DEATH AND THE HEALTH PROFESSIONAL: ORGANIZATION AND DEFENSE IN HEALTH CARE

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Organizational and technological developments within the health care system have helped consolidate a power structure that dehumanizes clients and fosters defensiveness in professionals. Frequent exposure to death renders health professionals vulnerable to severe anxiety, which they may try to avoid through death denial, leaving them psychologically unable to support dying clients. Professional education, attitudes equating death with professional failure, organizational coping strategies among nurses, and staff burnout interact to perpetuate this atmosphere. As a model for learning, this article analyzes a pediatric case study to illuminate the manifestations of professional defensiveness. Finally, I consider three specific problem-solving strategies: improving morale, opening communication, and expanding professional education to include death studies and psychological study of the health organization. Bringing humanity back into the health care environment is possible to the extent that both the organization and its members are responsive and open to change.

Today's health care system generates a power structure and an intensive work environment that fosters complex personal dynamics among staff that can severely affect patients' rights. The dehumanizing effects of these dynamics are specifically pronounced when a patient dies. As medical advances have created numerous opportunities for many ill and suffering people, the process of death and dying has become a highly technological, impersonal experience. It

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is not uncommon now for people to die in the sterile, institutionalized hospital setting, attached to a variety of life-support machines. Thompson (1) asserts that this phenomenon has obscured the boundaries between death, personhood, and individual rights, relegating the dying person to a secondary role in his or her own death—in essence shifting control from within the patient to the outside environment. The complex interaction between patients, staff, technology, and the entire system helps create this shift.

In recent decades, health care provision has become increasingly industrialized. As part of this process, advancing technology has created a proliferation of new occupations, causing greater stratification and bureaucracy within the health care system. According to Krause (2), the medical profession remains at the top of this hierarchy, sharing power with the hospital industry and other corporate interests. On a smaller scale, medical professional power is obvious on hospital wards; only doctors have the licensed right to diagnose illness and prescribe medication and care. While nursing, as a profession, does have some autonomy in administering care, it remains primarily under the direction of doctors; nurses carry out doctors' orders, contributing to an overall plan of care through the processes of suggestion and collaboration.

The dynamics described above reflect a pattern of relations, involving power and control over others, present on every level of the system. Inevitably these patterns impact on the staff–patient relationship. In his consideration of medical training, Gerber (3) shares a letter written by medical students that directly addresses issues of power and control:

> Besides being told we are special, we are being taught . . . that we are . . . totally responsible for the life and death of our patients. This last attitude conveyed in the medical education process . . . disarms the patients from being able to care for themselves. . . . (3, p. 48)

Gerber continues by describing the serious implications of encouraging such attitudes in medical education—the profession is set up for attributions of power and responsibility far exceeding their human capability:

> For a profession to accept a view of itself as so very special means that it must expect societal demands that are unrelenting . . . for patients to thrust such special powers and responsibilities onto doctors means that nonmedical people abdicate their rights and powers for their own treatment and care. (3, p. 48)

Yet another force influencing power dynamics in health care is our increasing technology. We now have machines, therapies, drugs, and protocols that offer pain relief, remission of cancer, and even, sometimes, reprieve from death. The tendency in health care has been to use these technologies to prolong and sustain life, placing biological continuation above all else, at the cost of human dignity and individual rights (1). Another function of technology, described by Pruyser (4), is the temptation to use technology to distance oneself from contact with "patient's misery" by putting machines between oneself and the patient. Menzies (5) discusses a similar process among nurses, in which they protect themselves from work-related anxiety by focusing on task-work, while caring for a large number of different patients. This division of the nurses' attention among patients allows the nurse to avoid intimate contact with any one patient, thereby diminishing her potential for anxiety. The overall effect of using task-oriented technology in this way is to deny the patient's individual humanity, or as Menzies stated:

> The implicit aim of such devices . . . may be described as a kind of depersonalization or elimination of individual distinctiveness in both nurse and patient. (5, p. 289)

To understand how this dehumanizing process has taken place, it is important to consider some underlying philosophical issues influencing health care.

Human existence is limited. We live and die—both are inevitable where one exists. One cannot live life as we know it without eventually dying—the final act of living. This very reality—our finite nature—contributes to the development of the psychological phenomenon of death anxiety (6). Human beings have wrestled passionately with this fact, perhaps accepting it intellectually, but all the while tending to avoid death anxiety through death denial (6). The impact this has on patient care is profound.

Working in the hospital setting, health professionals frequently

witness tragedy and death. Trained to anticipate any untoward events that may place patients at risk, health professionals constantly scan the environment, attempting to distinguish potential life-threatening situations, assuming the ability to prevent their occurrence. Taking this kind of responsibility can at times become overwhelming, leaving health professionals highly stressed and anxious. Gerber discusses the resulting impact upon physicians:

> This fear (of failure) is seen as a natural consequence of any undertaking . . . where risk is infinite, and where patient care responsibility is great. One can understand a resident fearing treatment failure, his own impotency as a treating person, and his patient's death, saying, "I did all I could . . ." (3, p. 61)

The underlying psychological experience is poignantly described by a senior medical student, who told Gerber:

> So much of what we do, what drives us, seems to be based on doubt and fear of failure. . . . Fear that we won't be able to save every patient's life, that we won't be good enough . . . (3, p. 61)

Channon (7) elaborates on this quite clearly, expressing the often unspoken yet pervasive attitude that death represents failure of medical expertise, perhaps even the personal failure of attending health professionals.

A variety of factors appear to influence physicians' experiences with death. Engel (8) believes exposure to death generates threat of personal death, leading the doctor to avoid the dying patient. Kane and Hogan (9) cite numerous descriptions of psychological strategies used to manage the anxiety provoked by the death experience. For example, they describe Verwoerdt's (12) contention that the medical profession places doctors in the position of firmly opposing illness and death, resulting in their refusal to deal openly with the issue. They continue with Weisman's (13) proposal that defining oneself as a healer allows the physician to circumvent the possibility of his or her own death. It seems plausible that regularly experiencing this impending threat on a conscious level would reduce health professionals' level of functioning.

Nursing as a profession has developed its own pattern of coping strategies, which, in concert with the doctors' approaches, could

further complicate the already emotionally-laden relationship between hospital staff and patients. In the Menzies study (5), nurses appeared to take on the emotional stress of their patients, requiring the nurses to formulate defense techniques to protect themselves from psychic disorganization. Menzies asserts (5) that this defensiveness is organizationally supported by the operational policy of "detachment," which is sometimes used by nurse administrators to justify "floating" (reassigning) nurses between wards, as it prevents nurses from becoming attached to their patients. Another protective strategy used by nurses is what Menzies calls "psychic vestment," whereby subordinate nurses project their competence upon supervisors, then expect these supervisors to make decisions for them, again alleviating the anxiety generated by the burden of responsibility nurses bear (5).

Further problems arise when health professionals are so highly stressed that they "burn out," a syndrome described by Maslach and Jackson (10) as emotional exhaustion, depersonalization, and reduced personal accomplishment. One critical consequence of burnout that has immediate, direct implications for patient care is the tendency to blame people rather than the work environment for problems. This can result in certain staff members or patients being labeled "bad" or "the problem." Other findings of the Maslach and Jackson study highlight the importance of control issues in the workplace. They found that nurses' feelings of burnout were related to feeling a lack of control over their daily routines—doctors' orders prescribe much of the daily work done by nurses (10). Doctors exercise a more covert form of control through their alleged tendency to "skip out" when a patient dies, leaving to the nurses the most emotionally stressful task of counseling the patient's family (10).

All things considered, life and death issues provide fertile ground for both intra- and interpersonal conflict among health professionals and their patients. Given the highly technological and scientific society we live in, death can represent both existential and individual, personal failure. When health professionals assume the responsibility of defying death, they must, to some degree, perhaps unconsciously, deny their personal feelings; they sacrifice the human needs and dignity of their clients in the process. Menzies addresses the often painful process of facing a patient's death and the

distressing effects of losing significant relationships with patients when she says:

> . . . the importance of stable and continuing relationships [is] . . . denied by the system. . . . This implicit denial is reinforced by the denial of disturbing feelings . . . within relationships. Interpersonal repressive techniques are culturally required . . . to deal with emotional stress. . . . It must not matter to the nurse whom she nurses or what illness. (5, p. 290)

Clearly, the health care environment has inherent anxiety-provoking, stressful qualities that significantly impact clients and staff alike. The power dynamics built into the system contribute to the stresses everyone experiences. In the situation where a patient is dying, feelings of powerlessness, lack of control, and failure are likely to emerge for the staff. Handling such a delicate situation takes patience and caring, qualities which sometimes become overshadowed by stress when they are needed most.

A Case Study

To discuss the problem further, I shall use a specific event as a model for problem-solving. The scene described is fictional, although it does reflect circumstances I have encountered in different work environments.

> J.T. was a 5-year-old boy who sustained a head injury at age 2, leaving him severely disabled. Mom was very dedicated to caring for him at home, and had learned to do many important nursing functions. Since his original accident, J.T. had been admitted frequently to the pediatrics ward for aspiration pneumonia, resulting from his intolerance of gastrointestinal tube feedings. Mom stayed with J.T. in the hospital each time, and was well known by the pediatric staff. Dad was out of town on business on a regular basis, and was infrequently seen by staff. There were no other children in their family. Mom's relationship with pediatric staff was somewhat troubled at times, resulting in her being characterized as a difficult, troubled person. The relationship became increasingly strained in the past year, so Mom insisted that only certain nurses and doctors care for J.T. It was not uncommon, when J.T. was admitted, to hear sarcastic, critical comments made by staff about Mom's behavior.
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> One morning J.T. came into the emergency room blue in the face,

without a heartbeat. Staff gave CPR and J.T.'s heartbeat returned almost immediately. He was sent to the ICU, where he was placed on a ventilator, and given numerous drugs necessary for maintaining his circulation. Despite efforts to keep him alive, J.T. died after 7 hours of care.

Upon his death, Mom began screaming for staff to do something else, that it couldn't be true. One pediatrician and four nurses were present at the death—the doctor offered Mom Valium to calm her down. When she refused, he left for lunch. Of the nurses, one was busily writing down the details of J.T.'s care, another was standing by watching two other nurses attempt to console Mom, shaking her while saying "You know it's the best thing, you've got to believe it, he's dead." Mom continued crying out, so loudly that the ICU supervisor wanted to remove her from the unit. Mom wanted to be at J.T.'s side; she wanted to hold him, but was told she couldn't because it would encourage her to believe he could be revived. Eventually Mom calmed down, and was allowed to hold her son. Dad, who had attempted consoling Mom earlier and then disappeared, returned to be with Mom while she held J.T.'s body.

In this situation, the child's death created significant disorganization among both staff and family. Kübler-Ross (11) has described fear of death and death denial as universal human reactions. The staff present at J.T.'s death seemed to lack knowledge about these processes. The nurses' attempts to convince Mom of the death demonstrate a lack of understanding about the shock and denial process she needed to go through. Perhaps this behavior also reflects the nurses' needs to protect themselves from feeling Mom's pain. To the extent that they refused her request to hold J.T., they denied her the right to grieve appropriately. Furthermore, the doctor, who had been directing the attempts at saving the child's life, disappeared suddenly, leaving Mom and Dad powerless to ask questions or solicit his support. In essence, the environment generated by the patient's death became chaotic, rendering the system unable to meet the personal or emotional needs of the family and staff alike. Human dignity and rights were sacrificed as the hospital system dysfunctioned in the anxiety-provoking face of death.

An Alternative Strategy for Coping with Death

The complexity and depth of this problem prevent an easy solution. In developing a strategy for implementing changes, it seems impor-

tant to address the problem organizationally, focusing on changes that can improve the function of the organization as a whole. Within this framework, I have identified three main areas for problem solving: communication, morale, and education.

Morale

The dominance of money as a primary motive in today's enterprising health industry has directly contributed to low morale among staff, through understaffing, undersupplying, and overworking existing staff. Being understaffed or improperly staffed directly affects quality and quantity of care for patients, and contributes to nurses developing a general feeling of inadequacy (5). Furthermore, understaffed and overworked staff tend to feel unimportant and disrespected, which hastens "burnout," and fosters feelings of anxiety, overwhelmedness, and defensiveness. Menzies (5) points out that morale in nurses is directly linked to recovery rates among patients—an obvious indicator of the need for measures designed to boost nursing (and staff) morale. Enhancing morale requires both individual and organizational sources of positive feedback for staff. Organizationally, hospital administration must nourish morale through actions ranging from providing adequate staff and decent work contracts, to smaller day-to-day expressions of gratitude and acknowledgment of employees. Actions such as these demonstrate concern and willingness to act on behalf of staff needs. On an individual level, nurses and other staff can take an active, conscientious role in providing encouragement and support to one another by commenting on jobs well done and offering support to distressed colleagues, etc.

Communication

Open communication is a fundamental part of both morale and coping within an organization. When an unspoken code of organizational conduct shuts down communication between members, imbalance and dysfunction are likely to result. For example, in J.T.'s situation, the health care team as a whole didn't regularly discuss plans to assist the family in preparing for death. Interaction between staff members rarely involved expression of staff's personal

feelings about the child's condition. Acknowledgment of his tragic condition came through defensive comments such as "it's the best thing for him [to die]," without reference to actual feelings on the part of the staff.

As a possible step to improve communication, hospitals might hold bimonthly meetings between nurses and doctors, wherein they could discuss work-related problems. In such meetings they could discuss, strategize, and solve specific problems pertaining to the ward on which they work. The collaboration might enhance feelings of worth and value for all involved. Hospitals could also provide informal time for interested staff to meet and share feelings about their work, not to solve problems so much as simply to express themselves and acknowledge one another. This group might include a therapist or social worker to facilitate group process. The desired effect would be to generate a sense of caring within the group, and encouraging staff to view themselves as a team. Pruyser (4) addresses the importance of caring among staff:

> . . . a team is not a mechanical contraption. Members of a team (as distinct from an administrative structure) form a community of caring in which the well-being of the members is as important as the well-being of the patients the team addresses. In fact, an experienced team realizes sooner or later that the quality of patient care suffers when its members are at odds with each other or any one of them is anxious, depressed, or angry . . . the keynote to a well-functioning team is *mutual aid.* (4, p. 367)

A work environment that actively cares for its members is more likely to have the strength and ability to nurture patients. Giving staff the validation and acknowledgment of their feelings and needs humanizes and personalizes the organization, thus diminishing the need for the organization and its members to deny human needs in patients.

Structurally, the organization could open itself up to addressing death and dying in two key ways. First, create a support group, composed of patients, family members, and staff, for dealing with terminal illness. The group could assist and prepare families for dealing with death before it actually occurs. Second, have 24-hour clergy and social work or psychological services available for families and staff in crisis. Along with these services, setting aside pri-

vate space within the hospital for grieving families would give patients and their families the message of respect and concern for their personal needs. These actions openly acknowledge both the existence of death in the environment as well as the need for those involved to have support. A final suggestion for improving staff communication and preparedness for death of a patient would be to develop a multidisciplinary team specifically responsible for organizing and implementing care for grief-bound families. This care might coordinate in-home hospice care, individualize in-hospital plans for care to assure that the patients' personal needs are met, and interactively discuss these plans with staff members directly administering care.

Education

These suggestions apply directly to intervention and problem-solving in the immediate situation. However, we must also consider preventive strategies—such as education aimed at raising the health professional's consciousness about the complex nature of death and dying in his or her work. Kane and Hogan (9) found that many young physicians felt they lacked training related to death and dying issues. Momeyer (6) suggests that open acknowledgment and recognition of death anxiety would better prepared health professionals for supporting their terminally ill clients. In light of the intense, anxiety-provoking nature of hospital work, it seems beneficial to invest the time and energy to prepare health professionals for their inevitable encounters with death. This would strengthen staff members' ability to understand and acknowledge their own feelings, and in so doing would help them empathize with and support their patients. To supplement this, I suggest that health professionals be taught about the psychological infrastructures of health care organizations. This would provide a basis for insightful learning and problem solving in the work environment. It could enhance self-awareness, leading to greater understanding of the interacting intrapsychic and organizational processes. This approach in the education of health professionals has the potential for increasing the staff members' ability to interact conscientiously with each other and with their patients.

I must point out the extreme difficulty faced when attempting

to change such complex structures as hospital environments. Menzies paints a rather bleak picture for change within the nursing service—a troublesome thought, since nursing is the primary service between patients and doctors (5). Because of the tremendous resistance to change displayed by nursing in particular and organizations in general, any attempts at changing the system require a well-thought-out strategy. One such approach would be to implement the least threatening, most anxiety-reducing plans first. For example, decrease patient-staff ratio, minimize "floating," and slowly, simultaneously, and consistently institute various positive feedback mechanisms. These measures may decrease anxiety levels, thus encouraging a feeling of safety, and perhaps openness to further change. At the same time, nurses (and doctors) who want change must make a personal commitment to themselves and the patients they care for to begin the change process from within. In this way, organizational changes can evolve alongside necessary individual changes in organization members. The ability to solve the intricate problem of maintaining humanity in health care is directly related to the responsiveness to change and ability to change of both the organization and its members.

In conclusion, preservation of human dignity requires education and open communication in a well-functioning organization that supports both staff and patients in coping with the emotional stress brought on by death and dying experiences. The degree to which the hospital organization can change is certainly limited within the current economic environment. Nevertheless, human attempts to effect change on a smaller scale can begin to bring humanity back into the health care environment.

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