



Making Death a Meaningful Transition

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As oncology nurses, we care for patients and their families across the cancer continuum—from helping newly diagnosed patients deal with the fears and anguish of confronting cancer to the attentive management of those receiving treatment. In addition, oncology nurses care for patients who are approaching the terminal phase of their disease, an experience that requires us to turn from the curative mode to one of loving support for dying patients and their families. Caring for patients at this stage is a difficult task, especially if we are not familiar with principles of palliative care or if their care is based on conflicting approaches, wavering between aggressive treatment and end-of-life comfort. Thus, hearing complaints from frustrated oncology nurses about needless tests or treatments being ordered for patients who are beyond the curative phase of disease is not uncommon.

This ongoing conflict concerning the “ideal care” of people who are dying results from modern medicine defining its main goal, namely to cure and stop death at all costs. According to Elisabeth Kübler-Ross (1995), accepting death in Western societies is difficult because we rarely see it. People die in the hospital receiving treatment despite advanced disease, and, once dead, their bodies are taken away under cover to reappear made up in a funeral home. Children are shielded from the dying; therefore, we grow up under the assumption that death is an unnatural, unspeakable event. Even the language used surrounding the death of a loved one or patient tends to maintain a sense of denial (Kübler-Ross).

Kübler-Ross (1995) explained that death never is welcomed, but in many societies, death is part of everyday life, one to which everyone is exposed with a basic approach. People spend their illnesses and die at home. Their bodies

are prepared at home as well. In these societies, death becomes familiar and acceptable. People are allowed to die with less interference toward curative ends (Kübler-Ross).

Kübler-Ross (1995) proposed that death is a transitional event in the unending process of spiritual growth that may or may not be based in a religious foundation, although the promise of life beyond physical existence is the crux of all major religions. Byock (2000) advised that by understanding death as an inherent part of life, we can concentrate on providing physical and spiritual comfort to patients and their families with a sense of purpose and ease.

When a patient is dying, we struggle to find spiritual growth in helping the dying person and his or her family make the death a life-affirming, meaningful experience. By leading them to and supporting them as they cross the bridge, we, as oncology nurses, grow as they grow.

Reaching out to patients and families is the first step for both our terminally ill patients and ourselves. We do this in many ways. Focusing on physical comfort and palliative-care principles are of paramount importance when caring for dying patients and their families. However, our own attitude and philosophy toward death, which we convey to patients and families, are indispensable. If we are at peace with the fundamental idea that death is a natural transition and an opportunity for those involved to grow spiritually, we are able to put aside our fears and help move our patients and their families toward this goal.

To provide this caring and reassuring approach, we often do not have to do much beyond sitting at the bedside or making and keeping a commitment to speak with the patient or family. According to Imara (1995), conversation is very healing, especially when

we concentrate on allowing others to talk. “Creative communication” (p. 157) allows us to experience a sense of belonging. It is the force that limits the selfish potentials in our lives and allows us to grow because we are engaged in extending our attention beyond our immediate concerns and needs (Imara).

If dying patients learn to talk meaningfully and are able to find a unifying philosophy to their lives, one that may or may not be religious, they will grow to a level of “ego-extension” (Imara, 1995, p. 162). Ego-extension is the capacity to find meaning in more than one’s body and material possessions (Imara). Patients need to be helped to reach resolution of their fears. According to Imara, “learning to live as a dying person is not unlike the re-learning necessary after a divorce or a separation from an important person” (p. 163). Like all learning processes, this teaches both the learner and the caregiver. A process of change requires steps that Imara described as denial and shock, anger, bargaining, preparatory depression, and acceptance/resolution.

These steps describe the universal human reactions when confronting catastrophic events in our lives. Healthcare providers should follow them as a universal guide. We also must know that the human being is a cultural being; how we incorporate universal truths depends largely on how we have been acculturated.

According to the Oncology Nursing Society’s (1999) guidelines for cultural

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