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In an age where medicine can do more than ever before to delay dying, is death sometimes now seen as failure in the medical profession? Failure to diagnose soon enough, failure to prescribe the correct treatment, failure to discover a radical new therapy? Or is death seen by some as a treatment choice? An ‘opt-out’ when suffering is too great?

As a nurse in a care home I see death neither as failure nor as choice. To me, having also nursed in acute medicine and surgery and in a hospice for teenagers, death will always be the enemy but I have never once seen it as a treatment choice. Patients have clung to life, fought valiantly, and often grown to accept dying – even ‘dying well’.

Dying Well

Tom was a 15 year old boy dying from a facial cancer. Mature beyond his years, he reduced staff to tears with his acceptance and his concern for his parents and siblings, together with his dying wish to watch X-rated horror movies and eat pink doughnuts. Fear only manifested itself in his insistence at having another human being always at his bedside, even as he slept, and in his call for the chaplain as he died: needs that were fulfilled and that brought comfort and peace.

Or Badly

Ruby was a 96 year old widow and a retired professor. She experienced an episode of confusion and diarrhoea, was placed on a morphine syringe driver without the consent of her family and despite being pain free. As she became weaker, she was not offered fluids or mouth care, and was denied a pressure mattress since none was available.

Merits and misuse of morphine

I am not against morphine as analgesia, I have seen its magic. But I have seen it administered too often to patients who are not in pain, with death often coming 48 hours after the commencement of a syringe driver. A dying lady was recently discharged to my nursing home with a morphine syringe driver and instructions that she was “for TLC”. In the three weeks before her death she remained pain free and responsive, she spent precious time with her family, and the syringe driver remained unused.

As I watched my own grandfather die in a hospital, a nurse administered intramuscular morphine because she felt he was in pain. I had seen no sign of pain, just a slight rousing from his sleep, yet was unable to speak out because of my felt helplessness. The morphine rendered him comatose and he died later. When seen on a final ward round, a doctor surveyed the drug chart and muttered “that was a big dose” before reducing it, albeit too late.

The incredible importance of the small things

Modern medicine is amazing in its complexity, capability and cleverness. But when it becomes clear that it’s not going to work, it’s time to step down a gear and think about making the remaining time count.

Ideally, you will have spoken with the family or relative about dying wishes well before death’s doorstep (in our nursing home we fill in the politely-named “advance care plan” on admission if we can). Do not resuscitate orders should be addressed early: in the nursing home resuscitation is often viewed as invasive and fruitless, with the order offering some protection.

Small things such as what should happen to the wedding ring, who should be present and whether a person is of faith or not really matter. I am still haunted by one case where a wife wished for her husband to be buried in his wedding outfit. Arriving back from annual leave to help clear the possessions after the man’s death, I found it still hanging in the wardrobe. I never told the wife.

The clinical details

Comfort is key when dying: pain and pressure relief, hydration, managing secretions and continence, reducing nausea and stopping non-essential medicines are vital.

More technical issues include deactivation of implantable cardiac defibrillators in patients with heart failure to facilitate a painless and comfortable death. Timing of deactivation seems an agonising decision but I have seen it handled skilfully by a heart failure specialist nurse, avoiding unwanted shocks at the end of life which can be distressing to patients, relatives and staff.

I see a lot of death in my role. In fact, it’s the only method of discharge I deal with. Families will always want to know how long death will take, and that’s an impossible question: diagnosing dying is a combination of science and art, and I don’t think anyone has mastered it.

Dying well, however, can start to be addressed by asking “what is it that’s making today so awful; what can we do to improve it, however small?”

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