "to know what was up". Though the nurses dissented strongly he insisted. They prepared the patient and under escort she left the ward. She returned four hours later. During her absence a friend came to visit. The following day the senior registrar was responsible for the ward round. At the door of the patient's room he asked aggressively "Did she have her EEG?" "Yes," answered the staff nurse. "We've done everything here. Take her off everything" he answered and moved on to the next patient. The patient died 36 hours later.

Example 1

The patient, a 78 year old lady, was conscious but very weak and exhausted. Surgery and medication had failed to reverse her decline. She was physically unable to hold a cup. Signs of cardiac embarrassment were evident. At the ward round the consultant observed the patient's appearance, then decided her state was due to over-infusion. Instructions were given to the junior doctor to "give her Frusemide, to bring her up" and the senior nurse was directed to "watch the infusion!" Inferences were made as the consultant discussed the patient's state with his colleagues: that the condition was due to the nurses' carelessness with the infusion. On the following day the patient's condition had deteriorated markedly. At the patient's bedside the consultant asked the senior nurse for details of the fluids given. After listening to her reply and to her description of leakage from the wound site, he replied sharply "That's not her problem!"

Again, in conversation with his colleagues, he decided over-infusion was the causative factor. The junior doctor was instructed to repeat the diurectic and the senior nurse told "She needs stimulating." No further guidance was given. After the ward round the senior nurse directed the junior nurses to "get Miss - up!" Following these instructions the patient was placed in a chair by her bedside for half an hour. The patient died 9 hours later. At the ward round the next day the consultant remarked as he passed the empty bed, "There's a patient in the mortuary just now who should be in that bed!"

The consultants (S:V:D:E) who indicated involvement with the dying patients held detailed deliberations on patient care with the senior nurses, gave precise instructions, and suggested appropriate measures to provide comfort for the patients. The other consultants whose approach to the dying patient was casual, brief or not at all, gave minimal or no guidance. There was no collaboration with the senior nurses. Directives given were curt and open to interpretation. During consultations the senior nurses listened to the conversations between the medical staff. They were left to draw their own conclusions.

Guidance on the dying state of the patient

Diagnosis of the patient's state is the doctor's responsibility. The fact that the patient was dying was rarely stated. Innuendoes indicating the senior medical staff anticipated an unfavourable outcome were the norm. This is shown in Table 45.

TABLE 45

Number of patients: analysis by reference made on the dying state during senior medical/nursing communications

Reference to dying state	No. of Patients	Percentage
Dying state identified	4	14.8%
Dying state inferred	19	70.3%
No reference made to the dying state	4	14.8%
TOTAL	27	99.63%

The state of four patients was identified by the term "dying" or "to die". There was no ambiguity; during communication the prognosis of the patient was stated and the judgement accepted without discussion by the listeners.

Example 1

"I think his liver is catching up with him, he's going to die," stated one consultant who spoke directly with regard to the prognosis of patient N.

Example 2

Fourteen days before patient P died the consultant remarked to sister "She was expected to die five days ago, she's still there?" This patient lay deeply comatosed day after day. The senior medical and nursing staff commented with incredulity on her survival.

"She has held on for so long."
"There is nothing more we can do. It's a puzzle."
"Draw the screens, not a pleasant sight."
"Don't know what to say, she shouldn't have survived this long."

The innuendoes implied not only that this patient's death was expected but that she had lived past the anticipated time of death.

Example 3

Four days before patient C died following a 4 week period of hospitalisation, sister said to the consultant "Mrs - is going to die. Biochemistry is alright but she's unable to move. I think she'll just slip away."

Example 4

Patient I, a 46 years old gentleman, lay propped up in bed opposite the nurses station in the centre of an open Florence Nightingale ward. His gaunt moribund appearance portrayed 'death'. He was emaciated and dehydrated. His eyes were sunk deeply in the sockets and he lay with his mouth half-open. The patient had alopecia as a result of chemotherapy for bronchial carcinoma. Though very ill the patient was conscious. When the ward round reached the bedside the consultant remonstrated "Screen off the bed, he should be in a cubicle." He walked half-way up the side of the bed to have a closer look. After a brief glance, and without verbal or tactile contact with the patient, he returned to the retinue and said angrily, "He should not be in the centre of the ward so that other people can see him. He's dying, definitely in a corner of the ward, not lying there for everyone to see him. How would you like to come in off the street and lie looking at that?" No further discussion ensued and the group moved to the next patient. The angry outburst and verbal confirmation of the patient's dying state ended the conversation. The patient died 17 hours later.

Euphemisms were used to describe the state of nineteen patients. The word 'death' and its derivatives were not heard during discourse concerning these patients.

Example 1

Two days before patient Y died the consultant said to sister "She's deteriorating, she's thrown in the towel."

Example 2

On the day of patient Z's death the consultant commented "I think she's on her way out."

Example 3

"She's on her way out," remarked the consultant to sister two days before patient D died. Then on the intervening day he remarked "She's still just hanging on."

Example 4

When the unconscious state of patient A deepened on the day of her death, the consultant stated "I think she's having a brain stem haemorrhage - that's it!"

Example 5

Five days before patient B died the sister commented to the consultant "I think she's moving into the terminal stage."

Example 6

Four days before the death of patient E the consultant commented "She's at the end of the day." Next day he remarked "Don't think she's going to make it." The following day he exclaimed "My, she's done - she's not much reserve." On the day of her death, sister said "I doubt if she'll make the day out."

- "He's deteriorating."
- "He's not responding."

- "He's going down."
- "He's finished. We won't be doing anything here."
- "If the drip tissues don't re-site it."
- "I suppose she's had 11 months which isn't too bad."
- "It's finished, hepatic failure and subarachnoid haemorrhage."
- "Remove the IV infusion if it stops and commence on Morphine and Brompton's,"

were ominous comments heard at the bedside of the patients intimating the expected outcome.

Further cues which implied that the deaths of patients were anticipated included:

1. the prospects of the patient's discharge home were no longer discussed.
2. mobility of the patient was not encouraged.
3. medication prescriptions were changed and the use of narcotics increased.
4. medical treatment was not initiated when the failing responses of the patient and change in the temperature, pulse and blood pressure recordings indicated a deterioration in the physical state of the patient had occurred.
5. the consultants ascertained the relatives had been or would be interviewed.

The changes in the management of the patient were made, no reason was given, no comment was passed by the consultant or senior nurse. In the absence of a direct statement or euphemism identifying the dying state of the patient, the senior nurse was dependent on these cues to elicit the senior medical staff's perception of the state of the patient.

All the deaths of the patients evoked no surprise from the senior medical and nursing staff. On the ward round following a death, the consultants asked sometimes, when the group passed an empty bed or room, "He/she died?" An affirmative

answer was given and the time of death stated. The situation was accepted and no further discourse developed unless a post mortem examination was required. In such cases the consultant received a report from the junior doctor on the response of the relatives to the request. At times no mention was made of a death if the bed space was already occupied by another patient. This apparent acceptance of the deaths of these patients suggested that the deaths had been anticipated. The death of patient X_2 (the one patient who did not die as anticipated by the observer) had been expected by the consultants and the senior nurses as when the condition of this patient improved one consultant remarked to his colleague, "I thought she'd snuff it last night. You'd better give me a loan of your fairy wand!"

Guidance on communication with the patient

The responsibility for determining the information a patient should be given concerning his/her condition and prognosis is regarded by the medical and nursing professions as the doctor's prerogative.

Information which had been divulged to the patients by the consultants was not revealed to the senior nurses. The senior nurses did not volunteer data on the conversations either they or the junior nurses had had with the patients, the consultants did not ask.

Cursory consideration was given to the tactics of communication to be adopted during the care of one patient. No detail was outlined only the trend of the pattern of communication with the patient was considered.

Example 1

Before entering the room where patient V lay, the sister said to one consultant, (V) "Listen, we'll have to do something about Mrs -. Nobody has said anything to her,

she must wonder, maybe if she was told she had inflammation of the lungs or something." "But she's been told that" he replied. "Oh well, something will have to be done." "The GP doesn't want her home" commented the consultant. "She wants home." sister continued. The consultant approached the patient and asked "How are you?" "Fine, but it's this chest," she replied. Slowly and kindly as he touched her shoulder he said "I'll see your husband. I'll have a word with him, we'll need to think about you going home." "Fine!" she replied. "It's your breathing that's the problem?" he asked. "Yes," she answered. He withdrew from the bedside.

The topic was alluded to during the consultations of another two patients.

Example 1

"Do you think she knows?" asked the consultant.

"She must" replied the senior nurse.

Example 2

After leaving the bedside of a patient another consultant commented

"I think he knows".

"Mmmm---" replied the senior nurse.

During all other senior medical and nursing staff contacts the subject was not raised. The senior nurses listened in silence if the consultants conversed with the patients.

Guidance on communication with the relatives

Twenty-six of the patients were members of individual family groups. Ten of the fourteen male patients were husbands, six of these patients were fathers also. Three patients were widowers; they were visited by their sons and daughters.

One unmarried male patient had a brother and sister in attendance. Seven of the thirteen female patients were both wife and mother in their respective family units. Two patients were widows, their families visited. Three of the female patients were unwed, their siblings visited. One lady had no family, she was attended by neighbours and friends. (Table 46)

Part of the routine procedure when a patient is admitted into hospital involves an interview between the junior doctor and the relatives. The junior doctor had spoken to a member of each family, but the content of this interaction was not outlined in the medical case notes. The senior nurses knew that the relatives had been interviewed. Their customary response when asked by the observer for details of these preliminary interviews was "Yes, they've been seen," they could not elaborate on what had been said. Apart from these initial meetings the relatives of fourteen of the patients spoke to the consultants, another four groups of relatives to the senior registrar; the families of theother patients had contact with the junior medical staff alone.

All the consultants asked if the relatives had been "seen". Ten of the consultants (T:G:M:W:S:V:D:E:H:L) met members of the families; the other four consultants (B:F:K:C) delegated the task to the more junior members of the medical staff. One consultant, who personally interviewed relatives, declined to meet the next of kin of patient X_2 since they were not blood relations, he indicated it was not essential for him to communicate with them.

The consultants intimated when it was expedient for them to meet the relatives, the senior nurses made the necessary arrangements. On two occasions when the sister arranged for relatives to come to the ward to meet the consultants without prior discussion, the doctors were willing to comply with the arrangements and gave instructions that they should be called whenever they attended.

TABLE 46

Relatives of patient, grade of doctor by whom interviewed opportunity given to be with the patient, if present at the time of death, expressed feelings afterwards

ent	Relatives available	Interviewed by Grade-doctor	Privilege granted	Present at death	Expressed feelings afterwards
	Wife	Consultant	Visit any time	No	Upset - understood death sudden
	Wife	Consultant	-		
	Family	Consultant	Visit any time	Yes	
	Husband & family	Resident	-	Yes	Upset - called to bedside by police
	Son	Resident	-		
	Wife & family	Consultant	Visit any time	No	
	Husband & family	Resident	-	No	Upset - not aware of imminent death
	Husband & family	Consultant	Visit any time	Yes	
	Wife & family	Resident		No	Upset as not present
	Sister, brother	Resident	Visit any time	Yes	
	Wife	Consultant	-	No	Upset as not present
	Wife	Resident	-	No	Upset as not present
	Wife	Consultant	Visit any time	Yes	
	Family	Senior registrar	-	No	Upset did not want patient admitted
	Wife & family	Resident	-		
	Wife & family	Resident	-	No	Upset as not present
	Wife & family	Senior registrar	-	No	
	Sister	Consultant	Visit any time	No	
	Husband & family	Consultant	Visit any time	No	Upset as not present
	Family	Registrar	Visit any time	No	
	Sister	Registrar	Visit any time	Yes	
	Husband & family	Consultant	Visit any time	No	Upset, did not understand
	Husband & family	Consultant	Visit any time	Yes	
	Family	Consultant	Visit any time	No	Upset not present
	Sister, Mother	Consultant	Visit any time	No	Upset as not present
	Husband & Family	Consultant	Visit any time	No	Upset, not aware of imminent death
	Friend	Resident	Visit any time	-	

The senior nurses were not present during the interviews. The doctors did not outline what had been said to the family. The content of the communication was encapsulated by the briefest sentence, "I've seen Mrs -"; "I've spoken to them." No indication was given of the response or reaction of the relatives. The interview was not documented in the medical case notes.

Seven interviews between the consultants and the relatives occurred during the observation periods.

Example 1

Following a visit of the consultant, the registrar, the junior doctor and the sister to the bedside of Mr D-, sister said to the consultant "I've spoken to Mrs D- last night, she was terribly upset and blanched, she just bolted from the room." - "Does she know it's tumour?" asked the consultant - "Yes" - "OK, I'll see her" - "She's coming up today at 10.30a.m. There's just the two of them. No family." - "Fine, just bleep me" replied the consultant. At the appointed time the patient's wife accompanied by her niece and the niece's husband came to the ward. The consultant came to the ward immediately he was contacted. The relatives were interviewed by him alone in the doctor's room. The interview lasted five minutes. Two days later the consultant reported to the sister on this consultation with the relatives. "They seem to have accepted it now," he said. No further discussion developed between the senior medical and nursing staff. Both accepted that this responsibility to the relatives was discharged.

Example 2

The relatives of Mr W- (his wife and teenage daughter) sat in the corridor as the consultant and the retinue of six in attendance progressed from room to room to visit the patients. After a discussion at the bedside of Mr W- the ward round proceeded to the next room. The consultant left the group

and approached the relatives. He spoke to them in the corridor for three minutes. They left the ward. The consultant re-joined the ward round. He did not report on this interview to the nurse in attendance.

Example 3

The relatives of Mrs S- were in attendance continually. When the group of doctors approached the patient, the four family members left the bedside and sat in the corridor. After deliberating on the deterioration in the patient's condition and subsequent treatment to be initiated, the doctors left the room. The consultant approached the relatives, talked to them in the corridor for four minutes then he re-joined the ward round. No details of this contact with the relatives were given to the senior nurses.

Examples 4 and 5

The brother and sister of one patient and the son and husband of another patient met the consultant responsible for care. At the appointed time the relatives sat outside the consultant's room, they were escorted in by the secretary. No reference was made to these meetings during any of the consultant/senior nurse communications.

Example 6

Mr R- on admission was known to be a critically ill man. His condition deteriorated suddenly due to severe haemorrhaging from oesophageal varices and two days after his admission death became inevitable as medical intervention could not retrieve the situation. It was recorded in the medical care notes - "I would suggest continuing conservative treatment and comfort control. At present surgery will be awkward if required." The patient looked gaunt and had a slightly icteric, sallow appearance. His extremities were

cyanosed and cold to touch, his breathing was sterterous, he groaned occasionally, his mouth was open and his eyes half-closed. The patient had lapsed into unconsciousness. The characteristic smell from haemetemesis and melaena pervaded the atmosphere.

Extract from data (17)

10.15 am The patient's wife and brother appeared at the ward doorway. No nurse was at hand. The maid reported their presence to the nurse in charge, who indicated they could enter. The patient's bed was screened.

10.30 am The consultant entered the ward and approached the bedside. He spoke to the relatives, then without communicating with the nurses he left the ward. (2 mins)

11.00 am The junior doctor went behind the screens for a brief period. (10 secs)

11.15 am The consultant returned with the registrar. Together they approached the bed area, but on noticing the relatives were in attendance, they withdrew and left the ward. No contact with the nurses.

11.30 am The patient's general practitioner visited. He stayed with the relatives by the bedside for 5 minutes.

11.40 am The respirations of the patient became very moist. "Who is that?" the senior nurse asked. "Mr M-" replied the nursing auxiliary. The nursing auxiliary went to check Mr M- and learned it was not this patient, but the patient who was dying. She returned and said to the senior nurse, "No, it's Mr R-". The senior nurse approached

the junior doctor who was at the nurses station. Following discussion the doctor drew up IV medication. This he gave to the patient. No contact with the relatives. The nurse did not attend. (20 secs)

11.45 am The patient's wife looked out from the screens then she returned to the patient's side. The gasps of her husband were heard in the ward. His wife again appeared from behind the screens. She looked at a junior nurse as she passed. The nurse returned her gaze but did not stop to speak to her. She looked at the other nurses as they passed by; they did not stop or move to her aid. She returned to her husband's side.

12.15 pm The consultant visited the patient alone. He was heard speaking to the relatives. He stayed one minute. He then spoke to the junior doctor who was in the ward and instructed him on further medication for the patient, which had to be given when the relatives left the bedside. No contact with the nurses.

12.35 pm The relatives left the bedside. At this point the junior doctor was not present.

12.40 pm The breathing again became noisy. The senior nurse popped in behind the screens (5 secs). She left the bedside and approached a second junior doctor - (not the one who had received instructions from the consultant.) He decided on medication and gave this to the patient. No nurse attended.

12.45 pm The relatives re-entered the ward and went to the patient's side. No contact was made with a nurse or doctor.

1.10 pm The patient's wife left the bedside and approached the sister who was standing at the nurses station and asked her to attend to her husband. The senior

nurse responded. She left the bedside 30 seconds later and said to the staff nurse, "I've told her, he's just about away." The relatives were left alone.

1.20 pm Mrs R- came urgently from behind the screens. The staff nurse approached her and accompanied her to the patient's side. The staff nurse left again 10 seconds later and telephoned the junior doctor. The relatives remained by the bedside.

1.25 pm The staff nurse returned to the relatives and escorted them to the doctor's room. Tea was provided by the nursing auxiliary.

1.30 pm The resident doctor certified the patient was dead.

1.40 pm The doctor spoke to the relatives. They were asked to wait in the room as the consultant, on being notified of the patient's death, had expressed a desire to see them.

This patient and his relatives were visited by the senior nurse and consultant separately on two brief occasions during the period recorded; at no time were the senior medical and nursing staff seen conferring together.

Example 7

The husband of Mrs F- sat by her bedside for long periods. When the consultant and the retinue approached he left to sit in the corridor. This happened on two consecutive days. Each time, after reviewing the patient's state the consultant went out of the ward and spoke to Mr F-. The sister did not accompany him on either occasion, but later he discussed the gist of his conversation and the husband's reaction with her. This behaviour of consultant V differed significantly from that of the other consultants. No other consultant was heard giving an account of his conversation with the relatives.

The senior nurses, when asked if they had ever been present when the relatives were interviewed, answered "No." To emphasise the situation a contrast was drawn by the nurses in one area, as they recalled a recent incident. "Oh, but you should have been here a few weeks ago, communication was really good then, we were in on everything, we had to witness all that was said to the relatives, because they were going to sue!"

One consultant was asked by the observer if he would prefer a senior nurse in the room when he spoke to relatives. He replied, "No, I wouldn't want a nurse present as they would be shocked at the things said. I often prefer to give them the worst side of the picture first and then subsequently see how they react, in each case it's different."

The consultants and senior nurses did not talk directly to one another about what had been said to the relatives (consultant V and sister B excepted). The relatives' understanding was not gauged nor their reaction to information considered. Their desire to be with their loved ones in the final hours was not assessed or arrangements made for them to be there. The interaction between the consultant and the senior nurse concerning the relatives was straightforward. The nurses arranged for the relatives 'to be seen', the consultants indicated that they 'had been seen'. The details of what had transpired during these meetings were not divulged by the consultants, the senior nurses did not ask.

Twenty-three patients died within the observation time. The relatives of 16 of these patients had been permitted to visit at any time. Relatives were present at the deaths of 7 patients. Twelve families were distressed because they had not been present at the time of death.

Guidance on resuscitation

Guidance was given by the consultants to the senior nurses

on the action to be taken at the moment of the apparent death of two patients; the course to be pursued regarding the remaining 25 patients was not defined.

There was no ambiguity on the management of the two patients, the consultants clearly indicated the measures to be adopted. One consultant had given instructions that the patient for whom he was responsible was to be resuscitated, the other consultant indicated clearly that no further intervention was to be commenced for the patient in his care.

Example 1

Consultant (L) insisted that patient K was to be resuscitated. No discourse between medical and nursing staff preceded the decision. The directive was not recorded in the medical case notes or the nursing kardex but was received and transmitted orally. This patient's heart had arrested twice, on both occasions he had responded to resuscitation therapy. He lay unable to communicate though the senior nurse felt he focussed on her when she talked to him. He was unable to move any voluntary muscle though at times his body moved involuntarily during spasmodic fits. He was completely dependent on the nurses. The medical management of this patient distressed the nurses.

"Dr - won't let them die; he won't give up; he won't discuss it; all his team are the same; there is no quality of life left; it's terrible" were the comments from the sister as she spoke of her concern for the patient whom she had nursed since his admission six months previously.

The senior nurses resented the decision but since this consultant (consultant L) visited the patient unaccompanied and rarely spoke to the nurses there was no discussion. A fellow colleague of this consultant remarked to the senior nurse as he passed the bed, "That's a corpse lying there." Sister desired the support of the other consultants in her

dilemma but it was apparent that though they had empathy with her in the controversy, the medical fraternity ranks closed in the dispute. It was expected that this patient would linger for a number of weeks sustained by nursing care and medical intervention. This did not happen. The patient was found dead at 1.05 a.m. two days later. Relief was expressed by all the nurses. During discussion they implied that they were pleased death had occurred at a time which outwitted the consultant. When it was known that a post mortem was requested, one senior nurse was heard to comment, "Going for a PM! Oh for ...'s sake, they're not even letting him rest yet!"

Example 2

"We've made our decision and we're sticking to it," confirmed one consultant (consultant S) after a prolonged discussion with the senior nurse on the care of patient X_2. This unconscious 87 year old lady who lay day after day, baffled the caregivers with her resilience and ability to 'hold on'. Each day the consultant reaffirmed and discussed the decision with the senior nurses. There was no ambiguity, nursing care was to be maintained but no resuscitative efforts were to be initiated. The senior medical and nursing staff reassured each other on the decision taken unanimously. Both professionals expressed relief when the autopsy report proved 'nothing could have been done'.

No direction or guidance to either initiate or withhold aggressive intervention was outlined by the consultants for the other 25 patients. Positive or negative action was implied in the management of the patients, the senior nurses had to deduce from these premises the activity expected.

Active medical intervention therapy had been withdrawn from the programme of care for 9 patients, it remained constant in management of 12 patients, was intensified for 3 patients and fluctuated between withdrawal and intensification for one

patient. These tactics were not discussed with the senior nurses. They were left to interpret the situation.

Example 1

At the bedside of patient Y, the consultant considered whether to intervene surgically or not, then said "Let's play it gently and see if we can resuscitate." He was not heard to clarify whether this statement referred to his proposed surgical operation or to other action which should be taken if the patient collapsed.

Example 2

Active intervention was implied when the consultant suggested for patient Z, "She may have to be ventilated." Again he did not state that active resuscitation was to be initiated if a crisis arose. This patient deteriorated. A chance visit of a second consultant to the ward in the evening provided an opportunity for the senior nurse to express to him her concern for this patient, as her overtures to the resident doctor on behalf of the patient had gone unheeded. The sister had extracted one meaning from the consultant's statement and the doctor another. Following consultation the patient was removed to the intensive care unit where, when she arrested 3 hours later, active resuscitation was initiated.

Nurses socialised to understand hospital jargon may be expected by the consultants to comprehend the verbal cues and understand the line of action. This supposition was confuted in the management of patient G.

Example 1

Patient G was an alert 85 year old lady who, on admission, looked pale, wasted and cachexic. Consultant G decided

surgical intervention would relieve her abdominal discomfort; this he intended to do 5 days later. On the day before the scheduled operation the patient's condition deteriorated, emergency surgery was undertaken by consultant M in the absence of consultant G. On the first post-operative day the patient lay pale and still, she was wrapped in a 'space blanket': intravenous infusion, nasogastric tube, urinary catheter and wound drainage were in situ. At the ward round consultant M looked at the patient, checked the recordings of the temperature, pulse and blood pressure and fluid balance, checked the patient's abdomen and wound drain, spoke to the patient and said to the senior nurse. "Alright?" She replied "Yes." "Just keep an eye on her," he recommended. On the second post-operative day the patient appeared less well. The nursing observations recorded indicated a deterioration, the patient was very distressed by pain when she moved. At the ward visit the two consultants examined the patient, looked at the nursing records and discussed the reason for the deterioration. Consultant M instructed the resident doctor on the infusion fluids which should be given and the sedation which should be prescribed. No direct discussion with the senior nurse. In the evening a marked deterioration in the patient's condition occurred, a haematoma developed in her loin and the wound drains filled with blood. Haematuria was present. Consultant M was contacted. He recommended ".... give her blood and plasma to tide her over." At the morning visit on the following day consultant M looked at the patient who was lying in a semi-conscious state and said, "I've been thinking about this. It must be from that area around her kidney. It's an aneurysm I think. I'm not going to do anything." Addressing himself to the resident doctor he said, "Treat it conservatively." No directions given to the nurse. The patient lapsed into unconsciousness in the afternoon. The following day she was conscious, was complaining of severe loin pain and was passing melaena stools. Consultant G visited. After examining the patient and reading the nursing observation charts, he discussed the

general state of the patient with his medical colleagues and advised on the care of the wound drainage, the wound dressing, outlined on intra-venous fluids and suggested the sedation prescribed be continued. This introduction of aggressive medical intervention contrasted with consultant M's instructions the day previously; this was not discussed. The patient's distress increased, she passed numerous copious melaena stools. The following morning she was rigid with pain. Consultant M attended at 9 a.m. "How is she?" he asked as he raised his eyebrows. "Her output has fallen, it's only 60 mls since midnight," the nurse answered. "Give her a bolus of mannitol and plasma. Is she on a urinometer?" "No." "Commence one then, this should be done when the output is low." "There's blood coming up the nasogastric tube and she's passing blood," the senior nurse answered. "I don't know what's on here," concluded the consultant. No more was said. At 9.30 a.m. consultant G approached the bed. He looked at the patient and examined the oedematous areas. The resident doctor reported that consultant M had recommended that the patient be given mannitol. "I think it's frusemide which you need here," he suggested. He prescribed further medication, instructed the resident to obtain salt free albumen plasma with a view to replacing the blood deficit and added ..."see how things go."

For the next few hours the patient lay alert but in dire distress. The pain and incontinence of melaena persisted, the analgesia was ineffective. At 11.30 a.m. the senior nurse asked the locum medical student to administer the frusemide. After giving the injection he asked the nurse "Is she having pain?" The nurse answered in the affirmative and outlined the distress of the patient due to the continuance of melaena. He recommended that hourly recordings of pulse and blood pressure be commenced. He contacted the registrar and received the message that the patient should be given Diamorphine 10 mgms four hourly and that 'no more was to be done'. This he relayed to the senior nurse.

At 12.25 p.m. consultant M entered the duty room and said to the staff nurse, "Mrs -- not so well at the moment?" "No," replied the nurse. "Call it a day" he responded. "Mr -- (medical student) 'phoned the registrar," the nurse explained. "Yes, I was there when he spoke to --. There's not much we can do. That's it!" He left the ward. Staff nurse reported to the sister at 1.30 p.m."..... just to leave her, keep her comfortable, well sedated. I haven't seen Mr - (consultant G) yet so I don't think he knows." After attending the patient, sister conferred with the senior registrar, the medical student and the staff nurse and asked why the recordings were being done as she felt it was unfair to interrupt when the patient's next of kin were in attendance. Staff nurse outlined her quandary saying that consultant M had wanted the urinometer recordings, consultant G the plasma, then the medical student was instructed to give the Diamorphine. "Why don't they spell it out," said the sister. "I suspect .. (consultant M) and .. (consultant G) have discussed it together and came to this conclusion," suggested the registrar. "They should tell us," retorted the sister and staff nurse.

The group discussed how essential it was that a definite line of action should be adopted - "not a half measure approach if they are to do something, it should be an endoscopy, transfusion and surgery if needed, if not, relief should be given." The sister complained of the lack of guidance.

Sister gave the Diamorphine, reduced the recordings and instructed the nurses to attend to the patient two hourly

Later she outlined to the observer that she was aware that she was not involved in decisions made and how she felt at odds with the aggressive medical therapy which was initiated sometimes. "This is just another prime example of science overtaking common sense." The lack of collaboration of the two consultants in making decisions also presented problems. "This is where it is difficult in this ward. If one is there he sees the patient then it's fine, but if the other

gets involved decisions are made and we don't know what to do. If I'd been on this morning it would have been different." When asked what she would have done, she replied, "I would have found out what they really wanted to do. A lot depends on who's on duty."

The senior registrar conducted the ward round the following morning. The team conferred together and agreed the drug Diamorphine should be administered regularly at 3 hourly intervals. The registrar decided "Give cemetidine, intravenous fluids and keep her comfortable." The resident doctor asked "What good will that do, to give cemetidine?" "Have you ever seen anyone die with this? It's a terrible way to die, vomiting blood." - "So you're using it prophylactically?" asked the resident.
"Yes," replied the registrar. Later that day consultant G visited. The patient was settled and very drowsy. He decided to commence nasogastric feeding and indicated his intention of asking the specialist feeding team to assist. There was no discussion with the senior nurse. Later she remarked, "I don't know what they are doing here."

During the crisis period consultant G prescribed aggressive therapy, consultant M scaled down the treatment and prescribed sedation. No directives were given, the senior nurse was left with the dilemma of deciding on which move to make if and when a crisis occurred.

The nurses sought guidance on resuscitation tactics for three patients from more junior medical staff. Twice the registrars advised the nurses on the tactics to be adopted, once a resident doctor advised the nurses.

Example 1

Active medical intervention was commenced when the condition of patient E deteriorated unexpectedly after surgery. The

patient did not show the expected response to therapy. The senior nurse asked the doctor during the ward visit for guidance on the line of action which had to be taken if the patient had a cardiac arrest. The answer was clear - "Do not resuscitate." The doctor responsible for the visit was a registrar.

Example 2

Patient Q was an 89 year old gentleman who suffered from senile dementia and had been bed-ridden for 8 years. He was wrapped in a 'space blanket', his rectal temperature was recorded hourly during his 5 hour stay in hospital. The consultant did not visit this patient. "Space blanket, 24% Oxygen nursing care only" was prescribed in the medical case notes. The nurse in charge asked the registrar for guidance with this patient. He advised - "No resuscitation."

Example 3

The nurse in charge asked the junior house doctor for guidance on the management of patient F. This elderly man suffered from cardiac failure and chronic obstructive airways disease. The latter condition he had had for 18 years. "Yes, I've put a cannula in so sodium bicarbonate can be introduced with no problem, he has got something reversible, no problem," he answered confidently.

In the absence of instructions the nurses had to interpret the the situation and make their own decisions.

Example 1

Patient J, a 61 year old gentleman who, though ill on admission, was not expected to die. Following extensive blood loss he was transfused with litres of blood, but as haemorrhaging continued his state became irreversible. This

moribund patient was sometimes restless. During one of these restless incidents, the infusion needle was dislodged. The nurse in charge notified the junior doctor who instructed her "The IV has not to be resited this time."

The nurses attempted to resuscitate four patients, one of whom had been identified as candidate for resuscitation by the doctors. All attempts were unsuccessful.

The management of the patients in the event of an emergency was not documented in the medical case notes. The senior nurses did not ask the consultants for guidance. The consultants advised the nurses regarding two patients only.

7.4 Pattern of senior nurse involvement.

The senior nurses interacted with different consultants who were responsible for different patients. The needs of the patients were multiple and varied. Though many variables were present, the individual senior nurses displayed a standard characteristic approach with regard to:

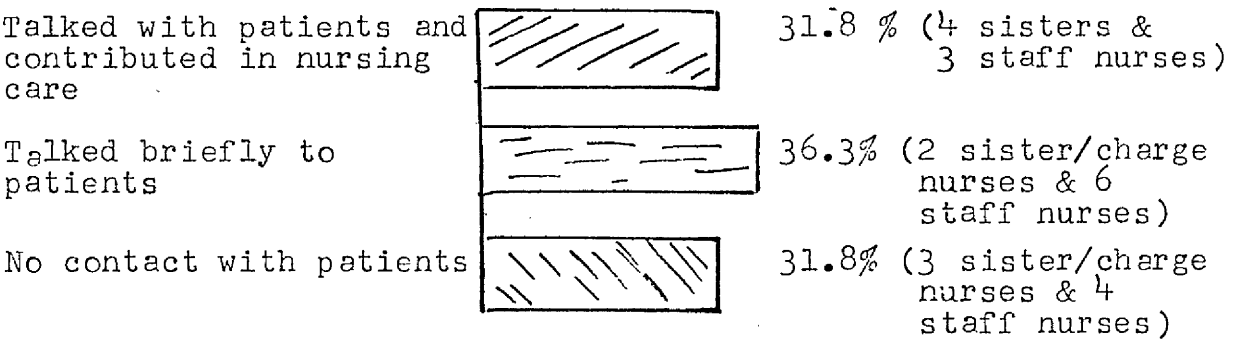
1. contact with the dying patient
2. participation during patient consultations
3. identifying pertinent problems for discussion
4. supporting the patient during consultations.

Contact with the dying patients.

Prior to the consultants' visits seven senior nurses (four sisters B:G:M:H and three staff nurses A:P:N) were observed talking with the patients and on occasion participating actively with the junior nurses in the nursing care. These senior nurses demonstrated features of 'caring' as recognised earlier in the study. Eight senior nurses (two sisters/charge nurses F:J and six staff nurses (Q:R:S:I:T:O) talked briefly to the patients but were not seen to contribute physically in the care of the patients. Seven senior nurses (three sisters/charge nurses K:L:C and four staff nurses D:E:V:W) were not seen in the presence of the dying patients apart from the brief interlude when they accompanied the consultant to the bedside during the ward round (Figure 5)

FIGURE 5

Contact between senior nursing staff and dying patients

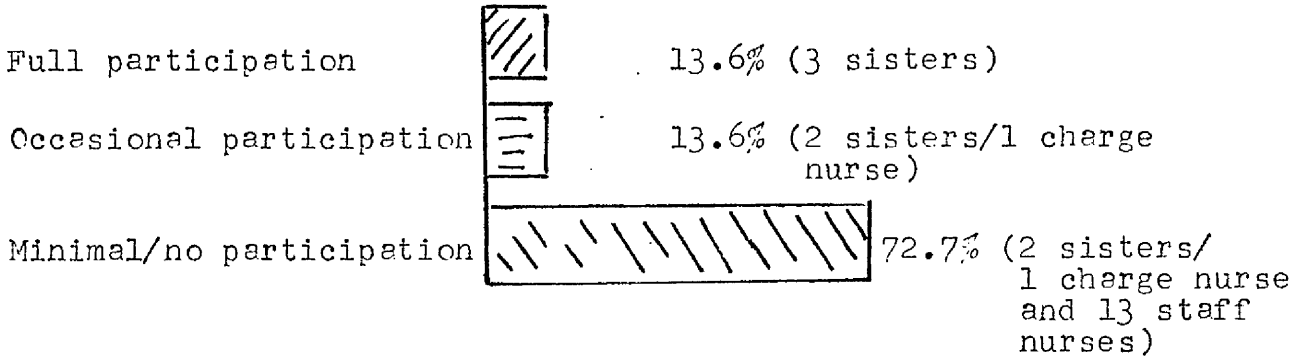


Participation during patient consultations

The contribution of the senior nurses during the consultant/dying patient consultations varied on a continuum ranging from full participation to little or no participation. A few senior nurses asserted themselves, asked questions, volunteered information and qualified their answers to the consultants' queries with subjective judgements; this contrasted with the majority of senior nurses who adopted a passive role, participated infrequently unless invited and gave brief factual answers to requests for data. (Figure 6)

FIGURE 6

Extent of nurse participation in consultant-patient consultations



Three sisters (B:G:M) (13.6%) played a major role. They had determined the topics on which they required a medical input before the consultant's visit. At the patient's bedside they gave a synopsis of the patient's state and outlined specific areas of concern thus inviting discussion from the consultants. They were advocates for the patients in their relationship with the consultants directing questions to the consultants on behalf of the patients. They demonstrated an awareness of the patients' needs, identified these to the consultants and asked for his considered opinion. If the response they received did not meet their demands, they were persistent and determined, continuing the dialogue until the consultant prescribed therapy which would assist in providing comfort for

the patients. The result was that most facets of the management of the patient were considered, discussed and defined when the consultations were concluded.

Example 1

Mr S, a 64 year old patient was suffering with grossly distended malignant cervical glands due to a primary tumour of unknown origin. The patient, though weak, was able to be up for his meals and was able to enjoy a few simple pleasures. He had a very attentive wife. Sedation had been commenced. As the doctors felt this was not adequately effective, the medication was altered. This had occurred during the absence of Sister B. In discussion with the patient, prior to the visit, this sister was told by the patient that he did not want the prescribed sedation as he felt it made him too sleepy during the day, when he wished to enjoy the company of his wife. During discussion with the consultant the Sister outlined the patient's position clearly as he, the patient, had indicated to her. The patient did not outline his problem to the consultant, when asked, he replied that he was "fine". The consultant was reluctant to review the dosage which he had prescribed. Sister reiterated her findings and maintained a different drug should be considered. The consultant replied that he was not keen to reconsider his decision but she insisted. Another drug was suggested, this she dismissed as she indicated a side effect of this medication was constipation. This would aggravate a problem which the patient already had. Eventually after thought he asked her what she had in mind. She named the drug which she felt would be most advantageous. This was prescribed for the patient.

Three senior nurses (two sisters and once charge nurse - H:F:J) (13.6%) were involved in discussions with the consultants to a lesser extent than the afore described senior nurses. They listened to the deliberations between

the medical staff, answered questions when asked and sometimes volunteered information. These nurses expressed concern to the consultants if treatment was prescribed which they felt was inappropriate but they were less persistent and aggressive with their demands and did not acquire the medical prescription which they felt was necessary to enable them to provide optimum nursing care.

Example 1

One patient who was dying required sedation as he was suffering pain due to metastasis from gastric carcinoma. This problem was presented to the consultant by the charge nurse and sedation requested. Medication was prescribed by the intramuscular route. The emaciated state of the patient presented difficulties to the nurses and added to the discomfort of the patient when the drug had to be administered. The charge nurse realised and commented on the problem to colleagues, but he did not voice his concern to the consultant. A second Sister, (Sister B) who was more persistent, during her spell in charge unhesitatingly outlined the situation to the consultant who readily agreed that the medicine could be administered intravenously using the infusion which was in situ.

Sixteen senior nurses (three sisters/charge nurses K:L:C and all the staff nurses - 72.2%) were passive and receptive during consultations at the bedside of the dying patients. They answered questions which were directed to them, provided documents and charts when requested to do so but infrequently proffered information unsolicited on aspects of the daily care of patients. On most occasions they stood by silently. After the consultations three of the staff nurses voiced dissatisfaction to their colleagues with some of the treatment prescribed, but at no time did they speak on behalf of the patient to the consultant or voice their disagreement with the course of action determined. They did not substantiate their

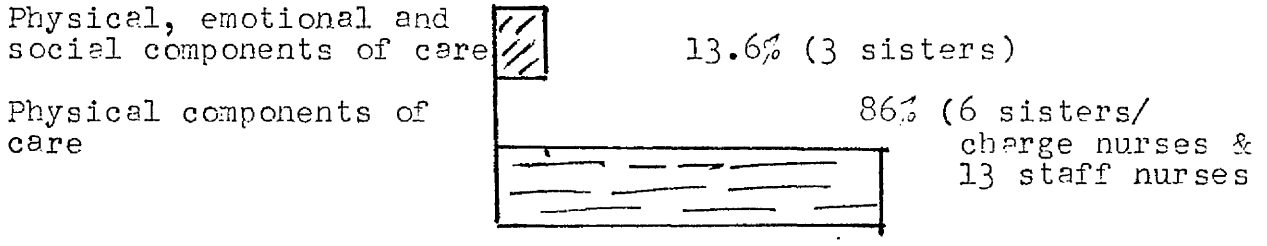
dissent by describing the patient's needs at the opportune time.

Problems presented for discussion

Physical and a few emotional and social components of care were considered when three senior nurses (B:G:M) (13.6%) attended the consultant/patient consultations. The remaining nineteen senior nurses (86%) based their queries on physical problems associated with the disease from which the patient suffered. (Figure 7)

FIGURE 7

Percentage of nurses who introduced physical, emotional and social components of care for discussion during consultant-patient consultations.



The three sisters (B:G:M) outlined the patients' physical problems and reported on the patterns of behaviour of the patients which indicated depression or anxiety, but they did not communicate to the consultants what had been said and consider with the consultants what should be said giving thought to the patients' awareness. They detailed the visiting pattern of the relatives and the information they had given to the relatives. Some 'care' aspects of the management of the 'person' of the patient were introduced by this minority group for discussion during their dialogue with the consultants.

Guidance sought by the majority of the senior nurses (six sisters/charge nurses and thirteen staff nurses) was concerned

Table 47

Percentage number of patient consultations during which specified topics considered

Topics considered	Percentage number of times						
	5%	10%	15%	20%	25%	30%	35%
Topics related to the physical state of the patient -							
pain	▬	▬	▬	▬	▬	▬	
problems related to breathing	▬	▬					
problems related to nutrition -							
dysphagia							
anorexia							
vomiting	▬	▬					
drinking - dehydration							
elimination - urinary output	▬	▬	▬	▬	▬		
constipation	▬						
problems related to care of							
oral hygiene	▬						
pressure areas	▬	▬	▬				
personal hygiene							
movement							
results of - TPR recordings	▬	▬	▬	▬			
PB recordings	▬	▬	▬	▬	▬		
Urinalysis	▬	▬					
FCB analysis	▬						
Blood analysis	▬						
Laboratory analysis	▬						
Topics related to emotional state of the patient							
Depression	▬						
anxiety	▬						
loneliness							
sleeplessness							
Topics related to communication with the patient	▬						
Topics related to the family	▬	▬	▬	▬			
Topics related to cultural/ spiritual aspects							

with the disease related physical components of care only. This included the volume and type of intravenous fluids given, the removal of naso-gastric tubes, the management of bladder drainage and wound management. Complications which developed eg. melaena, haemetemesis, cardiac arrythmias and observations indicating physical deterioration eg. an elevation of temperature, a fall in blood pressure, diminished urinary output were reported. Pain, mental confusion and vomiting were mentioned on occasion. Many physical problems experienced by the patients were not presented by these senior nurses for consideration during consultations. The awareness by the patients of their condition and the psychological distress of the patients was not outlined.

At times aspects of patient care which merited a combined approach by medical and nursing staff were discussed between the senior nurses and junior members of the medical staff. The consultants were not privy to these problems.

The topics introduced by the senior nurses for consideration during senior nurse-consultant communications concerning the dying patient are shown on Table 47. This does not indicate the amount of discussion which took place, but that the topic had been raised. These figures were obtained following an analysis of ninety-one patient consultations. The senior nurses were inclined to introduce factual observations but they did not put forward their subjective assessments of the patients needs.

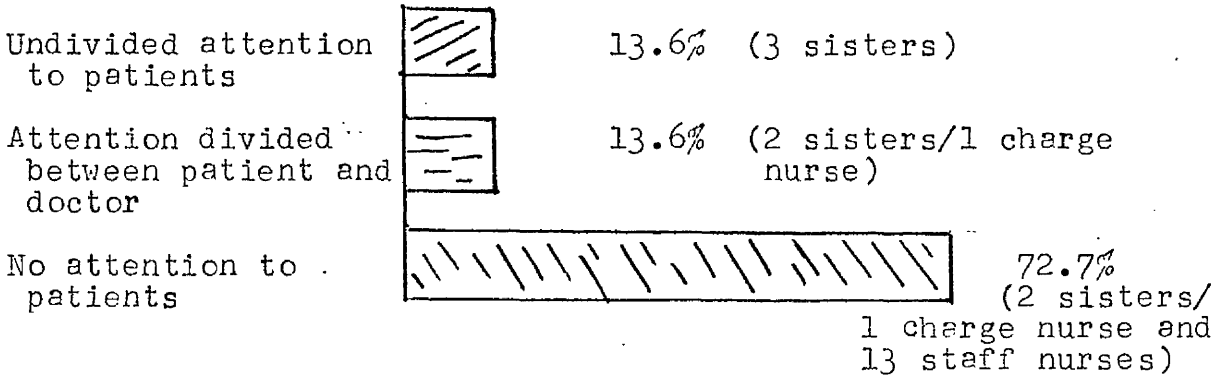
The patients were observed by the researcher to have many and varied problems (Tables 19 and 20). The lack of detailed discussion by the senior medical and nursing staff of the patients' needs and subsequent care was evident.

Support to patients during consultations

The deportment of the senior nurses towards the patients varied. (Figure 8)

FIGURE 8

Deportment of senior nurses towards patients during consultant-patient consultations



During consultations three sisters (B:G:M) (13.6%) stood near to the patients and supported them by touch, look or word, assisting them to relate to the consultant, or they interceded on their behalf. Before leaving the bedside after a consultant's visit they ensured the patient was repositioned and at rest. Another three sisters/charge nurses (H:F:J) (13.6%) also gave support, a hand was held or a word of encouragement was given "I'll come back and see you", but frequently these nurses moved from the bedside to provide reports of investigations or charts if these were requested. If the patients were not settled when the consultations were completed they either reassured the patient that they would return or they delegated other nurses to reposition the patient and enable the patient to find comfort. The remaining senior nurses (72.7%) did not assist the patients to relate to the consultants or attend and support the patients during consultations. They stood away from the patients either at the foot of the bed or at the medical

case records trolley. They distanced themselves from the patients and occupied their time keeping documents and charts in order.

The senior nurses (B:G:M) who were actively involved in providing nursing care for the dying patients expressed a sensitivity to the physical and psychosocial needs of the patients and outlined these problems to the consultants for discussion. The consultants responded to the communications of these senior nurses and asked for their opinions on various aspects of care and made decisions of the management of the patients which gave credence to the senior nurses' contributions.

The remaining senior nurses proferred few problems to the consultants for consideration; if a facet was forwarded for discussion it related to the disease or physical aspects of care, the emotional and social components were not discussed.

The senior nurses (B:G:M) used the ward rounds as an opportunity for exchange of information, whereas the other senior nurses acted as 'handmaidens' to the consultants answering to the consultant needs rather than the patients' needs.

7.5 Summary

The dying patient has physical, emotional, social and spiritual requirements which require to be recognised. A plan of care has to be devised to meet these demands. The needs of the patient are peculiar.

The approach of the consultants to the situation differed. Each consultant demonstrated a characteristic style of behaviour which varied little from one patient to another patient, i.e. all patients irrespective of their individual needs evoked a similar response from the consultants. (Table 48)

TABLE 48

Consultant - dying patient contacts

Category	Characteristics of behaviour of consultants during patient consultations	Consultants
1.	a) conducted comprehensive consultation b) established rapport with patients c) maintained contact with patients d) considered the patients - physical, emotional, social needs and the disease pathology.	S:V:D:E
2.	a) conducted brief consultations b) talked to the patients, did not establish rapport. c) distanced from the patients d) considered predominantly the disease pathology	W:G
3.	a) conducted brief consultations b) did not establish dialogue with the patients c) distanced from the patients d) considered the disease pathology	B:F:K:C M:T
4.	Not observed	H:L

The consultants' response to the dying patient was predictable. The consultants (category 1) who conducted comprehensive consultations, established a rapport with the patients and demonstrated a holistic approach to the care of the patients, maintained contact with the patients until death. The other consultants (categories 2 and 3) who conducted brief consultations, did not establish a rapport with the patients, they concentrated on the disease rather than the patient and withdrew from the patients when dying became more evident. Slight variations in the style of interaction of two consultants (G and W) on occasion indicated that these consultants had the potential to be grouped differently but these incidents were unusual and the trend of behaviour of all the consultants remained consistent.

This constancy in the behaviour of doctors was noted by Byrne and Long (1976). Following a study of 103 general practitioners' surgery consultations (60 in the United Kingdom, 17 in New Zealand, 15 in Australia, 5 in Holland and 6 in Ireland) Byrne and Long stated "Doctors appeared to have achieved set routines of interviewing patients - few of them demonstrated the capacity for variations of normal style and performance to meet the needs of those patients whose problems did not fit into an organic disease pattern" (p.5). What is remarkable - is the consistency of style shown by doctors. Within the normal range of patients seen in a series of morning and evening surgeries one would expect to find a range of illnesses running from the purely organic through to the more difficult to determine psychosomatic. Equally, one would expect, - (and in fact does find), while the patients input into the consultation contained a wide range of variables, it is surprising to find that the individual doctors responses are standardised to a remarkable degree (p.112) - we concluded, we can with tape recordings of twenty consecutive consultations predict more than 80% of a doctor's behaviour pattern. We can also establish his preferred style of relating to patients for diagnosis and prescriptions (p.131).

During consultant/senior nurse contacts a similar constancy in the behaviour of the consultants was evident. (Table 49)

The consultants (category 1) who involved the senior nurses by asking for their subjective assessment of the patients, discussing with them the management of the patients and permitting them to be party to the decisions made, outlined a precise comprehensive policy of patient care giving consideration to the physical and psychosocial needs of the patients. These consultants demonstrated an appreciation of the senior nurses' professional input. The consultants (categories 2 and 3) who did not involve the senior nurses during patient consultations gave less guidance and often no direct instructions. Any directives which were issued by the consultants in categories 2 and 3 were either vague or curt and inflexible. The

consultants who talked with the nurses outlined the care of the patients required. The consultants who talked to the nurses gave few or no guidelines.

A twinning in the pattern of the behaviour of the consultants towards the dying patient and the senior nurses was noted.

TABLE 49

Consultant-senior nurse communications

Category	Characteristics of behaviour of consultants during senior nurse contacts	Consultants
1.	a) asked open-ended questions b) acknowledged the contribution of the nurse c) discussed the management of the patient with the nurse d) involved the nurse in decision making e) outlined a comprehensive policy of care	S:V:D:E
2.	a) asked closed questions b) listened to the nurses response c) infrequently discussed the management of the patient with the nurse. d) infrequently involved the nurse in decision making. e) issued vague or inflexible directives on limited aspects of care	W:T:G
3.	a) asked closed questions b) listened to the nurses response c) did not discuss the management of the patients with the nurse d) did not involve the nurse in decision making e) gave few,but inflexible instructions	B:F:K:C:M
4.	a) did not communicate with nurse	H:L

The consultants (category 1) who developed a rapport with the patients and demonstrates a holistic approach to patient care also spoke with the senior nurses and involved them in decision making. The consultants (categories 2 and 3) who indicated less involvement with the patients similarly communed less with the senior nurses and gave few or sparse instructions. (Table 50)

TABLE 50

Comparison of consultant-dying patient contacts and consultant-senior nurse contacts

Consultant-dying patient contact		Consultants	Consultant-senior nurse contact		Consultants
Categories	1.	S:V:D:E	Categories	1.	S:V:D:E
	2.	W:G		2.	W:T:G
	3.	B:F:K:C M:T		3.	B:F:K:C M
	4.	H:L		4.	H:L

The guidance given by the consultants to the senior nurses concerning the dying patients was contingent not only on the attitude of the consultants towards the patients and towards the senior nurses but also on the dynamic contribution of the senior nurses.

The senior nurses demonstrated differing but consistent responses to the dying patients. (Table 51)

TABLE 51

Senior nurse-dying patient contacts

Category	Senior nurse responses	Senior nurses
1.	a) talked with the patients	Sister B:G:M:H
	b) actively contributed in nursing care	Staff nurses A:P:N
2.	a) talked to the patients	Sister/charge nurses F:J
	b) did not contribute in nursing care	Staff nurses Q:R:S:I:T:O
3.	a) no contact with the patients	Sister/charge nurses K:L:C
		Staff nurses D:E:V:W

In contact with the consultants, the contribution of the senior nurses varied but again a constancy in behaviour was evident. (Table 52)

Three senior nurses - B:G:M (category 1) - who demonstrated a 'caring' attitude also acted as 'advocates' for the patients' needs and outlined to the consultants facets of care which demanded a medical input. This attitude of these 'caring/advocate' senior nurses contrasted with the responses of their nineteen collegues who rarely spoke with the consultants.

The four 'caring' consultants (category 1) and three 'caring/advocate' senior nurses (category 1) shared information regarding the dying patients and designed a comprehensive plan of care for each patient, which indicated a holistic approach to patient care. During contacts between the

TABLE 52

Senior nurse-consultant communications

Category	Characteristics of behaviour during consultant contacts	Senior Nurses
1.	a) supported patients during consultations b) volunteered information on physical and psychosocial components of care c) interceded on behalf of the patients	Sisters B:G:M
2.	a) attention divided between patient and consultant b) volunteered information on a few physical components of care c) did not intercede on behalf of patients	Sister/charge nurse H:F:J
3.	a) attention to consultants, no support to patients b) infrequently volunteered information on physical components of care c) did not intercede on behalf of patients	Sister/charge nurse K:L:C Staff nurses A:P:N:Q:R:S:I:T:O:D:E:V:W

'caring' consultants and the remaining nineteen senior nurses, though the senior nurses contributed with less vigour the consultants responses were unaltered. They outlined a detailed plan of care.

When the ten consultants (category 2 and 3) and the 'caring/ advocate' senior nurses interacted, the senior nurses proferred less information but if decisions had to be made which were outwith the jurisdiction of the junior medical staff, they prepared for the appearance of the consultants and insisted the patients should be visited and the management of the patients discussed and defined. A policy of care was devised but this was less precise and was orientated towards the organic disorder of the patients. Discussions between the ten consultants (categories 2,3 and 4) and the remaining nineteen senior nurses were brief, fragmented and deficient. No precise guidelines were set. Any directives given referred exclusively to the physical components of care.

The fact that the four 'caring' consultants (category 1) interacted most frequently with the three 'caring/advocate' senior nurses (category 1) and the ten consultants (category 2, 3 and 4) who did not demonstrate these responses interacted most frequently with the senior nurses (category 2 and 3) of like mind is of interest and may indicate more than a coincidence. When the 'caring' consultants (category 1) interacted with the senior nurses (category 2 and 3) the guidelines on patient care remained comprehensive. When the 'caring/advocate' senior nurses (category 1) interacted with the consultants (categories 2, 3 and 4) they were not able to achieve similar results. The four senior nurses - H:A:P:N (Category 1 - Table 51) who were 'caring' but did not have 'advocacy' characteristics when in contact with consultants of categories 2 and 3 were swamped, as although they indicated a sensitivity towards the patients this was not demonstrated during the consultant patient consultations. These findings suggest that the influence of the consultants on the senior nurses is substantial and paramount.

Chapter 8

Ward reports

In this chapter the content of written and oral reports is examined. The method of data analysis is outlined before the data are scrutinised. Independent judges were involved in a Q sort classification of reports to derive categories in 'patient state', categories in 'type of information given' and categories in 'nursing instructions'. Transcripts and verbatim accounts are used to illustrate the findings.

Observational data provide a basis for describing the bonding between senior medical and nursing staff. These data provide a basis for comparison of medical and nursing orientated guidance given in the reports and indicate the influence of medical ideology.

Nurses must know about patients and the nursing care required, so that they can provide effective care (Lelean 1973). Clair and Trussell (1969) in a study of ward communication systems found that there was a direct relationship between the ability of the registered nurse to carry out her duties effectively and efficiently and the detail and precision of the ward reports she received.

Information about patients, about nursing care and medical treatment required is conveyed to nurses by formal and informal channels of communication. Formal communication channels include the written individual patient reports, nursing care plans, instruction sheets, lists of ward tasks and oral ward report sessions. Information is also exchanged in a less formal way as the nurses come and go about their work.

The written individual patient report is the official nursing record of information on the patient completed (by the staff) at the end of a period of duty. The oral ward report session

is the allocated time at the commencement of a period of duty, when the nurses receive both an updated summary of the patients' welfare and guidance on the nursing requirements of the patients for the next shift.

Data were collected from these formal communication channels in order to study

1. the type and content of information on patients which was transmitted to the nursing staff
2. the guidance given to the nursing staff on the nursing requirements of the patients.

8.1 Scheme of analysis of written individual patient reports.

The development of an instrument to assess the content of the ward report was a difficult task. The problem arose principally because the majority of the reports were found to be a series of vague, incomplete and disjointed statements, which were ambiguous and open to semantic interpretation. They were therefore subject to misinterpretation and misunderstanding.

There were many variables, none of which could be controlled, which influenced the content of the reports. Patients had many and varied needs, the nurses writing the reports had different experiences and priorities. There was a variation in the number of written reports available, as some patients had been in hospital for a number of weeks, whereas for other patients their final sojourn in hospital was brief - perhaps only a number of hours. To control the latter variable the report sample chosen for analysis was the penultimate written report on each patient.

Forty-eight reports were analysed, the reports of two patients were excluded as one patient recovered, the second patient died six hours after hospitalisation. No documentation was drawn up for the latter patient.

Content analysis as commended by Stacey (1969) was used for the classification. According to Stacey (1969) this method is

> "particularly useful for the analysis of documentary evidence --- for reducing qualitative data to quantitative terms" with the proviso that "the content analyst must have a good background in the knowledge of the issues and documents he is analysing."

To analyse the forty-eight reports the content of each report was sectioned into 'statements made' irrespective of whether the statement was a structured sentence or group of words. Three hundred and eighty-seven statements were identified. Each of the statements was transcribed on to cards which were sorted into categories suggested by the contents of the abstracts. A first grouping of the statements was made according to the 'subject matter'. The statements were reread and further sorted into classifications related to the intent of the statement, i.e. a record of an activity performed, an observation or an instruction. Then each report was read and classified into categories which implied the state of the patient i.e. whether the patient was "ill but likely to recover," " critically ill but expected to recover," "terminally ill" or "dying." Finally the age and diagnosis of the patient were retrieved and included. The reports were again read and regrouped as required into the predetermined categories.

To reduce the subjective input of the researcher four registered general nurses, each having many years of nursing experience, were invited to read and group the reports and statements. Each worked independently. No definition or guidance was given for the classification categories, this was left to the assessor's professional judgment.

8.2 Written reports

The overall impression was that the reports were fragmented

and lacked precision. The patient and his needs as a 'person' were not mentioned. There were few comprehensive accounts of the patient's state, the nursing care initiated, why the care was given, the effect of the nursing intervention and the future nursing care requirements.

Example 1

Condition very poor. Remains very dyspnoeic at rest. Diarrhoea persists. F.C.B. positive. No chemotherapy given this p.m. Borderline pyrexia. 37.2°C. Blood pressure 115/60. Parentral nutrition continues. Urine collection still in progress.

Example 2

Hourly volumes. ½ hourly BP and pulse. Cardiac monitor. Urine for osmolority. Catheter care. Oral hygiene. Encourage fluids as tolerated.

Example 3

Condition remains poor. Large clots in nostrils. Incontinent. BP unrecordable. All basic care required. Common-law husband phoned. Nil orally and not responding. Diarrhoea. FOB -ve this p.m. Continues to have epistaxis.

Example 4

Temp. 39°C. Blood cultures done. Positive pneumococcus. Penicillin treatment - IV. O_2-4 litres via nasal cannula. 2 hrly pressure areas, fine at moment. Heel pads, sheepskins. 2 hrly recordings. Hypotensive BP 60/45. Not well. Plenty fluids - complan, tea. No urinary output despite Frusemide. Catheterised.

Principally the reports were an account of the nursing tasks which had been performed during the foregoing shift.

Example 1

Bed bath and all care as before. Condition deteriorated. Hourly turning. Brompton's mixture orally 8.05 a.m. and repeated 12.10 p.m.

Example 2

Bedbathed by two nurses. Oral hygiene given 2 hourly with tellodont, two hourly change of position. Condition poor and continues to deteriorate. Relatives and priest informed. Remains on bed rest. Commenced on Diamorphine 10 mgs - 3 hourly as required for pain.

Example 3

Remains unconscious, no change. IV infusion continues as charted. Oral hygiene 2 hourly, pressure areas intact - 2 hrly care and position changed. Pulse 92, BP 100/72. Catheter draining. Coma recordings - no change.

Repetitive documentation was evident. The first written report set the precedent, which the nurses tended to follow with monotonous repetition. The nursing activities reported were perpetuated during the oncoming shift and subsequently reported again.

Example 1

Written report on patient V on six consecutive days.

1/6/81. Bedbathed. All nursing care given. Oral hygiene 2 hrly. All P/A given, buttocks red. IV fluids as charted. 4 hrly urine. Volumes poor. On continuous gastric suction, 580 mls at 12 noon. Very drowsy and lethargic. Condition remains poor. Wife seen by Mr - this a.m.

2/6/81 Bedbathed. All nursing care given. IV fluids to be resited. Nasogastric tube spigotted urinary output poor. Positive FOB this a.m. Has diarrhoea. 12md 80 mls nasogastric aspirate. Cyclomorph 10 mgs given at 2.40 p.m. Largactil 25 mgs and Stemetil 12.5 mgs given at 5.45 p.m.

3/6/81 Bedbathed and P/A care. All nursing care given. Nasogastric tube on continuous drainage. IV fluids charted. Varidase pack to heel. Catheter on continuous drainage.

4/6/81 Bedbath and nursing on alternate sides. All nursing care given. Varidase pack to heel. Nasogastric tube on continuous suction. IV fluids running 6 hourly as charted. Catheter on continuous drainage.

5/6/81 Bedbath and all nursing care given. N/G suction continued. Vomited 150 mls this a.m. Urinary output poor. (R) foot very oedematous.

Content of the reports

Three hundred and fifty-six (91.9%) of the three hundred and eighty-seven statements in the forty-eight reports were either dissociated, incomplete or meaningless, only thirty-one statements (8%) were linked in a cause-effect relationship.

- 10 times the state of the patient which merited intervention was stated and linked with the action taken.

- 5 times a reason was given for the action taken.

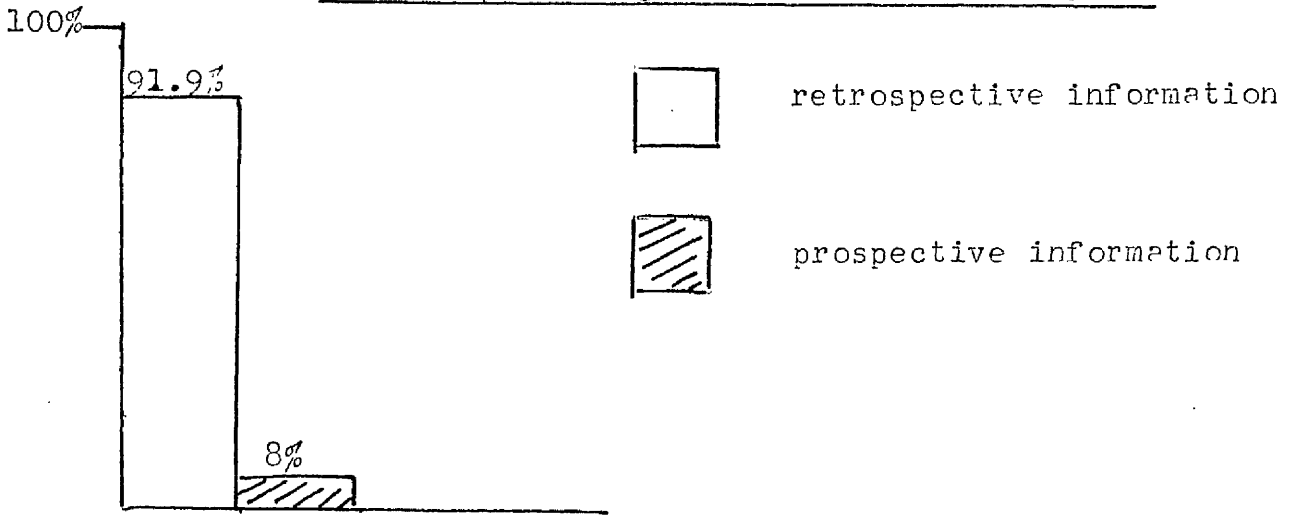
- 13 times the result of the action taken was linked with the action taken.

- 3 statements linked the state of the patient with the action taken and the effect of the intervention specified.

Three hundred and fifty-four statements (91.9%) provided retrospective information and thirty-three statements (8%) gave guidance on the prospective needs of the patients. Figure 9.

FIGURE 9

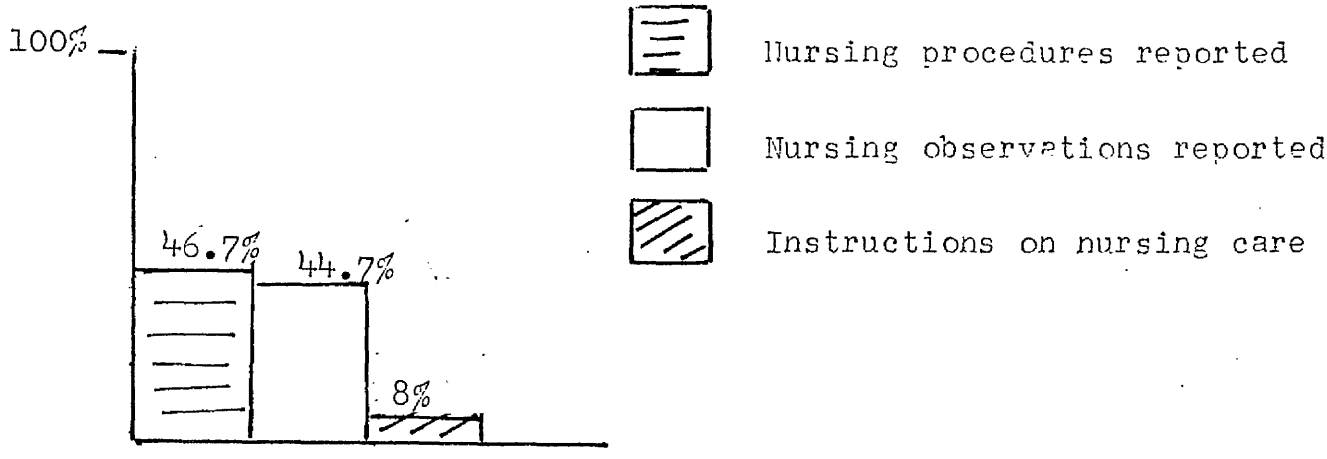
Proportion of retrospective information and prospective guidance in written reports.



One hundred and eighty-one statements (46.7%) gave an account of the nursing procedures which had been performed. Nursing observations i.e. measured technical recordings, facts observed or subjective judgments accounted for one hundred and seventy-three statements (44.7%). Thirty-three statements (8%) gave directives on the nursing care to be given. Figure 10

FIGURE 10

Proportion of topics concerned with nursing procedures, nursing observations and instructions on nursing care in written reports



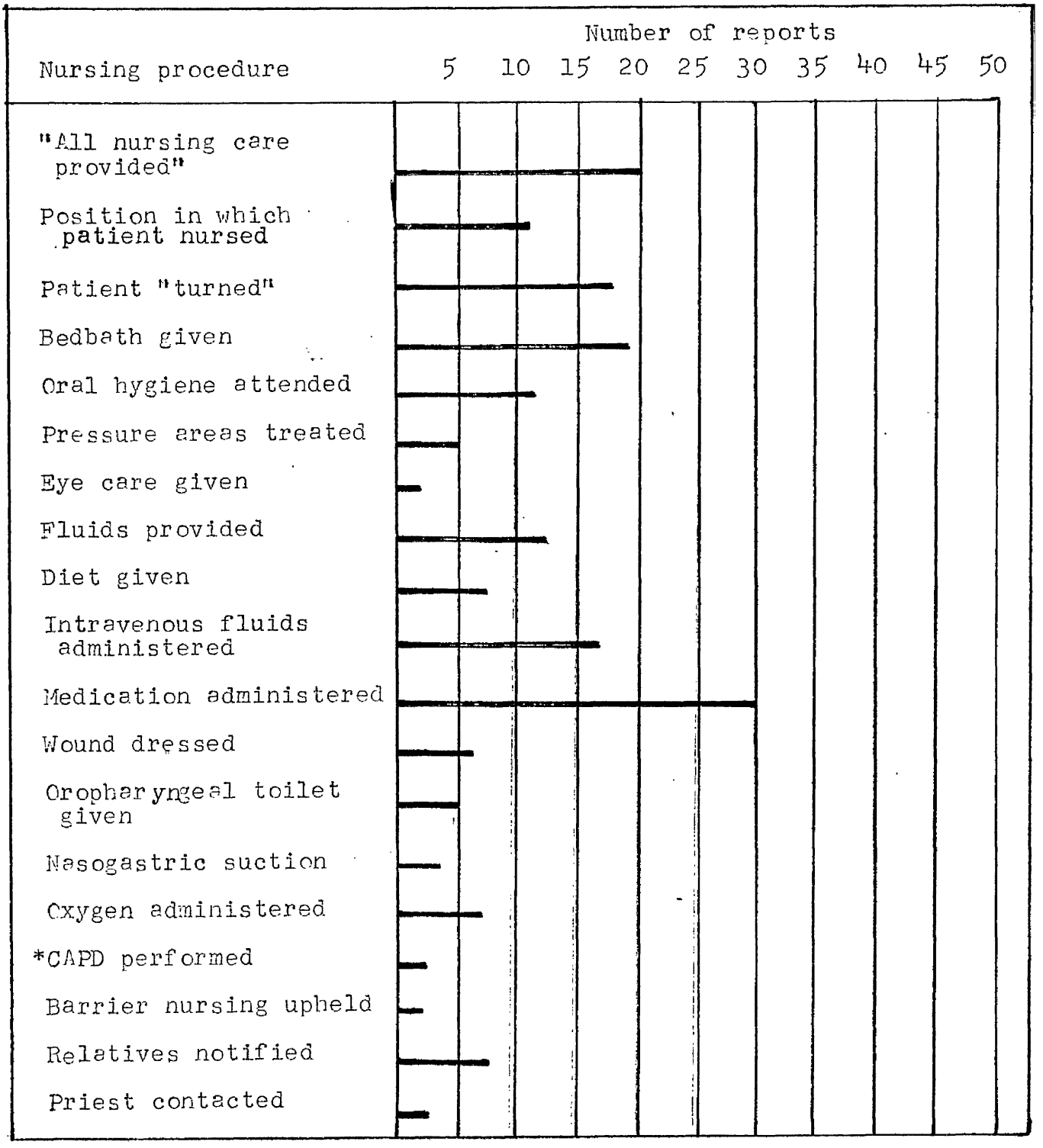
The independent assessors classification of 'nursing procedures' reported and 'nursing observations reported' was at variance, however there was correlation on the number of statements which gave 'instructions on nursing care'.

Nursing procedures reported

The nursing procedures and the frequency with which the activities were reported are shown on Table 53. The administration of medicines was the task most frequently reported, this was outlined in thirty reports (60%). The medication, the dosage and the route of administration was stated in thirteen reports, the medication and dosage were recorded in eight reports, in seventeen reports the name of the drug administered was given and in two reports the fact that sedation (unidentified) was given was stated. The effect of the drug administered was mentioned in only three reports.

TABLE 53

Incidence of nursing procedures recorded in penultimate individual patient reports



* Continuous ambulatory peritoneal dialysis

The nursing care given to seventeen patients (34%) was recorded briefly as

"All care given"

"Total patient care given"

"All general nursing care carried out"

In nineteen reports (38%) the fact that the patients had been given a bedbath was stated

"Bedbath given"

and that the nurses had "changed the patients position" either 4 hourly, 2 hourly or 1 hourly was recorded in twelve reports (24%). The statement was invariably

"2 hourly change of position and oral hygiene."

It was stated in thirteen reports (26%) and eight reports (16%) respectively that the patients had been given fluids and diet. No details of times or amounts, only

"Fluids and diet tolerated".

All technical nursing procedures were documented, but no detail was given. Sixteen patients were reported to have intravenous fluids which were

"running as charted"
"running to chart"
"continued as charted"

Four patients had naso-gastric suction

"continuously on free drainage"

and it was recorded that five patients had naso-pharyngeal suction

"as required"

Eleven patients had a urinary catheter

"on free drainage"
"on continuous bladder drainage"
"draining"

and six patients had oxygen therapy
"as tolerated"
"via mask" or "nasal catheter"

The tasks done were documented. The reason for the nursing intervention or the response of the patients to care was not identified.

Nursing observations reported

The reporting was uniformly poor. There was a paucity and inadequacy of written evidence on the physical ability or nurse-dependencies of the patients i.e. the ability or inability of the patient to communicate, to eat, to drink, to pass urine, to defaecate, to move or to sleep and rare mention of the patients emotional state. Few professional judgments were committed to paper. Measured technical recordings much of which could be obtained elsewhere on the designated charts were included in the reports e.g. temperature readings, pulse and blood pressure recordings, fluid intake and urinary output volumes, urinalysis and faecal findings and laboratory reports.

The topics and the frequency with which each topic was reported in the written reports are shown on Table 54.

Details of the physical state of the patients were scanty, apart from the general reference to either the condition being "poor" or "deteriorating". In twenty-six reports (52%) the state of the patient was noted as e.g.

"condition remains very poor"

"condition unchanged"

"condition remains fairly poor"

"fine at the moment"

"not well"

Twelve reports (24%) indicated a deterioration of the condition of the patient had occurred.

"condition has deteriorated"

"gradually deteriorating"

The state of the patients' oral hygiene and pressure areas were rarely mentioned. Fourteen times it was stated that "oral hygiene" had been "given"; in only four reports the state of the mouth was described;

"mouth very dry and coated"

was recorded in three reports, and in one report -

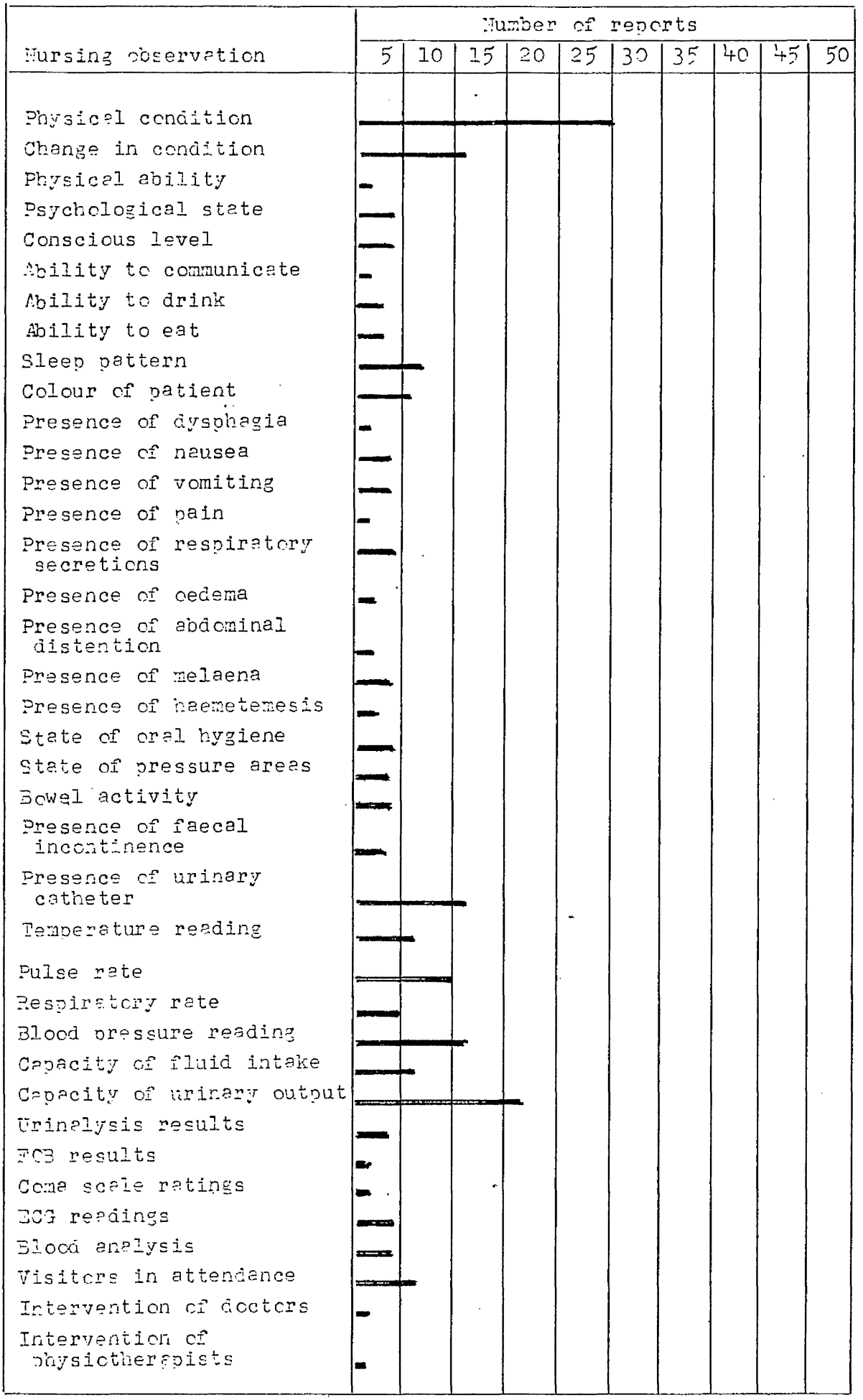
"gums ulcerated and bleeding".

Reports on the condition of the skin were sparse. Seventeen times the nurses recorded the patient was "turned" and five times that the pressure areas "had been attended". No break in the skin was described though in five reports the treatment outlined, suggested a pressure sore was present. Twice the pressure areas were stated as "intact".

There was a deficit of documentation on the psychosocial aspects - the emotional and mental state of the patient and his response to contact. The psychological state of three patients (6%) was stated as distressed, agitated or depressed. No suggestion was made or reason given for the mental state of two of these patients; the third patient was reported as -

"depressed this morning - wanting to go home".

Incidence of nursing observation topics recorded in penultimate individual patient reports



All the patients suffered from a number of complications - Tables 19 and 20. These complications were scarcely mentioned in the reports. A comparison of the number of patients suffering from complications and the number of patients reported to have these problems is shown on Table 55.

The need for the control of pain for patients who are dying is widely reported. (Twycross 1978). Thirty-four of the patients were observed to suffer. Reference was made to the presence of pain in only six reports. These were as follows

"patient in some discomfort"
"restless night"
"patient quite distressed at times"
"commenced on Fortral for pain relief"
"give analgesia routinely please"
"keep as comfortable as possible"

A number of narcotics and analgesics - Diamorphine sulphate, pethidine, omnopon, DF118, Fortral, Palfium and Brompton's mixture were administered implying that pain was present but there was no reference to the presence of this symptom. The effect of the medication was mentioned in only three reports as follows

1. "Pethidine 50 mgs at 11.30 a.m. with little effect"
2. "Palfium 5 mgs at 3.45 p.m. and 6.45 p.m. with fair effect".
3. "Diamorphine 15 mgs given at 1.15 a.m. and 4.55 a.m. -- very restless, spent most of the night on the floor ----,
   Diamorphine 30 mgs given at 6.10 a.m. I.V, further
   Diamorphine 20 mgs given at 6.15 a.m."

Dysphagia, nausea, vomiting, confusion and faecal incontinence were reported but no cause was indicated or effective measures outlined to assist the patients or relieve the distress, although this was within the province of nursing prescription.

TABLE 55

Comparison of number of patients observed suffering from complications and number of patients reported to have complication in penultimate individual patient reports.

COMPLICATION	No of patients observed with complication	No of patients reported to have complication
Dysphagia	2	1
Anorexia) Nausea)	30	-
Vomiting	10	6
Dehydration	28	-
Dyspnoea	26	-
Pain	34	6
Depression	15	1
Anxiety	20	2
Loneliness	28	-
Confused/Disorientated	4	1
Urinary Incontinence	3	-
Faecal Incontinence	13	6
Constipation	3	-
Pressure sores	19	-

From a number of the nurse actions it was assumed that the patients had problems e.g. the administration of oxygen, the application of oro-pharyngeal suction, catheterisation, the administration of glycerine suppositories and the positioning of cot-sides but there was no written evidence of these problems in the reports.

The attendance of family and friends was occasionally reported e.g.

> "relatives with patient part of the morning"
>
> "visited by wife and son"
>
> "husband and daughter up this evening"
>
> "relatives present all day"

That the relatives had been 'informed' was recorded in four reports e.g.

> "relatives and priest informed"
>
> "patient's condition deteriorated, relatives informed"

and that the doctor 'had seen' or 'would see' the relatives was noted in four reports e.g.

> "doctor spoke to daughter"
>
> "relatives to see Mr - at 10.30 a.m."

There was no explanation or detail given of the content of the communication when the relatives were 'informed', 'seen' or 'spoken to'.

On only one occasion was the reaction of the family outlined -

> "wife seen this evening and diagnosis explained, taken home by niece shocked and upset".

The response of the patients to the presence of the relatives or close friends was not mentioned.

The reporting of nursing observations overall was scanty, diverse and generally a series of clichés, which the reader had to interpret, and assimilate for herself.

Instructions on nursing care

Instructions for the nursing care patients required were infrequent, lacked precision and were found sporadically in the reports. Thirty-three of the three hundred and eighty-seven statements (8%) in the forty-eight reports related to nursing requirements.

The topics and the frequency with which instructions were given are shown on Table 56.

There was a poverty of detail and guidance on the physical care, psychological and the spiritual care required by the individual patients. The nurses were advised in clichés to give e.g.

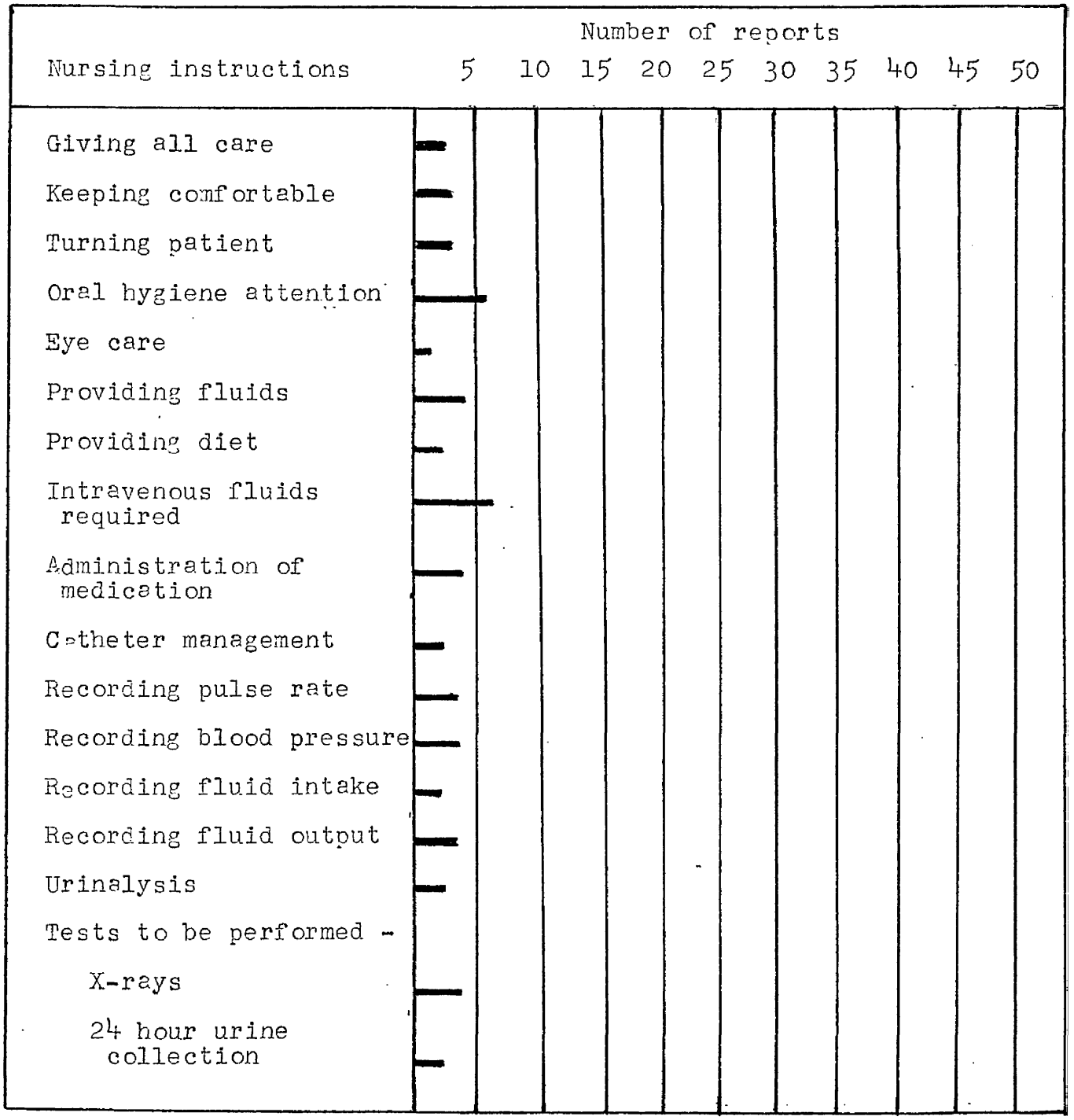
"All GNC"
"All nursing care"
"Keep as comfortable as possible"
"Keep comfortable"
"Give analgesia routinely, please".
"Please ensure Brompton's is given at 6 a.m."
"Diconal to be give 4 hourly, please"
"Needs oral hygiene".

No guidance was given on the knowledge the patient had of his prognosis, or the tactics of communication adopted.

There were no directives given on the course of action to be taken if or when the patient died ie. guidance on resuscitative intervention or guidance on conveying the

TABLE 56

Incidence of nursing instructions recorded in penultimate individual patient reports



information to the family.

Guidance on the state of the patient

No report stated death was imminent. Innuendoes in a few reports suggested that death was expected.

The independent assessors, who had not been briefed that the documents were the penultimate reports on patients who had died, classified the reports as indicated on Table 57.

TABLE 57

Number of reports: analysis by prognosis indicated in reports.

Expected Prognosis	Ill but likely to recover	Critically ill but likely to recover	Terminally Ill	Dying
Number of reports	8	25	7	8

When the age of the patient and the diagnosis was considered and the reports were reread, the independent assessors findings were as shown on Table 58.

TABLE 58

Number of reports: analysis by prognosis indicated in reports when evidence of age and diagnosis given.

Expected prognosis	Ill but likely to recover	Critically ill but likely to recover	Terminally Ill	Dying
Number of reports	2	15	16	15

The figures on Table 57 and 58 are an average of the findings of the independent assessors. There was agreement on the 'prognosis of patients' in only ten reports.

The discrepancies in the assessments made of the patients' state from the penultimate reports, may have been in part due to the category headings, but it does indicate the ambiguous nature of the reports. This fact is even more poignant when it is realised that all the patients died within four hours of these written nursing documents.

Orientation of reports

Stereotyped, ambiguous, meaningless phrases were repeated in a monotonous way in every report. This format only changed when medical intervention occurred. This was then graphically described and each stage in the procedure was recorded.

Example 1

Anuric, given 240 mgs Frusemide IV at 10.30 p.m., physicians contacted; seen by medical registrar who commenced - nurse upright, oxygen therapy 56% via Hudson mask, U's and E's checked 6.6 plasma,glucose checked 13 mols, given 12 units soluble insulin sub-cu. Omnopon 10 mgs at 11.30 p.m. also given 350 mgs aminophylline IV, urinary output improved, hourly urine volumes maintained overnight oro-pharyngeal suctioning as required, 2 hourly observations BP, pulse, temp. continued, remains hypotensive, BP between 80/50 - 118/80, pulse 80/120, pyrexial overnight temp. 40.2°C, tepid sponging as required. Electric fan in use. Temp. 37.8°C. 4 hourly B M sticks. Plasma glucose Immol. this a.m., diabetic urinalysis blue no ketones. Dr informed. Hourly volumes overnight. 40 mgs frusemide at 6 a.m. 2 hourly turns, oral hygiene. Dry dressing as required to groin wound which continues to leak. Chest remains moist though not so congested this a.m. Ankle oedema also appears less. Condition very slightly improved overnight.

Example 2

To be reviewed by surgeons today. Blood transfusion continues. Hourly observations temp, pulse and BP continues - all remaining stable. To go for upper endoscopy at 1 p.m. today. Consent form signed. 1.30 p.m. Theatre for endoscopy. Returned from theatre 3 p.m. Vomited 1300 mls fresh blood with clots. 400 mls melaena. Dr informed, IV no. 2 sited in left hand, blood run in quickly. ¼ hrly BP 80/50, P. 128, SB Drs. Relatives spoken to by Dr. 2 units fresh plasma given, IV continues as charted. Relatives in attendance. Further haemetemesis with melaena. Diamorphine 5 mgs IV at 9.50 p.m.

Information which described the nursing implementation of the doctors orders was given high priority and recorded before or instead of nursing notes. Medical prescribed therapy to combat the disease process was outlined in detail.

Example 1

Bedbathed, remains on bed rest. Having 2 hourly change of position and oral hygiene. IV infusion continues as charted. May have sips of water as tolerated. Wound satisfactory. Colostomy functioning. Faecal fluid empty as required and chart loss at 12 mn. Observe output. 40 mgs lasix given IV. To be taken to have chest X-ray; to have antibiotics as charted. 4 hourly TPR and BP recordings continue. Apyrexial at 10 a.m. Relatives to see Mr - at 10.30 a.m. Urinalysis at 5 p.m. negative. BM stick 10 mol. 5 p.m. - blood pressure 80/50, P134. To have plasma as per regime. IV infusion commenced in left arm with Gentamycin. Hourly recordings of BP. P and T. Remains very cold, clammy, hyperventilating. Chest remains very moist to be nursed upright in bed, encourage to deep breathe and expectorate. O_2 24%, 2 litres via ventimask not being tolerated very well. Urinary output 1000 mls. Chest X-ray carried out. Blood

gases taken off. Condition remains poor. Urinary output nil. 40 mgs Frusemide given IV. Hourly urometer readings commenced. Antibiotics changed to Neticillin. BP 80/50, pulse 105, temp 37.5°C. Seen by Mr -. Colostomy leaking faecal purulent material. Stitch line also leaking - one suture removed, dry dressing applied.

Example 2

Bedbathed. Remains on bed rest. Having 2 hourly change of position and oral hygiene. Peripheral infusion continues as charted with antibiotics in regime. Parenteral feeding continues as charted now running to time, 6 hourly urinalysis continues negative at 11 a.m. 24 hour urine collection continues until 12 mn. 4 hourly recordings continue. Remains pyrexial 39.5 C at 2 p.m. Condition remains very poor. 80 mgs Frusemide given at 2 p.m. 4 hourly change of position, oral hygiene given, rikospray to buttocks. Oro-pharyngeal suction as required - intensive physiotherapy continues - chest very moist. Peripheral infusion running as charted. Parenteral feeding as charted with 24 hour bottles. 6 hourly urinalysis at 5 p.m. -ve. 4 hourly recordings continue. Pyrexial. Output at 9. p.m. 3100 mls. Urinalysis 9 p.m. -ve. Condition remains very poor. Pyrexial at 39°C.

The detail given in these reports throws into sharp contrast the reports of other patients who were also dying.

Example 1

No change in patient's condition. Visited by wife and son.

Example 2

Fair day. All care given 2 hourly. Brompton's mixture 10 mls at 12.30 p.m., 4.15 p.m. and 9 p.m. and MST 1 tab given at

5.30 p.m. Fluids and diet as tolerated.

Example 3

Depressed this morning - wanting to go home.

Example 4

Condition remains unchanged. All care given.

8.3 Oral reports

In every ward at the commencement of each spell of duty, there was an oral report session, following which duties were delegated to the staff. These sessions took place three times daily. In ten wards the night nurse gave the report to all the day shift nurses immediately they assembled for duty, in the remaining three wards, the nurse in charge was given the report by the night nurse, she/he then gave a report to the day nurses after they had assisted with the breakfasts. A further report session was held in all the wards between 1 - 2 p.m. In five wards all the nurses - both morning and afternoon/evening shifts attended these sessions, in eight wards only the nurses on afternoon/evening shifts attended this report. The final report of the day was given by the nurse in charge to all the night nurses before they commenced duties.

Following the ward report, when the nurses had dispersed, in each ward the senior nursing staff i.e. the sister/charge nurse and staff nurses conferred together. During these discussions significant and crucial information concerning the patients and their nursing care was exchanged. The junior nurses were never privy to these dialogues.

Two hundred and seventeen ward report sessions were attended.

The ward reports were conducted as a monologue. In ten wards, the nurses who listened were not encouraged to interrupt and give an account of their work with the patients; in three wards the situation was reversed; there frequently the nurses

were asked to give pertinent information on the patients for whom they were responsible; they were asked for both factual and subjective information.

The format of the ward report was uniform. All the patients were identified by name, age and diagnosis and in the surgical units the number of days since surgical intervention was stated; this was followed by a narration of the written report. In five wards no further information was given to supplement the reading of the written data. In six wards the written data were augmented by a few further details. In two wards (wards 7 and 10) where patient assignment ward organisation was practised, after the report sessions the sisters discussed the details of the nursing management with the nurses responsible for the specific patients. Table 59 outlines the sessions of formal group communications.

Most of the oral reports were delivered as a perfunctory duty. The content was as disjointed and as vague as the written reports; any additional data relating to physical psychosocial and spiritual aspects were given at random and on the aside.

Example 1

Written report at 1.30 p.m. - Patient E

Bedbathed. All nursing care. 4 hourly oral hygiene. Chart intake and output. Continuous bladder drainage. Feeling nauseated. Fluids and diet tolerated.

Verbal report at 1.30 p.m. - Patient E

Mrs E - 64 years. Gastric carcinoma. Superficial burns of buttocks. Poor Mrs E - bedbathed this morning and up for a short while: not well today: nauseated: give her just what she fancies. She's really miserable. If she's sore get something for her. She bursts into tears if her husband 'phones and she is told. Tell him to come in and bring her teeth.

TABLE 59

Sessions of formal oral, group communication

WARD	Report session 8 a.m. by night nurse	Report session 8 a.m. by sister/charge nurse	All nurses attended 1.30 p.m. report	Afternoon/evening nurses attended 1.30 p.m. report	Nurses contributed to reports	No contribution from nurses	No supplementary guidance	Detailed guidance	Few added details
1	✓	—	—	✓	—	✓	—	—	✓
2	✓	—	—	✓	—	✓	✓	—	—
3	✓	—	—	✓	—	✓	—	—	✓
4	✓	—	—	✓	—	✓	✓	—	—
5	✓	—	—	✓	—	✓	—	—	✓
6	✓	—	—	✓	—	✓	✓	—	—
7	✓	—	—	✓	✓	—	—	✓	—
8	✓	—	—	✓	—	✓	✓	—	—
9	—	✓	✓	—	—	✓	—	—	✓
10	—	✓	✓	—	✓	—	—	✓	—
11	—	✓	✓	—	—	✓	✓	—	—
12	✓	—	✓	—	✓	—	—	—	✓
13	✓	—	✓	—	—	✓	—	—	✓

Example 2

Written report at 9 p.m. - Patient C

No change, keep comfortable, up to sit most of the a.m. Please ensure Brompton's is given at 6 a.m.

Verbal report at 9 p.m. - Patient C

"Miss C - 41 years. Query hepatic carcinoma. No change, gradually deteriorating, too weak to get up tonight. Give Brompton's at 6 p.m., given at 8.35 p.m. Has Diamorphine. Keep comfortable. She feels a little bit better, but I don't know. Output - just a little. Up to the commode tonight. Her folks were in."

Guidance on physical care

The information given on the physical nursing care was unstructured. The nurses were advised to

"Just do anything you can for her"
"Just have to give her all nursing care"
"Give TLC plus, plus"
"Give plenty attention to her this afternoon"

Example 1

"Mrs C - 79 years. Ca. gall-bladder. Jaundice. Laparotomy fourteen days ago. Resuturing of wound - six days - for dehiscence. Total nursing care. Her condition's very poor, she's drinking when awake. Nurse her on either side. Just do anything you can for this lady. Her relatives are allowed in at any time."

Example 2

Mr Y - 69 years. Carcinomatosis. Admitted for pain assessment.

Gastroscopy biopsy two days ago. MST one tablet given for pain relief, having variable effect; sometimes good, sometimes no use. He has a bit of diarrhoea, query due to the vitamin C supplement, we'll maybe stop that. Fluid chart. Fluid and diet as tolerated. Looks quite well but sometimes forgets and shouts at the nurses. Thin, turn two hourly. Not up to eating much; he doesn't feel like it, but if he does, OK. He can get up."

Example 3

"Mrs N - 73 years. Haematemesis. Her condition remains very poor. IV infusion and nasogastric tube. Incontinent, catheter in situ. She's conscious but not very well. She's drowsy, keep her comfortable. Her pressure areas are intact. 60 mls water hourly. Oral hygiene, keep her mouth moist. TLC plus, plus. 24 hour urine collection. She's sweating - tepid sponge. Keep her dry and comfortable."

Guidance on psychosocial aspects of care

There was a paucity of guidance on the psychosocial aspects of care. The nurses were counselled on the emotional state of a few patients

"seems very worried"
"anxious, must have a word with her"
"a bit weepy last night"

they were advised

"keep as comfortable as possible"
"give him anything he wants"
"don't agitate him"

No guidance was given on the supportive measures the patients required.

Example 1

"Mrs L - 40 years. Carcinomatosis. Bedbathed this a.m. Up to sit for bed-making. Patient quite distressed and very breathless on exertion. Please encourage all oral fluids and diet. Only a little diet managed at lunch-time."

Sparse guidance was given on the knowledge the patient had of his/her condition or prognosis or on the tactics of communication being used.

Example 1

" - doesn't know her condition, so don't say anything inadvertently to her."

Mrs T - 78 years of age was alert and suffering from bronchial carcinoma.

Example 2

" - said last night he wanted a chat with me sometime. He's very aware so you know."

Mr Y - 69 years of age was alert and suffering from gastric carcinoma.

Example 3

"His wife has been seen and may be seen again by the doctors in the next few days, but she won't be coming in any time just in case he guesses. He's settled meantime."

Mr F - 48 years of age was alert and suffering from carcinomatosis.

Example 4

"Both husband and patient know her condition. She didn't sleep too well, to remain in bed. Bedbath given. When up last night to the commode, she fell and bumped her head. She's promised not to get up again. She's not saying anything."

Mrs M - 40 years of age was alert and suffering from metastasis, having previously had a mastectomy operation.

Details of the spiritual care or cultural care was limited to "priest informed".

Example 1

"Mr M - 60 years. Melanoma. Small bowel obstruction. His condition has deteriorated. Wife and priest informed. Bed bathed. All nursing care given as care plan. Keep as comfortable as possible. Continue IV fluids as charted. Nasogastric suction continuously - large amount of coffee-ground aspirate."

The benefit to the patient which may accrue from the presence of relatives was not mentioned. An account was given of the visiting pattern of the relatives.

- "saw his wife and son up yesterday"
- "poor Mr - was in, one feels sorry for him"
- "her son will be coming up from England, let him in when he comes"
- "they know, don't want to be disturbed during the night if anything happens"
- "relatives seen by doctor and told"
- "her husband is aware of her condition, he wishes to be informed."

The nurses' task to ensure that the relatives "had been told" or that "they know" was stated. Once the nurse reported the distress of the relatives - "she just bolted from the room when

I told her, it was terrible, I've made an appointment for her to see Mr -". The nurses were given no guidance on the needs of the family or friends of the patient.

Example 1

"Mrs S - 65 years. Carcinomatosis. Bed 16. Bedbathed two hourly change of position. Oral hygiene and oropharyngeal suction three times. Condition very poor. Relatives visited this morning, they are back up just now. Check the wall suction. Diamorphine 10 mgs at 1.30 p.m."

No policy to meet the needs of the person who was dying was outlined. The directives concentrated on the actions which were necessary to combat the deterioration resulting from the disease process.

Example 1

"Mrs S - 75 years. Diabetic. Right profundoplasty eighteen days ago. CCF. Became unwell after visiting. Centrally cyanosed. BP down, pulse also fell. Frusemide given IV. Night staff observations of BP and pulse remained stable, the BP's fallen again. Condition quite poor. Physicians not contacted yet. Frusemide IV. Fair effect. She dropped back into CCF. Her relatives were contacted and are there. Priest contacted. She in herself doesn't feel well and is a bit aggressive again. Urine analysis to continue, fluids, nothing solid. Turn her 2 hourly. Grey, cyanosed, oedema of her ankles and sacrum. Urinary catheter - hourly volumes, BP, pulse, chest moist. Try to get her to cough. Oxygen by ventimask. All nursing care. ECG ordered. Quite poor at the moment."

Example 2

"Miss O - small bowel obstruction. 7 days ago. They completely mixed up her parenteral feeding during the night -

that has happened before I don't know what they get up to. The resident 'phoned Mr - during the night, though he was advised not to. 2 hourly oral hygiene. Pressure areas. Peripheral feeding as charted it's still going, don't know how. 24 hour urine collection. Her wound is still leaking bile, he says he's not bothered in the least about that, given Frusemide. Condition still very poor.

Action to be taken at the time of death was not specified, apart from the occasions when referring to the next of kin the nurse stated "they want to know" or "not to be disturbed."

Example 1

Mr T - 54 years. Lymphoma. Condition still poor, his relatives 'phoned, his wife wishes to be notified if anything happens. He was seen by doctor last night, given 5 mgs diamorphine IV at 12.10 a.m. and 2.30 a.m. Relatives were seen by doctor and told. Unable to swallow tablets and fluids, incontinent of urine and faeces at 8 a.m. Positive for blood, BP is down. Apyrexial this a.m. Remains breathless.

Guidance on resuscitation

Guidance on the controversial issue of resuscitation of a patient was not given. One patient was identified "for resuscitation" by the consultant. The junior nurses were not instructed on the course of action for this patient. There were no written directives in the nursing notes. The information was conveyed orally during the senior nurse chat sessions.

Guidance on the state of the patients

The terms death and dying were not used. The fact that one patient was dying was stated in the verbal reports of that patient, in the reports of all the other patients the nurses

euphemised.

- "going down"
- "condition deteriorating"
- "just finished"
- "condition poor, relatives present"
- "her husband's aware of her condition, he wishes to be informed"
- "on the sick report"
- "think we'll have to sick report him, he's not well this morning"
- "relatives know his condition is poor, we'll bring his bed down, I think, we'll place him in that bed there"
- "condition very poor, requires a sideroom."

Example 1

"Mr T - 54 years. Condition deteriorating. His relatives have been in this morning. Diamorphine 10 mgs at 9.15 a.m. He appears to be Cheyne-Stoking. The parenteral feeding's to be discontinued and the line kept open with normal saline. Has had all nursing care."

Example 2

"Mrs T - 78 years. Ca. bronchus. She has deteriorated since last night. She's very drowsy and lethargic, looks awful. Her mouth is dirty, her teeth are out, she looks awful. They were taken out as her mouth was sore. Eusol soaks to sacrum it's much worse. She's very drowsy. Unable to speak, not communicating today, not taking diet, fluids. I'll see her husband. I doubt if she will last the week-end. Bring her into the ward. Take her hand. TLC. She's not complaining she is too drowsy."

Example 3

"Mr C - 60 years. Small bowel obstruction. Think we'll

have to report him, he is not so well this morning. Commenced on largactil and stemetil. To be catheterised as hasn't passed urine since early this morning. Doctor notified twice, trolley ready for her. His pressure areas are getting red continue with total care. IV fluids. No oral fluids."

Example 4

"Mrs F - 70 years. Carcinomatosis, Fortral 50 mgs at 10 p.m. Fluid balance 500 intake, nil output. Catherised - 500 mls. CSU taken. Urinalysis recorded. Slept very little. Managed a little breakfast. Very thin weak and dyspnoeic. Bedbath. Pressure areas red. Half a block of ice-cream taken last night. Diet as she feels. Relatives know her condition is poor. We'll bring her bed down, I think, will place her in that bed there."

Example 5

"Mrs D - the 68 years old bronchial ca. Her condition has deteriorated. She is a bluish grey colour. Diamorphine continued. Just finished. General nursing care. Not keen for diet."

The one patient who was identified as dying was an elderly lady who had not responded to treatment. A decision had been taken by senior medical and nursing staff that further intervention was not valid.

9 days before death

"Mrs L - 86 years old. IVF and MI. She has never recovered from her infarct, she's drowsy, confused and gradually deteriorating. Keep her comfortable, two hourly turns and eusol to left buttock sore, the condition is unchanged."

"She responds when touched" interjected the nurse who had given care.

"Don't know what to say, she shouldn't have survived this long. Urinary output satisfactory. No hydration. All nursing care, Oral hygiene. Eye care. All TLC, as they say."

8 days before death

Mrs L - 86 years - LVF and MI. Her condition remains poor. This woman is dying, keep her comfortable until she goes. Oral hygiene frequently. Pressure area care, turn two hourly as she has a small sore on her buttock, her heels are discoloured. Nurse prone intermittently. No recordings as we won't be doing anything anyway.

7 days before death

Mrs L - 86 years. LVF and MI. This woman is dying, just keeping her comfortable. She's very poor, deteriorating daily. Oral hygiene. Eye care. TLC. Her pressure areas are the same, continue with eusol, nurse prone to keep her off the sore. Her catheter is by-passing, continue on free drainage.

5 days before death

Mrs L - 86 years. LVF and MI. She's been going for ages. I wouldn't give her more than a few hours really, I wouldn't, but I don't think she is going to die today! Her heels are red, the sore on her buttocks is much the same. Just continue as before. She needs suction as there is a lot of horrible green sputum, suction as necessary. She hasn't passed urine, continue TLC.

4 days before death

Mrs L - 86 years. LVF and MI. She's unconscious now. Attend to oral hygiene 2 hourly. Bathe her eyes with normal saline. Keep her off her buttocks, continue as before, the

small sore on her buttocks is unchanged - she's not marked, 2 hourly change of position. Having nil orally. Has not passed urine. Requires all nursing care.

The patient died four days later.

The oral reports were comparable with the written reports. Little or no guidance was given on the 'care' requirements of the patient. If medical intervention occurred, this was outlined in detail. At all times the accounts were punctuated by hospital jargon, which was incomprehensible to the uninitiated junior nurses.

Example 1

"Mr - 48 years. Carcinomatosis. He's not very well. IV fluids with morphine packed up and taken down. For Temgesic orally. Actively sick query obstruction, query naso-gastric tube. Paracentesis abdominis successful, now 200 mls in the bag. Catheter draining. Turn, bottom red. Pressure area care. Sheepskin in situ. I'll let you know - give small amounts of fluid. His wife was up last night, got Dr -- to see her. Sit him up, it may help his breathing. Give suppositories or enema this p.m. If you think for a minute he is having pain ask them to step it up. He knows I think, he doesn't talk about it. He must know he's not well and is keeping it to himself."

Semantic content is the major but not the only component of communication. Information reached the nurses by 'other channels'. One student outlined the situation while discussing the condition of one patient -

"It's awful with Mrs F, a fortnight ago she was super, just talking like everyone else, it's pathetic, just look at her now, she's flattened by the drugs, it's awful for her."

"Do you know what's happening?" asked the observer.

"Well, sort of."

"What do you mean?"

"Yes, well, mm-"

"How do you know?"

"Well nobody says she's got so long, you can't go up to anyone and ask, it's really by the tone of their voice, how they speak, not what they say, you sort of guess, having seen the same thing before."

"Would you like to be told?"

"Yes, it would let you know how to talk to people, you really just nurse in the dark, I've just gradually had to learn."

8.4 Nursing care plans

Instructions on the individual nursing care plans or individual patient instruction sheets were almost impossible to follow. The plans were partially completed at the time of the patient's admission, but thereafter were either not kept up-to-date to meet the immediate requirements of the patient or due to numerous crossings-out it was difficult if not impossible to decipher the current instructions. In only three wards the data on the nursing care plans synchronised with the patient's needs. Nurses were observed consulting the nursing care plans in only two wards. At the commencement of the study, data were collected from these documents, but this was abandoned since for the aforesaid reasons they seemed on the whole to be ineffective giving little or no information or guidance to the nurses.

8.5 Summary

1. The reports were incomplete, imprecise and disjointed. Hospital jargon, abbreviations and innuendoes interspersed the data. Repetition was common.

2. The data was predominantly retrospective information - a reporting of nursing tasks performed and clinical nursing observations with little qualitative data. There were few instructions and very little prospective guidance on the nursing care requirements of the patient.

3. The dying state of the patient was not defined.

4. The emphasis was on the disease and medical intervention. Information on the 'person' and his specific needs were deficient.

5. Physician-dictated aspects of care outweighed the nurse-dependent areas of care.

6. The verbal report was similar to the written report; occasionally the verbal data were augmented by subjective assessments of the patient and/or by anecdotes of incidents involving the patient, relatives or doctors.

7. The report sessions were conducted in an autocratic manner; nurse accountability was not encouraged.

8. Instructions on nursing care plans did not follow a logical sequence and due to alterations and being 'out-of-date' were of little value.

The dying patient was identified by name, age and diagnosis as was every other patient. The crucial fact that he was dying, which differentiated him from the other patients who had positive recovery prospects, was not stated. The nurses had to elicit the true/factual state from the various cues, many of which were subtle and required a modicum of experience and education. The cues in the reports which guided the independent assessors to determine the dying state of the patients were:

1. The descriptive terms applied to the condition eg. 'poor' 'deteriorating'.

2. A reference to the presence of relatives.

3. The use of specific medication eg. Diamorphine sulphate, Brompton's mixture.

4. Specific changes eg. Cheyne-Stokes breathing.

5. The termination of treatment eg. "IV infusion not to be re-sited"

6. The response of the patient to medical intervention eg. no output of urine following the administration of Frusemide.

7. The 'general tone' of the report linked with the diagnosis.

Though nurses, conditioned by experience, may have acquired the skills to interpret the innuendoes, the student/pupil nurses did not always appreciate the situation. This was evident when one junior nurse standing by the bedside of a patient whose death was imminent (and dying obvious) expressed surprise to learn from a colleague that the patient was in the terminal stage of life. Communication was in one direction only - downwards. There was no recognised method of feedback: it was assumed that the nurses understood.

The dichotomy between the sisters' awareness of the dying state of the patient and the nurses' appreciation of the situation was unbridged.

The disease was the central focus of the nurse reports. Not only was the patient linked inextricably in the reports with the disease from which he suffered, but also there was a preponderance of data on the medical intervention to combat the disease and the related technical nursing skills. Information on the 'person' needs of the patient and nursing intervention was deficient. There was little or no reporting on the physical state, the emotional state, or the social state of the patient: no identification of problems related to the state of dying and no guidance on the care required to meet anticipated needs. The nursing care given or to be given was incorporated in cliches - eg. - "All nursing care given" or "Give all nursing care". The care was not itemised, it was assumed to have been given or that it would be given in its entirety. It was also assumed that each nurse, each grade of nursing staff would know and act as the nurse in charge would herself in a direct care context, but specific preparation and experience were not relayed.

The nurses were aware of receiving inadequate information. "You get a poor report in this ward" was the comment of one student; another student nurse voiced what perhaps were the sentiments of the learners in her comment "You really just learn in the dark. I've just gradually had to learn." If not told, nurses are disinclined to ask for guidance; according to Revans (1966) they saw the sisters as "unapproachable and uncommunicative". To-day in hospital there may be more contact between senior and junior staff, but the complaint of inadequate information remains unchanged. One student commented following a misunderstanding on her action at the moment of one patient's death "What's wrong with me ..is I ask too much. You are not supposed to ask why."

It may be contended that the reports were considered out of

context, and the nurse requires to see and assess the patient; only then can she appreciate the situation and the role she must play. This assumes the learner nurses have the capability and experience to identify the problems and prescribe the care to meet the need. Though interaction between one patient and a nurse may develop, the general concept of patient care is that it is discharged in teamwork. The sister, in her position of leader of the nursing team, plans the nursing input which complements the medical therapy. She is responsible for giving directions to the nursing staff on the care required by the patient.

The reports which were studied did not provide evidence of this concept. The sister gave little information on the patient to the nurses. No policy of nursing care for the dying patient was outlined. The emphasis was on the disease, not on the person needs of the dying patient. The influence of the medical profession and the infiltration of medical ideology on the nursing management of the patient was recognised in these data as information concerning the disease and medical intervention predominated in written and verbal nursing reports.

Chapter 9

Summary and conclusions

The overall aim of the study was to find out how the patients who die in urban general hospitals fare during the last week of life. The intention was to

a) describe the nursing care of the patient,
b) determine factors which might influence the nursing care of the patients.

The principal finding from the study of nurse activities concerning the dying patients was that the nursing care was less than adequate. ie. The equivalent of a safe and adequate standard of care for a totally helpless bedfast patient was not met in accordance with the acceptable standard described in SHHD Reports Numbers 3 and 9. Nursing services were governed by the 'ward routine' and provided predominantly by the junior nurses. Attention to the patients' physical needs outwith this framework was rarely observed. Interactions between the nurses and the patients were brief, occurring on average once or twice hourly. The patients were often alone.

The fifty patients observed were highly dependent and required skilful physical and psychosocial nursing skills. The majority of the patients (66%) though conscious were very weak and were unable to attract the nurses' attention or sustain contact with them in the aggressive competitive environment of the acute general hospital ward. The needs of the patients had not been determined systematically by the nurses. This was most apparent in the care of the patients who had been 'admitted to die'. These patients received fewer visits, less time and less nursing care than the patients who, when admitted, had a positive prognosis.

Alterations in this pattern occurred when a 'caring' nurse was present, when patient assignment work organisation was practised or when medical interest in the patient was intense.

Thirty of the one hundred and ninety-three members of the nursing staff observed (15.5%) demonstrated a 'caring' attitude. These nurses from different grades and with varied professional experiences spent time with the patients who were dying. They endeavoured to establish contact and to provide a service to meet the specific nursing needs of the patients. The increased attendance time and individualised nursing care activities remained the consistent characteristics of the behaviour of these 'caring' nurses throughout repeated observations. This pattern of nurse activities threw into sharp focus the behaviour of their colleagues who spent little time with the patients and 'distanced' themselves from the patients.

In eleven of the thirteen wards nursing work was organised by task allocation and by patient assignment in two wards. The patients nursed in the two wards where patient assignment ward organisation was practised received more contact time and nursing care from qualified nursing staff than the patients in the other units.

The input from qualified nurses and senior nursing students increased for patients in whom the consultants demonstrated interest. This relationship between qualified nurse-dying patient interactions and consultant-dying patient interactions was explored further. The medical practitioner's philosophy and practice was thought to be one factor which might influence the nursing care of the dying patient. It was expected that the senior nurses would mimic the consultants' attitude towards the patients and that medical ideology would dominate discussions concerning the patients. This area was studied by attending ward rounds, observing the activities of the senior medical and nursing staff at the patients' bedsides and by noting the content of the discussions between the two key figures.

The expectations were borne out in the data. Most qualified nurses distanced themselves from the dying patients when the consultants demonstrated less interest. Analysis of

communications between consultants and qualified nurses indicated that medical problems dominated discussions about patients. Sparse consideration was given to joint discussion on nursing problems. Discussion with nurses was infrequent on aspects of patient management over which the consultants had control and which had a direct influence on the nursing care of dying patients.

Medical staff interest in the patients varied. Four consultants (28.5%) demonstrated a 'caring' attitude. They spent time with the patients and tried to establish contact. The remaining ten consultants (71.4%) did not linger at the patients' bedsides unless a definite medical instruction related to the organic disorder was required. The time these latter consultants spent with the patients was dependent on the continuation of active medical intervention. When active medical intervention was discontinued they withdrew from the patients. The consultants who were seen to be 'caring' demonstrated a holistic approach to patient care. They discussed with the nursing staff the varied physical and psychosocial needs of the patients and the responses of the patients to medical and nursing intervention. The nurses responded and were forthcoming in these discussions. Consultants who exhibited interest in the organic disorder only, maintained a watching brief on the patients, referred to the disease manifestations when these were apparent and considered aspects of medical intervention. The contribution of the nurses to these conversations was minimal. There was a similarity in the attitude of the consultants to the patients and the attitude of the consultants to the nurses. The consultants who tried to establish contact with the patients also spoke with the nurses in attendance. Consultants who indicated less involvement with the patients, spoke less frequently to the nurses. This finding is open to different interpretations but it is an area which merits further exploration.

The qualified nurses differed in their attitude to the patients

and in their response to the consultants. Fifteen of the twenty-two qualified nurses (68.2%) had little or no contact with the patients unless the consultants indicated interest. During patients' consultations they introduced no aspects of patient care for discussion with the consultants, but referred only to the technical recordings of vital signs which monitored the deterioration of the patients' condition. These nurses seemed to have become an extension of the doctors' diagnostic and curative role. Four qualified nurses (18.1%) had contact with the patients, but were reticent during the consultants' visits and reported few of the patients' problems for joint consideration. Three sisters (13.6%) were self-sufficient and demonstrated professional autonomy. These qualified nurses accepted responsibility as individual practitioners. They were involved in the nursing of the patients, had a holistic approach to the patients' needs and in conversation with the consultants introduced pertinent problems to be resolved in current discussion with them. These nurses (few in number) acted as advocates for the patients. They used their professional judgment to assess the patients' needs and were persistent until medical intervention, if necessary, was initiated to give adequate relief. This autonomy demonstrated by these qualified nurses made them the exception amongst their colleagues. These nurses also differed in methods of ward organisation, for they organised the discharge of care by patient assignment whereas the other nurses managed by task allocation. Pembrey(1980) in her study of ward sisters reported that "sisters who organised work on an individual patient basis were among the most highly qualified academically and professionally". To suggest that the behaviour of the three sisters who differed from their colleagues by demonstrating professional autonomy and interacting more freely with the consultants is directly related to their academic and professional qualifications goes beyond the present material but indicates another area for further study.

All the consultants responded positively to the qualified

nurses who demonstrated professional autonomy. On the few occasions when the qualified nurses, who had contact with the patients, but were reticent towards the consultants proferred the patients' problems for discussions, the response of the consultants varied. The consultants who had a 'caring' attitude listened and considered the problems with the nurses. The other consultants who were orientated towards the organic disorder listened but invariably dismissed the nurses' contribution. These nurses was passive in response to the peremptory attitude of these consultants. The consultants spoke infrequently to the nurses whose contributions were linked only to recordings of the patients' deterioration. Two consultants did not communicate directly with the qualified nurses.

In this study it is shown that the 'caring' consultants worked most often with the qualified nurses who demonstrated professional autonomy and the consultants who indicated an interest primarily in the disease worked most often with the qualified nurses of a similar inclination.

The relationship between the activities of the senior medical and nursing staff towards the dying patients and the varied responses between the consultants and the qualified nurses during patient consultations were detailed during non-participant observations. The data are concerned with a description of what occurred, however the causal significance of these actions and the underlying motivation of the qualified nurses and the consultants cannot be explained by observed-behaviour. Exploratory interviews with the key participants, with further observations involving a number of doctor-nurse teams and different types of patients, might give evidence of a causal relationship. This area remains to be explored.

There was a lack of discussion on aspects of patient management over which the consultant had control and which might have a direct affect on the nursing of dying patients. These aspects include

1. Prognosis of the patient
2. Medication prescription
3. Communication with the patient
4. Active resuscitative intervention.

1. Prognosis of the patient

It was noted that the state of the patient was not defined. The patients continued to be labelled with the organic disorder from which he/she suffered initially. This was the point of reference when the patients were considered by the senior medical and nursing staff. On entry to hospital patients progress along a predetermined path. Following admission a clinical history is written and the patient is examined by the junior and senior doctors. When the diagnosis is confirmed, medical treatment is prescribed. The treatment of the disease is specific to the disease. Modifications in the standard treatment are made at the discretion of the consultants, who have individual preferences in the management of the disease. The qualified nurses are aware of the pattern of therapy of each disease and know the idiosyncracies of the consultants with whom they work. Therefore when the patient's condition has been diagnosed and treatment commenced detailed discussions on its management are not required unless a complication develops. The treatment of the disease is 'routine'.

A dilemma existed when the patients regressed into the dying phase. Dying is not an identified 'disease'. There is no predetermined plan of care for this 'phenomenon'. The 'routine' which governed the activities concerning the dying patient in the absence of recognition and acknowledgement of his/her dying state was little more than 'speaking to the relatives'.

2. Medication prescription

One means of providing relief for patients is by the use of

drugs. The prescription and hence administration of medicines is controlled by the doctors. Discussion between the senior medical and nursing staff on medication to provide adequate relief for patients varied. The 'caring' consultants considered the symptomatic physical problems and subsequent responses of the patients to medication. Therapy was tailored to provide relief. The senior nurses who demonstrated professional autonomy defined and discussed with all consultants the patients' problems. These nurses were intransigent until medication was prescribed to give adequate relief. In the other teams medication was prescribed but the effectiveness of the medication was rarely reviewed. The distress of patients was often evident.

3. Communication with the patient.

Communication and the need for this with the dying patient was not discussed. In the Ministry of Health Report (1963) on the subject of communication with patients it was recognised that the decision about the details of what is said or done must rest with the consultant. Cartwright (1964) found that when the doctor did not disclose knowledge to the patient neither did the ward sister. This behaviour was evident in the study. All qualified nurses identified with the specific approach adopted by the consultants. Sharing of knowledge with the patients was not discussed. The consultants did not disclose to the qualified nurses the knowledge they had shared with the patients or the relatives.

4. Active resuscitative intervention.

The course of action to be taken at the time of cessation of breathing was not discussed. Directives from the consultants on resuscitative intervention were rare. Communication was a dialogue of innuendoes. It was assumed that everyone within the team understood. This presumption was not always valid.

Analysis of the content of written and verbal nursing reports indicated that the emphasis towards the disease and its treatment as detected during senior medical and nursing staff interactions was perpetuated in the communication between senior and junior nursing staff. The junior nurses were given no goals to achieve whether in terms of quality or quantity of life. They were left to attend to the patients in an atmosphere of uncertainty. In this atmosphere of uncertainty they were guided by the ward routine. The routine, though an 'effective means of ensuring the work is done within safe limits' (Pembrey 1980) did not accommodate for the needs of the patients who were dying, in particular it did not designate time to 'be with the patient'. The nurses required to be guided in their activities to meet the needs of the dying patients and to be given license to take time to linger with the patients. This did not occur. It is of interest that the three sisters already identified as having a patient-centred approach rather than a disease-centred approach, discussed with the nurses responsible for the patients the proposed nursing care of the patients to supplement the written and verbal reports.

In teams where the consultants and qualified nurses had a holistic approach to patient care i.e. the consultants had a 'caring' attitude and the qualified nurses demonstrated 'professional autonomy' then the needs of the dying patients were met. When neither consultant nor qualified nurse demonstrated these attributes or showed a specific interest in the dying patient a corresponding deficit in patient care occurred. In these instances the nursing of the dying patient, by default, became the responsibility of the junior nurses.

The patient is the combination of a person and a disease. These entities i.e. the person and the disease require different skills. The aim of the care-giver will be directed towards the needs of the person or the needs of the disease according to his/her education, professional and

personal experiences. Though the needs of the person and the disease are interwoven and care of both should dovetail, the activities of those giving care can be considered to fall on a continuum between management of the disease - cure and management of the patient - care.

Medical care is orientated towards management of the disease processes and the skills of the doctor are developed to diagnose, prognose and cure or alleviate the symptoms of the disease (McLean 1979). Fletcher (1972) from his experience wrote "We have had no training to fit us for the many complex skills, emotional and spiritual which communication with the dying presents".

Doctors who tended towards the disease end of the continuum demonstrated interest when the organic disorder of the patients challenged their technical medical skills. Other clinicians tended towards the person end of the continuum demonstrating psychosocial skills in their efforts to achieve a peaceful death for the patients.

Nursing care is outlined as "primarily to assist the individual (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge" (Henderson 1969). The skills of the nurse are directed towards assisting the person, who due to the disease is a patient.

Senior nurses tended to move away from the care end of the continuum except in exceptional instances. Medical orders, the one dependent area of the nurses' work, was given pre-eminence and the area of nursing which is defined and practised by the nurses under their own professional powers was neglected. Written and verbal nursing reports were dominated by medically orientated detail. Medical investigations i.e. recordings of temperature, pulse, respiratory rates, blood pressure recordings, faecal and urine

analysis were continued until the death of the patient. Ward rounds with the doctors concentrated on the disease problems of the patients at the expense of the needs of the person. The nurses role in achieving a peaceful death for the patient was not discussed.

The concept of the nurse as a handmaiden (though intelligent handmaiden) of the doctor has been outlined in literature. This is one of the important tasks which she performs. However, if she begins to identify with the medical care (disease needs) of the patient and hence relinquishes some of her responsibilities for the person needs of the patient a deficit in the nursing care of the patient becomes apparent. Few qualified nurses displayed professional responsibility and interceded for the patients by outlining the needs of the patients to the consultants.

The consultant is responsible for the treatment of the patient. He is the custodian of vital information which might have a bearing on the nurses' relationship with the patients. He is aware of the prognosis of the patient and the subsequent goals to be achieved - a peaceful death or aggressive resuscitation. He communicates with the patient and the family disclosing information which he feels is appropriate. If the flow of information from the doctor to the nurse is not full and free, nursing care of the patient will be in deficit.

Nurse and doctor cannot work in isolation. Mutual support and understanding are essential. In the care of the dying patient the state of the patient must be recognised and acknowledged. Means of achieving a peaceful appropriate death for the patient must be discussed. Dialogue between the key caregivers is essential to ensure the objective is achieved.

APPENDIX I : PATIENT PROFILE

APPENDIX II : WARD ROUND PROFILE

APPENDIX I

PATIENT PROFILE

Name: _____

Age: _____

Status in family: _____

Occupation: _____

Diagnosis: _____

Date of onset of illness: _____

Length of present illness: _____

Dates of hospital admission: 1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Date of present admission: _____

Reason for admission:

Clinical appearance of the patient:

State of awareness: alert _____
aware of environment _____
semi-conscious _____
unconscious _____

Ability to communicate:

Patient's expressed needs:

Nursing requirements:

Nursing care prescribed:

Nurses perception of the patient:

Technical equipment:

I V fluids	_____
Oxygen	_____
Catheter	_____
Suction	_____
Drainage	_____
Dressings	_____
TPR monitoring	_____
BP monitoring	_____

Complications:	Present	Absent	Not observed
Pain	_____	_____	_____
Vomiting	_____	_____	_____
Cough/breathlessness	_____	_____	_____
Constipation	_____	_____	_____
Faecal incontinence	_____	_____	_____
Urinary incontinence	_____	_____	_____
Dehydration	_____	_____	_____
Anorexia	_____	_____	_____
Pressure sores	_____	_____	_____
Depression	_____	_____	_____
Anxiety/panic	_____	_____	_____
Loneliness	_____	_____	_____

Medicines given: Date of commencement:

Relatives/friends involved:

Privileges granted:

APPENDIX II:

WARD ROUND SCHEDULE PATIENT _____

Ward _____ Date _____ Time _____

Doctors participating
Consultant _____
Senior Registrar _____
Registrar _____
Senior House Officer _____
Resident _____

Nurses participating
Sister _____
Staff Nurse _____
Nurse/Grade _____

Others participating

1. Note the activity of the doctor and the nurse.
   (a) Did any team member perform unscheduled activities?
   (b) Were any codes of practice waived aside by any team member?
   (c) Did each member talk to and be addressed by the patient with mutual acceptance by other team members?

2. Note the formation of the team
   (a) Who initiated the ward round?
   (b) How was it announced?
   (c) Who led the procession?
   (d) Who provided the equipment?
   (e) Who entered the room first?
   (f) Who left the room first?

3. Note the format of the conversation - manifestation of control.

(a) Who opened conversation? _____

(b) Who closed conversation? _____

(c) Who dominated conversation? _____

(d) Did the doctor ask the nurse questions? _____

(e) Were reasons given for asking the questions? _____

(f) Were all answers accepted by the doctor? _____

(g) Did the nurse ask the doctor questions? _____

(h) Were reasons given for asking the question? _____

(i) Were all answers accepted by the nurse? _____

(j) Did the doctor advise the nurse? _____

(k) Did the nurse advise the doctor? _____

(l) Did the doctor criticise, comment on, judge the nurse's activities? _____

(m) Did the nurse criticise, comment on, judge the doctor's activities? _____

At the bedside of the dying patient

1. Note the attitude of the doctor to the patient.

(a) Subject for technical medical skills. _____

(i) Teaching material? _____

(ii) Research material? _____

(iii) Material to demonstrate technical skills? _____

(iv) Discarded failure? _____

(b) Subject for psychosocial skills. Did the doctor

(i) Spend time with the patient? _____

(ii) Talk with the patient? _____

(iii) Communicate openly with the patient? _____

(iv) Wait for an answer from the patient? _____

(v) Touch the patient? _____

(vi) Give regard to the specific needs of the patient? _____

(vii) Consider the patient's relatives? _____

2. Note the attitude of the doctor to the nurses

(a) Was he receptive to nursing problems? _____

(b) Did he give support, encouragement? _____

(c) Did he give suggestions implying autonomy? _____

3. Note the content of communication from the doctor. Did he

(a) Give clear, concise guidance? _____

(b) Outline a policy of care? _____

(c) Ask for suggestions and opinions from the nurse? _____

(d) Concentrate on medical topics? _____

(e) Consider nursing topics? _____

(f) Give guidance on resuscitation? _____

(g) Outline information conveyed to the patient? _____

(h) Outline information to be conveyed to the patient? _____

(i) Outline information conveyed to the relatives? _____

(j) Outline information to be conveyed to the relatives? _____

(k) Communicate by cues? _____

4. Note content of communication from the sister. Did she

(a) Report on the physical state of the patient?

pain _____

problems related to breathing _____

problems related to nutrition _____

eating - dysphagia _____

anorexia _____

vomiting _____

drinking - dehydration _____

elimination - urinary output _____

constipation _____

problems related to

oral hygiene _____

pressure areas _____

personal hygiene _____

movement _____

the results of

TPR recordings _____

BP recordings _____

Urinalysis _____

FOB results _____

Blood analysis _____

Laboratory results _____

the progress of the disease _____

(b) Report on the emotional state of the patient?

depression _____

anxiety _____

loneliness _____

sleeplessness _____

(c) Problems related to communication

the patient's awareness _____

providing for special needs _____

(d) Report on the family involvement?

communication with the family _____

problems relating to the family _____

(e) Report on the spiritual aspects of care?

contact with the Priest/Minister _____

(f) Ask for guidance on resuscitation policy? _____

5. Note attitude of the sister to the patient.

(a) Subject for 'disease' pattern interest _____

(b) Subject for psychosocial skills _____

Support the patient by touch _____

word _____

look _____

Assist the patient to relate to the doctor _____

BIBLIOGRAPHY

ALTSCHUL, A.T. (1972). Patient-Nurse Interaction. A Study of Interaction Patterns in Acute Psychiatric Wards. Edinburgh: Churchill Livingstone.

AULD, M.G. (1979). Nursing in a changing society. Journal of Advanced Nursing, 4, pp. 287-298.

BAINES, M.J. (1978). Control of other symptoms. In Saunders, C.M. (ed.) The Management of Terminal Disease. London: Edward Arnold.

BALY, M.E. (1973). Nurse and Social Change. London: Heinemann.

BECKER, H.S. and GEER, B. (1957). Participant observation and interviewing: A comparison. Human Organisation, Vol. 16, No 3, pp. 28-32.

BELLAMY, P. and ORIBABOR P. (1980). The history of the present-contradiction and struggle in nursing. In Davies, C. (ed.) Rewriting Nursing History. London: Croom Helm.

BIRCH, J.A. (1978). Anxiety in nurse education. Unpublished Ph.D. thesis. University of Newcastle-upon-Tyne.

BLEEKER, J.A.C. and POMERANTZ, H.B. (1979). The influence of a lecture course in loss and grief on medical students: An empirical study of attitude formation. Medical Education, 13, pp. 117-128.

BOND, J. and S. (1980). A taboo of our times. Nursing Mirror, Vol. 150, No. 11, pp. 23-26.

BOND, S. (1979). Communication study. Unpublished Ph. D. thesis. University of Edinburgh.

BOLAND, M. (1977). Care of the dying patient in intensive care areas. Nursing Mirror, Vol. 145, No. 8, pp. 20-21.

BOWERS, M. et. al. (1964) Counselling the Dying. New York. Thomas Nelson and Sons.

BROWN, E.L. (1966). Nursing and patient care. In Davis, F. (ed.). The Nursing Profession. London. John Wiley and Son.

BUCKINGHAM, R.W. et. al. (1976). Living with dying: Use of the technique of participant observation. Canadian Medical Association Journal, Vol. 115, No. 2, pp 1121-1125.

BYRNE, P. and LONG, B.E.L. (1976). Doctors talking to patients: A study of the verbal behaviour of general practitioners consulting in their surgeries. London: H.M.S.O.

CALMAN, K.C. (1978). Physical aspects. In Saunders, C.M. (ed.). The Management of Terminal Disease. London: Edward Arnold.

CARTWRIGHT, A. (1964). Human Relations and Hospital Care. London: Routledge and Kegal Paul.

CARTWRIGHT, A. HARVEY, L. and ANDERSON, J.L. (1973). Life before Death. London: Routledge and Kegan Paul.

CENTRAL HEALTH SERVICES COUNCIL and MINISTRY of HEALTH (1963) Communication between Doctors, Nurses and Patients. An Aspect of Human Relations in the Hospital Service. H.M.S.O.

CLARK, J.M. (1981). Communication in nursing. Nursing Times. Vol. 77, No. 1, pp 12-18.

CHAPMAN, C. (1976). Nursing - rhyme or reason? Nursing Times. Vol. 72, No. 31. Occasional Paper. pp. 109-112.

CICOUREL, A.V. (1964). Method and Measurement in Sociology. New York: The Free Press.

CLAIR, L.L. and TRUSSELL, P.M. (1969). The change of shift report - study shows weaknesses, how it can be improved. Hospitals, 43, 19, pp. 91-95.

CORMACK, D. (1976). Psychiatric Nursing Observed - a Descriptive Study of the Charge Nurse in Acute Admission Wards of Psychiatric Hospitals. London. Royal College of Nursing.

DENTON, J.A. and WISENBAKER, V.S. (1977). Death experience and death anxiety among nurses and nursing students. Nursing Research. Vol. 26, No. 1. pp. 61-64.

DENZIN, N.K. (1970). The Research Act in Sociology: A Theoretical Introduction to Sociological Methods. London: Butterworth.

DEWI REES, W. (1972). The distress of dying. British Medical Journal, 3, pp. 105-107.

DOYLE, D. (ed.) (1979). Terminal Care. Edinburgh: Churchill Livingstone.

DUFF, R.S. and HOLLINGSHEAD, A.B. (1968). Sickness and Society. New York: Harper and Rowe.

EXTON-SMITH, A.N. (1961). Terminal illness in the aged. Lancet, 2. p. 305.

FLETCHER, C.M. (1972). Communication in Medicine. Nuffield Provincial Hospital Trust.

FIRST REPORT OF A SPECIAL COMMITTEE ON NURSING EDUCATION (1964). A Reform of Nursing Education (Platt Report) London: The Royal College of Nursing.

FOX, D.J. (1976). Fundamentals of Research in Nursing. 3rd Ed. New York: Appleton - Century - Crofts.

FRETWELL, J.E. (1980). Hospital ward routine - friend or foe? Journal of Advanced Nursing, 5, pp. 625-636.

GARFIELD, C.A. (1978). Elements of psychosocial oncology. Doctor-patient relationships in terminal illness. In Garfield, C.A. (ed.). Psychosocial care of the Dying Patient. New York: McGraw-Hill.

GLASER, B. and STRAUSS, A.L. (1965). Awareness of Dying. London: Weidenfield and Nicolson.

GLASER, B. and STRAUSS, A.L. (1967). The Discovery of Grounded Theory. Strategies for Qualitative Research. Chicago: Aldine Publishing Co.

GLASER, B and STRAUSS, A.L. (1968). Time for Dying. Chicago: Aldine Publishing Co.

GLASER, B. and STRAUSS, A.L. (1972). The social loss of dying patients. In Browning, M. H. and Lewis, E.P. compilers. The dying patient: a nursing perspective. New York: AmericanJournal of Nursing. 1972. (Articles reprinted from American Journal of Nursing, Nursing Research and Nursing Outlook.)

GODDARD, H.A. (1953). The Work of Nurses in Hospital Wards: Report of a job analysis. London: Nuffield Provincial Hospital Trust.

GODDARD, H.A. (1958). Principles of Administration Applied to Nursing Service. Monograph Series. No 41. Geneva: World Health Organisation.

GODDARD, H.A. (1963). Work measurement as a basis for calculating nursing establishment. An analytical study. Harrogate: Leeds Regional Hospital Board.

GOLD, R.L. (1958). Roles in sociological field observation. Social Forces, 36, pp. 217-223.

GOW, C.M. and WILLIAMS, J.I. (1977). Nurses' attitude towards death and dying. Social Science and Medicine, 11 Feb. pp. 191-198.

HENDERSON, V. (1978). The concept of nursing. Journal of Advanced Nursing, 3, pp. 113-130.

HENDERSON, V. (1969). Basic Principles of Nursing Care. Geneva: International Council of Nurses.

HINTON, J.M. (1963). The physical and mental distress of the dying. Quarterly Journal of Medicine. Vol. 32, No. 125

HINTON, J. (1967). Dying. Harmondsworth: Penguin.

HINTON, J. (1974). Talking with people about to die. British Medical Journal, 3, pp. 25-27.

HOCKEY, L. (1977). The nurse's contribution to care in a changing society. Journal of Advanced Nursing, 2, pp. 147-156.

HOLFORD, J.M. (1973). In Care of the Dying. Proceedings of a National Symposium held on 29th November 1972. London: H.M.S.O.

HOPPING, B.L. (1977). Nursing students' attitude towards death. Nursing Research, Vol 26, No. 6, pp. 443-447.

JONES, D.C. (1975). Food for Thought. The Study of Nursing Care Project Reports. Series 2, No. 4. London: Royal College of Nursing.

KALISH, R.A. (1966). Social distance and the dying. Community Mental Health Journal, Vol 2, No. 2, pp. 152-155.

KECK, V.E. and WALTHER, L.S. (1977). Nurse encounters with dying and non-dying patients. Nursing Research, Vol. 26, No. 6, pp. 465-469.

KNIGHT, M. and FIELD, D. (1981). A silent conspiracy: coping with dying cancer patients on an acute surgical ward. Journal of Advanced Nursing, 6, pp. 221-229.

KNUTSON, A.L. (1970). Cultural beliefs on life and death. In BRIM, O.G. et al. The Dying Patient. New York: Russell Sage Foundation.

KRATZ, C.R. (1974). Problems in the care of the long-term sick in the community. Unpublished Ph.D. thesis, University of Manchester.

LANCET COMMISSION ON NURSING (1932). London: The Lancet Limited.

LAUBE, J. (1977). Death and dying workshop for nurses: Its effect on their death and anxiety levels. International Journal of Nursing Studies. Vol 14, No. 3, pp.111-120.

LELEAN, S.R. (1973). Ready for Report, Nurse. The Study of Nursing Care Project Reports. Series 2. No. 2. London: Royal College of Nursing.

LESTER, D. et al (1974). Attitudes of nursing students and nursing faculty towards death. Nursing Research, Vol. 23. pp. 50-53.

LEVINE, S. and SCOTCH, N.A. (1970). Dying as an emerging social problem. In Brim, O.G. et al. The Dying Patient. New York: Russell Sage Foundation.

LEVY, B. and SCLARE, B.A. (1976). Fatal illness in general practice. Journal of Royal College of General Practitioners, Vol. 26, pp. 303-307.

MATTHEWS, A. (1975). Patient allocation: a review. Nursing Times. Vol. 71, No. 28. Occasional Paper pp. 65-68.

MELIA, K.M. (1979). A sociological approach to the analysis of nursing work. Journal of Advanced Nursing. 4, pp. 57-67.

MELIA, K.M. (1981). Student nurses construction of nursing. A discussion of a qualitative method. Nursing Times. Vol. 77, No. 16, pp. 687-699.

MELIA, K.M. (1981). Student nurses' account of their work and training. A qualitative analysis. Unpublished Ph.D. thesis. University of Edinburgh.

MENZIES, I.E.P. (1960). A case-study in the functioning of social systems as a defense against anxiety. Human Relations. Vol. 13, 2, pp. 95-121.

MURRAY-PARKES, C. (1978). Psychological aspects. In Saunders, C.M. (ed). The Management of Terminal Disease. London: Edward Arnold.

MURRAY-PARKES, C. (1972). Accuracy of predictions of survival in later stages of cancer. British Medical Journal, 2, pp 29-31.

McFARLANE, Baroness J. (1981). Knowledge is everything. Nursing Mirror, Vol. 152, No. 20, pp. 16-17.

McINTOSH, J. (1977). Communication and Awareness in a Cancer Ward. London: Croom Helm.

MACLEAN, U. (1979). Learning about death. Journal of Medical Ethics. Vol. 5, No. 2, pp. 68-70.

NIGHTINGALE, F. (1859). Notes on Nursing. London: Harrison and Sons. (Reprinted in 1980 by Churchill Livingstone, Edinburgh.

NOVACK, D. H. et al (1979). Changes in physicians' attitude towards telling the cancer patient. JAMA, Vol. 24, No. 9, pp. 897-900.

OKEN, D. (1961). What to tell cancer patients: A study of medical attitudes. JAMA, 175, April 1, pp. 1120-1128.

PANDEY, R.E. (1974). Factor analytic study of attitudes toward death among college students. International Journal of Social Psychiatry, Vol. 21, No. 1, pp. 7-11.

PAYNE, J. (1981). Care of the dying and the bereaved. Library, Scottish Health Services Centre. (Library Bibliography No. 33, Supplement 1).

PEMBREY, S.E.M. (1980). The Ward Sister - Key to Nursing. A Study of the Organisation of Individualised Nursing. London: The Royal College of Nursing.

QUINT, J.C. (1966). Awareness of death and the nurse's composure. Nursing Research, Vol. 15, No. 1, pp. 49-55.

QUINT, J.C. (1967). The Nurse and the Dying Patient. London: Collier-Macmillan.

QUINT, J.C. (1967). The case for theories generated from empirical data. Nursing Research, Vol. 16, No. 2, pp. 109-116.

REPORT of the COMMITTEE on NURSING (1972). Department of Health and Social Security, (Briggs Report) London: H.M.S.O.

REPORT of the COMMITTEE on SENIOR NURSING STAFF STRUCTURE (1966) Ministry of Health and Scottish Home and Health Department (Salmon Report). London: H.M.S.O.

REVANS, R.W. (1964). Standards of Morale. Cause and Effect in Hospitals. London: Oxford University Press.

ROYAL COLLEGE OF NURSING (1981). Towards Standards. A discussion document. Royal College of Nursing. London.

ROWBOTTOM, Ralph et. al. (1973). Hospital Organisation. A Progress Report on the Brunel Health Services Organisation Project. London: Heinemann.

SANFORD, N. and DELOUGHERY, G.L. (1973). Teaching nurses to care for the dying patient. Journal of Psychiatric Nursing, Vol. 11, pp. 24-26.

SAUNDERS, C.M. ed. (1978). The Management of Terminal Disease. London: Edward Arnold.

SAUNDERS, C.M. (1959). Care of the Dying. London: Macmillan.

SCOTTISH HOME and HEALTH DEPARTMENT (1967). Nurses' work in hospitals in the North-Eastern region. Scottish Health Services Studies No. 3.

SCOTTISH HOME and HEALTH DEPARTMENT (1969). Nursing workload per patient as a basis for staffing. Scottish Health Services Studies No. 9.

SCOTTISH NATIONAL NURSING and MIDWIFERY CONSULTATIVE COMMITTEE, (1976). A new concept of nursing. Nursing Times, Vol. 72 No. 14, Occasional Paper pp. 49-52.

SELLITZ, C. and others (1965). Research Methods in Social Relations. Revised one-volume edition. London: Methuen & Co. Ltd.

SHUSTERMAN, L.R. et al (1973). Attitudes of registered nurses towards death in a general hospital. Psychiatry in Medicine. Vol. 4, No. 4, pp. 411-426.

SIMPSON, M.A. (1975). Teaching about death and dying. In Raven, R.W. (ed.) The Dying Patient. Tunbridge Wells: Pitman Medical.

SKEET, M. (1980). Notes on Nursing. The Science and the Art. Edinburgh: Churchill Livingstone.

STACEY, M. (1969). Methods of Social Research. Oxford: Pergamon Press.

STOCKWELL, F. (1972). The Unpopular Patient. The Study of Nursing Care Project Reports. Series 1. No. 2. London: Royal College of Nursing.

STOLLER, E.P. (1980). Effect of experience on nurses' responses to dying and death in the hospital setting. Nursing Research, Vol. 29, No. 1, pp. 35-38.

STRANK, R.A. (1972). Caring for the chronic sick and dying: a study of attitudes. Nursing Times, Vol. 68, No. 6, pp. 166-169.

STRAUSS, A.L. et al. (1964). Psychiatric Ideologies and Institutions. New York: The Free Press of Glencoe.

STRAUSS, A.L. et al. (1964). The non-accountability of terminal care. Hospitals, 38 Jan 16. pp. 73-87.

THOMPSON, I.E. ed. (1979). Dilemmas of Dying: A study in the ethics of terminal care. Edinburgh: Edinburgh University Press.

TWYCROSS, R.G. (1978). Relief of pain. In Saunders, C.M. ed. The Management of Terminal Disease. London: Edward Arnold.

VERWOERDT, A. (1966) Communication with the Fatally-ill. Springfield Ill. Charles C, Thomas Publishers.

WEISMAN, A.D. (1977). The psychiatrist and the inexorable. In Feifel, H. ed. New Meaning of Death. New York and Maidenhead: McGraw-Hill.

WHITEFIELD, S.A. (1979). A descriptive study of student nurses' ward experience with dying patients and their attitude towards them. Unpublished. Manchester University Thesis. (M.Sc.-taught)

WORLD HEALTH ORGANISATION EXPERT COMMITTEE on NURSING (1966) Fifth Report, World Health Organisation Technical Report Series, No. 347. Geneva. W.H.O.

WITZEL, L. (1975). Behaviour of the dying patients. British Medical Journal. 2. pp.81-82.

WOODBINE, G, (1982). The care of patients dying fromcancer. Journal of the Royal College of General Practitioners, 32, pp. 685-689.

YEOWORTH, R.C. et al (1974). Attitudes of nursing students towards the dying patient. Nursing Research. Vol. 23, No. 1, pp.20-24.