Chapter 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter literature from various websites, past studies, and other relevant aspects of this topic has been reviewed in order to provide a broader perspective for this study. Areas such as nurses’ self-awareness, its impact on patient-nurse relationships, barriers to an effective therapeutic relationship, the modern hospital and its expectations, death anxiety, attitudes, dying and grief will be described as well as existing research on death attitudes and anxiety. There was a paucity of South African literature available on the topic thus the research done in several other parts of the world has been included to form the basis of the literature review.

2.2 HEALTHCARE CONCERNS IN SOUTH AFRICA

South Africa is divided into nine provinces: Mpumalanga; Orange Free State; North West; Eastern Cape; Northern Cape Kwa-Zulu Natal; Western Cape; Limpopo; and Gauteng. Within each province, there are primarily two kinds of health facilities that offer acute patient care. These are public hospitals that are subsidized and run by the state and private hospitals that are governed by the country’s healthcare reform policies and are privately funded.

The 2003-2004 South African Health Review, which is an annual report on the state of the nation’s health produced by the non-governmental organization Health Systems Trust reflects a massive exodus of this country’s healthcare skills. Chronic nursing staff shortages were reported in Gauteng hospitals. The greatest imbalance in personnel distribution is between private and public sectors. Private health services consume 58% of the total health expenditure and consume a higher proportion of all types of personnel, except nurses, than the public sector, despite the fact that this sector caters for less than
20% of the population. However, even this sector has been affected by the loss of healthcare skills. According to Health Minister Manto Tshabalang-Msimang, the report also cautions that Aids related mortality, burnout and work overload will result in the continued loss of health staff (Anso Thom, Health-e News Service- The Star 29-07-2004).

The emergence of the AIDS epidemic in Sub-Saharan Africa has emphasized the urgent need to develop palliative care facilities. Sub-Saharan Africa has the highest prevalence rate with 8-10 million adults currently infected with the human immunodeficiency virus (HIV), the putative agent for AIDS (Doyle et al, 1998). A combination of HIV/AIDS, deteriorating health services and chronic diseases related to lifestyle is killing South Africans in increasing numbers, according to the latest South African Review, which was released in July 2004. Jillian Green of The Star (14-01-2005) quotes Gauteng Health MEC Gwen Ramokgopa as admitting that in at least two of the province’s hospitals mortality rates had increased over a five-year period. Spokesperson for the Gauteng Department of Health, Popo Maja, attributes the increase in the number of deaths as a result of pneumonia, tuberculosis, diabetes and illnesses associated with HIV and AIDS. He also states that the department has seen a number of deaths of pregnant women, mothers and children over the years and that most of these people were HIV-positive or had full blown AIDS. A study, sponsored by the South African Medical Research Council, found that the total number of deaths (all causes) in South Africa rose dramatically over the five years to 2000/1. In the year 2000/1, 556 585 deaths were recorded, more than 20% of which –112 630- were empirically caused by HIV/AIDS. This is almost three times the number of deaths explicitly certified as HIV/AIDS-related by the Department of Home Affairs According to an actuarial formula, the study reported that the death toll soared by 43% between 1996 and 2000/1. In 1996, 387 784 adults died of all causes, 168 801 fewer than the 2000/1 figure. This was mainly a result in an increase in mortality related to HIV. Among children under the age of five, 40 727 of the 54 313 deaths (74%) in 2000/1 could be empirically classified as HIV/AIDS-related, whereas those explicitly certified as HIV/AIDS-related on official death certificates numbered only 14 009 or 25% (The Star 30-01-2005).
In view of these developments, private health care facilities are also seeing an increase in the mortality rate of the population it caters for, due to complications of trauma, unhealthy lifestyles and chronic illness (for example: malignancy, endocrine diseases, cardiac and respiratory illnesses, HIV/AIDS), while not comparable to academic or public health institutions is significant. Hence the private health care sector has recognized a need for palliative care, education and training.

2.3 DEATH ANXIETY AND ATTITUDES

Anxiety and fear are common in the setting of life-threatening illness and may be a reaction to physical factors or to existential and psychological distress. Spall and Callis (1997 p.167) quoted Cassidy (1992) who wrote, “I believe fear is universally experienced, at some stage, by those facing death. It may not be articulated and it may well not manifest itself in anxious behavior, but it is there at some level.”

Faull, Carter and Woof (1998) state that it is humanity’s fear of death that has interested artists and scientists alike. Philosophers have considered death in terms of fear of extinction and insignificance, psychologists have devised models that explain death related emotions, and sociologists have observed how death anxiety can bind groups (example religious armies). It has even been suggested by the same authors that politics are influenced by a desire to control the anxiety death provokes.

Death anxiety is said to be driven by three separate fears:
- Fear of what happens after death.
- Fear of the act of dying (e.g. pain, loss of control, rejection because of illness).
- Fear of ceasing to be.

Concepts such as these illustrate the potency of death anxiety on thinking and help explain how people react when faced with death (Faull, Carter and Woof, 1998).

The relevance of this to health caregivers is explained by Cook and Oltjenbrun (1998), who write, that emotions, particularly anxiety, can affect the professional’s perceptions, diagnosis and even treatment of patients. They quote Selwyn (1998) who states that it is the physician’s fear of death and his/her own unexpressed grief that are the biggest
impediments to true empathy and result instead in pity, despair, revulsion and the kind of numbing detachment that finds refuge in technological interventions.

Nurses play a key role in caring for the dying patient. Attitudes toward death, as well as attitudes toward the dying patient may affect the care nurses provide. The multidimensional and complex nature of attitudes is evident throughout the literature (Bene and Foxall, 1991; Neimeyer and Moore, 1989; Conte, Weiner and Plutchik, 1982). Determinants of attitudes encompass not only cultural, societal, philosophical, and religious belief systems for giving meaning to death but also personal and cognitive frameworks from which individual attitudes toward death and dying are formulated and interpreted. Neimeyer and Moore (1989) suggested that subtle changes might occur in these frameworks across the adult life span, adding to the complexity of death attitudes.

Modern technology also plays a role in altering expectations and attitudes toward death (Haisfield-Wolfe, 1996). Considerable literature is available to support the assertion that attitudes toward death are a key factor influencing the behavior of healthcare professionals (Servaty, Krejci and Hayslip, 1996; Haisfield-Wolfe, 1996; Kaye, Gracely and Loscalzo, 1994).

2.4 THE DEATH AWARENESS MOVEMENT

The hospice approach has emerged as the leading alternative to the established pattern of care that has been the target of much criticism over the past few years. Perspective on the hospice approach is offered through a brief examination of the death awareness movement. This movement is traced through several phases. A period that might be described as the conspiracy of silence was followed by exposure and attack on this taboo against dealing openly with death (Kastenbaum, 1981).

Benner and Wrubel (1989) write that society’s meanings of death and dying are predominantly obscured by future goals, progress, and becoming. It’s language and meaning has less to say about being, arriving, and dying. They write that death has no technological fix; death is not a ‘problem’ to be solved. For this reason, the normal
instrumental, strategic language does not lend itself to discussions of death and dying. Consequently, it is not surprising that one of the predominant ways of ‘coping’ with death is to identify progressive stages in the process and then turn the process of dying into a developmental achievement. Kubler-Ross’s (1969) pioneering work on death and dying identified the stages of denial, anger, rejection, bargaining, and acceptance. Each stage was to follow the other. Initially intended as descriptors of the dying person’s process, assuming the dying person has time before their death, these stages have become scales against which to measure the correct way to die or grieve and have to some extent grown into a prescription. Death became an acceptable topic, perhaps because we were given a ‘culturally’ acceptable approach, a structure, and a predictable set of stages. However a drawback of this work was that not everyone experienced these predictable stages. It was found that empirically that the stages did not hold up (Parker, 1981; Kestenbaum and Costa, 1977). The problem with the achievement-orientated approach to dying was that, though Kubler-Ross did not intend it, the stages became a prescription for a ‘healthy’ way to die. Kestenbaum (1979) points out that the quest for a ‘healthy death’ in the current death awareness movement is paradoxical. Kestenbaum (1979) outlines the following factors that have led to the ‘healthy dying’ movement:

1. A critique of the extensiveness and intrusiveness of biomedical technology that may assault human dignity and prolong suffering.
2. A critique of the withdrawal and avoidance of the dying person by family and health care workers and of the ‘mutual pretence’ (Glaser and Strauss 1965,1968) that may surround the dying person.
3. A reaction against the lingering course of terminal illness.
4. A fear of being in a state between life and death, being kept alive but unconscious on life-maintaining machines. The patient and family may feel that the person is ‘trapped’, suspended between life and death.
5. An increased apprehensiveness about the suffering that may be associated with dying. In the context of the modern era, even minor symptoms of discomfort are expected to be controlled.
6. Finally, the emergence of an image of a ‘good’ or ‘acceptable’ or ‘self-actualized’ death. Kubler-Ross offers the positive image of achieving ‘acceptance’ and
Weisman (1979a, 1979b) offers the notion of an ‘appropriate death’- a death consistent with a person’s lifestyle and one that a person would choose if he or she were able.

All these factors may raise unrealizable expectations about the death experience (Brunner and Wrubel, 1989) and provides a source of stress for the health-caregiver.

2.5 MODELS OF GRIEF IN RECENT PSYCHOLOGY

Recent psychology that has focused on death and dying has evolved from a medical orientation. Disease and death have been labeled as enemies to overcome (Kearl 1995: Neimeyer, 1995). Positivist thinking shapes stories around grief as a deviation from normalcy that requires corrective action (Silverman and Klass, 1996). These influences can be seen in Freud’s work. Psychoanalytic theory describes grief as something to get over and move on from. As a way of restoring the individual’s functional life, detachment from memories of the deceased and accepting the reality of death is assumed to offer wholeness back to the mourning person(s) (Silverman and Klass, 1996; Rando, 1995). According to Freud, mourning is completed when the ego becomes free from and uninhibited by the lost object (Rando, 1996).

Before one can fully comprehend the impact of loss and the human behavior associated with it, one must have some understanding of the meaning of attachment. British psychiatrist John Bowlby’s attachment theory provides a way to conceptualize the tendency in human beings to make strong affectional bonds with others and a way to understand the strong emotional reaction that occurs when the bonds are threatened or broken (Worden, 1991). Object relations and attachment theory frameworks set forth a prescriptive order that make it necessary to die or grieve in the appropriate way. Only then, when this prescription is followed, does one become a healthy individual.
Worden (1991), states that mourning may be seen as involving four basic tasks as outlined below:

- Accepting the reality of the loss or coming to an acceptance of the reality of the loss takes time since it involves not only an intellectual acceptance but also an emotional one.
- Acknowledging and working through the pain of grief is necessary or it will manifest itself through some symptoms or other form of aberrant behavior.
- Adjusting to an environment in which the deceased is missing. Not only does the bereaved person have to adjust to the loss of roles previously played by the deceased, but death also confronts them with the challenge of adjusting to their own sense of self. Bereavement means not only the loss of a significant other but also the sense of self (Zaiger, 1985).
- To emotionally relocate the deceased and move on with life, involves that the bereaved find an appropriate place for the dead in their emotional lives, a place that will enable them to go on living effectively in the world without them giving up their relationship with the deceased.

Other authors, not necessarily associated with a particular theory, have made dramatic contributions to this evolution of understanding grief as a linear, positivist event. Erich Lindemann coined the term ‘grief work’ in his 1944 article *Symptomology and Management of acute Grief*. Beverly Rapheal’s *The Anatomy of Bereavement* outlines normal and pathologic grief (Rando, 1996). Although these names may not be commonplace, they were among the contributors to shape discourse in the field of grief and death. As evidenced from these titles, the medicalization of death and grief has been prolific. In all of these traditional models of grief, assumptions are made that we should be capable of standing alone, independently of others. Collaborative interdependence is shunned as weakness (Rando, 1996).

In a culture that tends to be less supportive of a professional caregivers’ need to emote, these rigid rules of how we should grieve can be especially challenging to caregivers.
As with many forms of professional knowledge, it creates distance between professional and ‘patients’. Professionals can start to act as gatekeepers of knowledge about the right way to die or grieve (Anderson, 1997; Gergan, 1994), thus undermining the opportunity to experience one’s grief.

2.6 IMPACT OF TECHNOLOGY

From the beginning of time, humans have interfered with their physiological and psychological functioning by using herbs and other medicines, spas and surgical techniques. These earlier kinds of interference however were aimed at relieving pain (physiological and psychological), at achieving spiritual transcendence and at increasing physical, psychological, spiritual, or sexual power; they aimed at improving the existing quality of life. For the first time in history, modes of interference made possible by modern science are aimed at prolonging life, with the quality of that life being sometimes a secondary or neglected consideration (World, 2003).

Benner and Wrubel (1989) write that science and technology has become more central to nursing practice. Nurses now have the resident knowledge of administering and monitoring a wide range of diagnostic tests and treatments, sometimes without the autonomy to utilize these effectively. They state that nurses could make their claims for increased recognition, rights, and status through the recognition of their highly specialized knowledge of science and technology related to health and illness. In doing so, they might avoid the battle to gain legitimacy and status for caring. The problem with this approach is that it ignores the essential relationship among caring, science and technology in nursing. In the best nursing practice, science and technology are the tools for caring, used without caring; technology becomes ominous to be efficacious (World, 2003).

Medical advances and the resulting emphasis on acute care and curing mean that palliative care takes a backseat in terms of medicine’s priorities. Caring for the dying
patient does not attract the same kind of enthusiasm among most health care professionals as does caring for those who can be cured (Swanson, 2001).

There are a number of circumstances in which the needs or interests of the professionals may come into conflict with those of the patients and families. Underlying such circumstances often is the sense of helplessness that is so common in terminal care situations. Ours is a culture where the watchword is “Don’t just sit there, do something!” Health care team members often become frustrated and sick at heart when their interventions “fail” to produce better results. They may feel compelled to promote different treatments (minor medical heroics) even against the interests of the patient’s quality of life (Cook and Oltjenbrun, 1998; Ghonda and Ruark, 1984).

For nurses, medical development means they need to provide even more and often complicated services for their patients. Complex technology is introduced into many deaths without full consideration of the consequences. Capability for the indefinite extension of life has a major impact on the reality of modern terminal care. Nurses who are working with chronically ill patients are now on the cusp of an evolving field (World, 2003).

The practice of nursing has changed beyond all recognition. The health service is increasingly under pressure from reforming politicians and lack of financing, from demands of new medical technology and advances in nursing practices. An editorial in The Journal of Advanced Nursing asserted that a holistic philosophy, privacy and supportive staff relationships should be developed wherever care is given. Evidence suggests that this is more difficult in the acute setting with its obvious and pressing competing demands (Jones, 1995). Kramer cited by Hemmila (2002) states that nurses find little support for their idealism and that there is a hiatus between ideals taught in university and her real situation, which is both exploitive and detrimental to nurses and their well-being.
In modern industrialized societies, death and dying increasingly become institutionalized and medical issues (Corr 1998, Clark 2002, Evans and Walsh 2002). Today, in urban areas almost 90% of the population die in an institutionalized setting. These figures indicate the importance of the role nurses play in relating to the dying and those who are significant in their lives. A troubling situation nurses and families frequently face is preparing psychologically for the impending loss of the patient and then watching the person live on indefinitely, sometimes in pain and hopelessness, with the help of life-sustaining devices. Confronting the fact that a patient has an illness for which little can be done medically is frustrating and painful for the nurse (Doyle et al, 1998; Ellis and Nowlis, 1994).

Benner and Wrubel (1989) explain that coping with professional care giving is shaped by the cultural meanings and institutional forms associated with care giving. Nursing stands out in literature as highly stressful. In acute care settings, nurses daily confront life-threatening situations and complicated treatment regimens that allow little margin for error. Nurses are confronted with societal failure – the breakdown in caring that is evidenced in violence, abuse and the loss of self-care. The knowledge explosion in a highly technical health care requires constant continuing education and confronts the nurse with the fear of failure. Nurses who work in hospitals must face the problems inherent in working in a complex organization. These problems are compounded by lack of authority and recognition commensurate with the life-and-death responsibility of nursing care. Furthermore, the demands of working in complex organizations are increased by chronic nursing shortages and ill-advised reductions in nursing staff as a cost saving measure (Hemmila, 2002).

Today, nurses face more challenges and have greater scope of practice than any of their predecessors, largely as a result of the evolving technological advances and related shift in societal expectations of the health care professional (Jones, 1995). However, nurses trained in sophisticated techniques of medical care are sometimes no better equipped to cope with their own emotional responses to illness and death. At times, educational
institutions may actually teach health care providers to disassociate their feelings and emotions from intellectual concerns by placing emphasis on the technical (rather than the human) aspects of medicine and focusing on the disease instead of the whole person (Cook and Oltjenbrun, 1998).

2.7 DIFFICULTIES FOR HEALTH PROFESSIONALS

Myers (2000) states that any health professional who deals with dying patients on a frequent basis would not find that it is an easy or painless thing to do. Rather, a whole range of emotions may be provoked in the health professional: helplessness, distressing reminders of previous personal bereavements in their own lives, anger and frustration, feelings that they or ‘medicine’ generally have failed the patient, fear of dying themselves and reminders of their own mortality. She states that failure to address these issues will have one of two outcomes. The first is that a range of unhelpful attitudes or behaviors may develop. They may develop a remote attitude to patients, hiding behind their white coats and never admitting to anyone that their situations are having an emotional impact on them. Avoiding patients altogether, or standing dutifully at the end of the bed, not knowing what to say, resorting to technical language, avoiding eye contact and communicating embarrassment and ‘there’s really little else they can do’, before moving on. The second outcome is less frequent and happens when a particular patient’s death suddenly ‘takes the top off’ their suppressed emotions and the caregiver becomes overwhelmed.

Doyle et al (1998) and McEvoy (1990) state that diverse issues may trigger stress in those providing care for individuals and families who are nearing the end of life. For example, feelings of ambivalence, guilt, and failure over the inability to cure, and worry about being overwhelmed by multiple losses may present difficulties for staff. Myers (2000) supports Vincent (1982) who explains that ongoing, unresolved stress can trigger burnout, the features of which may include shifts from a caring approach to apathy, involvement to distancing, openness to self-protection, trust to suspicion, enthusiasm to disillusionment or cynicism, and self-esteem to personal devaluation. Given the perception that expression of emotion is incongruous with being a ‘professional,’ the
emotional aspects of loss may go unacknowledged and unsupported in institutional settings (Miaskowski and Buchsel, 1999). Just as bereavement is a most important issue for families, the impact of loss on staff can also be significant in a setting where close and valued relationships have developed with patients and family members over a long time (Miaskowski and Buchsel 1999; Chochinov and Holland 1989).

Lugton (1987) cited by Spall and Callis (1997) reiterates the importance of acknowledging such feelings by stating that caregivers are not protected from fears, anxieties and other normal reactions associated with loss by being in the role of professional helper. However, Burnard and Chapman (1993) write that in nursing it is often far easier and sometimes encouraged, either to ignore or to rationalize feelings as they occur in day-to-day practice and even to pretend that they simply do not exist. This is evident in the image of the nurse as an implacable, objective carer who has somehow learned to detach herself from emotion.

Spall and Callis (1997) cite a study by Davies (1996), which reported that nurses struggled between expressing their sad feelings and knowing such emotional expression contradicted the expectations for professional behavior. Giving an impression that one is confident and competent in one’s professional role may be very important. Autton (1969) suggests that a professional exterior is as important for the professional as it is for their clients; he also suggests that it is adopted by the professional to hide a real weakness. Underlying a front of confidence there may be a feeling of vulnerability. Most people have this professional image in their heads of what a nurse is. They’re supposed to be kind, caring and supportive. They’re never supposed to show that they’re upset, and their emotions are always supposed to be in check. The attitude of the professional towards the patient is one of service on an individual basis; the patient’s needs being placed before those of the professional (Burnard and Chapman, 1993).

The problem with clinical detachment is that feelings are not acknowledged (Spall and Callis, 1997). Many writers have commented upon the caregiver’s own feeling concerning death as constituting a crucial dynamic in the terminal care situation. Kubler
Ross (1970) stresses that, unless the worker has come to terms with her own feelings concerning dying and death, she cannot become an effective caregiver to the dying patient. Her own personality, ideas, feelings, values, beliefs and morals, that is “herself”, must to some extent, influence her response to frequent, close contact with dying and death and consequently her ability to remain in the terminal situation.

According to Cook and Oltjenbrun (1998), the quality of care is a function of both the professional’s skills and the psychological state of caregivers. According to Stedeford (1983) health professionals care for dying patients best when they have allowed themselves to reflect on their own mortality and therefore not to shy away from dying patients. If we project our own fears about death on patients, this may interfere with our ability to care effectively, particularly if the dying person is in pain or in a lingering trajectory. Unspoken fears and anxieties about death will act as a barrier and prevent one from truly getting alongside dying people. Studies of nurses and doctors suggest that professional helpers’ fears about their own deaths can affect the physical and emotional care they provide, how they feel and decisions about informing patients of their diagnosis and treatment. This is the potential value of considering personal issues to do with death, which may reduce underlying fears (Callis and Spall, 1997).

The majority of studies on the attitudes and experiences of nurses in caring for the dying and on the communication patterns within the ward team and with patients and relatives have been found to present disappointing pictures. Nurses in the general setting feel anxious and ill prepared to care for the dying and their families and, therefore tend not to engage in open communication which may be more supportive and helpful for all involved (Doyle, Geoffrey, Hanks, Macdonald, 1998).

When the care of fifty dying patients was observed in hospital wards, the research team concluded that contact between nurses and the dying patients was minimal; distancing and isolation of patients by most medical and nursing staff was evident; this isolation increased as death approached (Mills and Davies, 1994). These studies also emphasize
the marked differences in care and attitudes of hospice nurses towards death and dying as opposed to those working in an acute care setting.

In the hospital the idea of dying in a sense labels a patient, places a frame of interpretation around a person. Dying patients may be assigned a private room at the end of a corridor, away from other patients and the nurses’ station. This is ostensibly for the patient’s peace, quiet, and privacy, but a closer analysis could indicate the staff’s unwillingness to be in contact with that patient. The behaviors demonstrated by caregivers in the above studies could be related to the reminders death has on the limitations of the professional caregiver in a highly technical environment, where death is considered a failure of the health system. Knowledge of the psychology of death and grief combined with sensitivity to existential concerns are important components in a balanced approach to terminal care.

It has been shown from studies using audio and visual recordings that, in the face of psychological and interpersonal stressors, staff distance themselves from their patients. Also, some staff rationalize their lack of response to patient’s psychological and emotional needs on the grounds that patient’s are expected to be upset by their plight. In one participant-observer study cited by Doyle, Geoffrey, Hanks and Macdonald (1998), the author masqueraded as a terminally ill patient and found that in the surgical unit he had only brief contact with doctors, who were usually accompanied by other staff. In the hospice, however, the staff was more likely to make contact with him on their own and initiate communication about personal matters. Doctors who find it difficult to deal with their own psychological reactions displayed two distinctive patterns of communication. They become either increasingly vague or inappropriately abrupt and frank (Doyle, Geoffrey, Hanks, Macdonald, 1998). Johnson and Gross (1998) quoted a study by Gresinger (1997), in which patients reported that while they received good physical care, the spiritual, existential, emotional or family relationship issues that most concerned them were not rarely addressed.
Overall evidence suggests that the majority of health care workers are prepared inadequately for terminal care issues and concerns in general hospital settings and that caregivers in hospices are better equipped in the psychosocial care of the dying (Mill and Davies, 1994). Studies suggest that nurses commonly experience a sense of therapeutic impotence and helplessness that engenders anxiety and distress (Doyle et al. 1998). Spall and Callis (1997), cite death anxiety as leading to the above responses in health caregivers, stating that unspoken fears and anxieties about death will act as a barrier and prevent one from truly getting alongside dying people.

Kaye and Loscalzo (1998) support Poss (1981) who states that training for terminal care, as for many other service activities, involves the learning of knowledge, attitudes and skills but knowledge about terminal care does not automatically lessen the caregiver’s apprehension about her work since subjectivity, denial and projection abound in this field. Hence the accumulation of mere facts regarding dying and terminal care is unlikely to constitute adequate preparation for the task. The caregiver needs to look at herself in relation to her work and to invest in continuing adult learning in-order to develop her skills in this area. Understanding, insight and knowledge may therefore be viewed as starting points to attaining skill.

The most successful death education efforts seem to be those that integrate intellectual content with the opportunity to explore feelings and attitudes. Although formal training on how to help dying individuals and grieving families has increased, little training is designed to help professionals deal with their own feelings of loss, grief and self-doubt (Doyle et al, 1998; Neimeyer, Behnke and Reiss, 1983).
2.8 **SUMMARY**

Studies of nurses and doctors suggest that professional helpers’ fears about their own deaths can affect the physical and emotional care they provide, how they feel and decisions about informing patients of their diagnosis and prognosis. This is the potential value of considering personal issues to do with death, which may reduce underlying fears and improve end of life care in acute care settings. In the next chapter the research methodology used for this study will be addressed.