Bereavement Care in Hospitals

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The dying patient's troubles will soon be over, those of the family may just be beginning. In hospices the family (which includes the patient) is the unit of care but in other hospitals, in Britain, as the research reported here discloses, support for the family at the time of a patient's death may be minimal. Further confirmation of this view comes from a survey of NHS hospitals by Wright which is reviewed on page 24. The evidence points out the need for action by managers, tutors and volunteer organisers. Is it too much to suggest that the role of hospital Bereavement Officer might come to include more than issuing of Death Certificates and of a plastic bag containing possessions of the deceased?
Editor

'Bereavement care' in hospital is usually limited to the period immediately after death. Competing priorities limit the time that is available for interaction between relatives and health care staff, and few empirical studies have focused on the short but crucial period spent by the nurse in the company of grieving relatives. Studies[1-4] indicate that pre-bereavement assessment, support during the critical phase immediately after bereavement, and short-term follow-up can all positively affect the eventual bereavement outcome of the grieving relative, but publications in the nursing and National Press[5, 6] have suggested that relatives are not adequately supported after bereavement in general hospital wards.

The Camberwell Bereavement Project was born out of an awareness that hospital staff have failed to meet the needs of bereaved families[7]. It was decided that action should be taken to identify both positive and negative aspects of bereavement care in the Camberwell area and, as the first step in a complete review and restructuring of bereavement care services, an exploratory study was designed. This offered bereaved relatives the opportunity to express their personal perceptions of the support and care they had received from nursing staff in medical and surgical wards following the death of a close relative.

A qualitative approach was used to yield a broad and richly detailed range of data. Semi-structured interviews were conducted with a sample of 20 adults, six to nine months following bereavement. These centred around themes of:

1. nurse-relative communication immediately before and after the death
2. privacy for personal grief
3. the attitudes and apparent emotional involvement of nurses and other health care staff
4. aspects of care viewed as supportive by the bereaved themselves, plus anything not felt to be helpful at that time.

The data obtained was subjected to content analysis and categorised according to the response of the interviewee. Latent themes emerged, which were deemed to represent the underlying attitudes of the relatives from whom the information was obtained.

Although the exploratory nature and sample size of this early work limited the conclusions which could be drawn, the findings closely corroborate the evidence of previous research[8-10], and are therefore of interest to any who deal with the bereaved in the hospital setting. These included:

1. The lack of communication with nurses and other health care staff prior to, and immediately after, the death of their loved one. This was a major issue for all the respondents, particularly in relation to their awareness of the impending death and the events leading up to it. Relatives interpreted a lack of communication as an inference of their stupidity or inability to understand the implications of the illness; this acted to undermine their future trust in health professionals.

2. All expressed a need to be with their loved one at the time of death, and to be able to view the body in privacy, alone. None expressed any wish that the nurses had remained in the room. Expression of grief was limited to a kiss; several respondents expressed regret that they had not been encouraged to touch or hold the body.

3. Few articles in the nursing press comment at any length about faith at this time of grieving. Despite the small variety of religious preferences (80 per cent were Christians), most respondents' religious needs were met only after they had left the hospital, and it was a matter of surprise and pain to the bereaved that the nursing staff seemed unaware of their spiritual needs.

4. Although 80 per cent of respondents perceived a need for personal support of some kind, most found it difficult to express this in concrete terms, and none saw the hospital staff as being in a position to help them. No contact with any agency was suggested by doctors or nurses. Few of the widowed had ever heard of the voluntary organisation Cruse—Bereavement Care; one widow contacted Cruse herself, having found the number in 'Yellow Pages' when desperate, but some concern was expressed by her family that she might be getting involved with a 'cranky group' as a result of her grief, and they discouraged her from attending. One man, an atheist, sought out the hospital chaplain because he didn't know who else to turn to.

5. All remarked positively about any member of staff who responded to them in a caring or empathetic way. These people and their actions were remembered with clarity and described with great warmth.

6. The lack of follow-up support by the hospital was not professed to be the reason why respondents had agreed to be interviewed.Nevertheless for some it seemed very clearly to be the contact they had hoped for, and four stated that they appreciated the opportunity to talk to somebody about their bereavement. The majority of respondents passionately wanted to explain what had happened and to work again through their feelings. This made

the interview guide almost obsolete, as the topics were covered during 'ordinary' conversation. For some people the urgency of what they had to say almost took the form of a monologue. For others, partcularly the elderly, the chance to talk seemed to be a primary facet of their agreeing to be interviewed.

Respondents felt that nursing care was not extended to include the bereaved, nor was it intended to be. This feeling prompted a neutral attitude towards the staff, because the nurses were not perceived to be appropriate resource persons for the relatives' own emotional needs. Respondents found it difficult to specify exactly what nature of support would have been most helpful to them, but their appreciation of the concern shown by individual nurses or doctors indicated that support from this source would not be refused. In many hospital wards it is unrealistic to expect staff to allow relatives time freely to express their fears and anxieties because of personal and professional constraints. Introducing other supportive agencies is therefore an essential part of the caring role, in itself an indication to the bereaved that they are important. In Camberwell this need has been recognised; a bereavement framework group has been established so that some of the issues derived from the study can be further investigated, and research continues with a view to improving care of the bereaved in hospital.

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The Funeral Service in the Process of Grieving

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There is no society known to anthropologists which does not carry out some formal ritual or rituals after death. These may be seen as a tribute or service to the dead but their importance to the survivors should not be underestimated. In a society which is bewildered by death the ideal ritual often seems to be one in which nobody gets upset and the whole thing is got through as quickly, hygienically and efficiently as possible—the result, the production-line cremation service. In this paper the Revd. David Durston suggests that, far from being a 'meaningless' ritual, the Christian funeral, if well conducted, can assist the process of grieving in a number of ways. **Editor**

My starting point is a quotation from Colin Murray Parkes:

> 'Grief itself I see as a process of realisation, the process by which we make real inside us an event that has already occurred outside of us.'
> (from 'Good Grief', Institute of Religion and Medicine, 1970)

This process is a difficult one. It's hard to 'take in' the fact that someone close to you has died, someone whose life is very much bound up with yours. An event has happened in the outside world and it requires an adjustment to the inner world of thoughts and feelings. It is a painful process, especially if the death has been sudden or out of time. People feel themselves torn apart by the pain. They may fear they are going mad. 'I think I'm going crazy', one widow said to me shortly after her husband's death.

At some level the psyche resists and rejects the idea that the loved person is dead. 'I can't take it in.' 'I still can't believe it.' Or, as one young man said to me three times after his father died suddenly of a heart attack, 'It's unbelievable . . . It's unbelievable . . . It's unbelievable.' These are examples of what is often called the phase of Denial, the first phase of the grief process.

A significant part of the function of the funeral is, by providing a public ritual at the point at which the body of the dead person is disposed of, to help people to 'take it in.'

I write as a minister of the Church of England, and my understanding of the function of the funeral service is based on my experience of Church of England funerals. I anticipate that most of what I say would be equally true of funerals of other Christian churches.

How far it is true of other religions, such as Islam or Hinduism, I am not competent to say. Grief is a universal human experience, but expressions of grief vary greatly from one culture to another, and those of other faiths will have to judge for themselves how far what I have written is also true in their experience.

The funeral service, in the Christian tradition at least, assists the process of grieving by helping people to 'take in' the fact of the death of the one they love. In this it responds to the healthy recognition that ordinary people have the need to 'take it in'. They are struggling to do so.

In this they are not like Miss Havisham in Charles Dickens's book 'Great Expectations', who preserved everything as it was at the moment her bridegroom died on the day of their wedding. She tried to maintain a denial of his death. But ordinary healthy people know they need to 'take it in'. So there are conflicting tendencies: a conscious desire to take it in, and, at a deeper level, resistance to this.

The pain of the process has to be experienced and borne before the loss of the loved one is fully 'taken in', and the denial phase is ended. Only then can the mourner start to work at the process of