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July 2004

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The Duke Patient/Family Resource Center

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- A lending library offering books, audio and video tapes, magazines and free brochures dealing with cancer and certain blood disorders and with issues of coping, survivorship, caregiving, and grieving
- Open 8:30 to 5:00 every day the Morris Clinics are open
- Located in the White Zone, first floor, of the Morris Cancer Clinic, Room 15123.
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“We grieved, we despaired, we hoped, we denied, we planned, we gave up, we hoped some more. I don’t know what to advise others. You do what you ‘have’ to do. You feel what you feel.” –Spouse of terminally ill patient

Planning Life’s End, Part 2 Needs of the Dying and Their Caregivers



When a person dies of a diagnosed cancer, this death will more often than not be foreseen and to some extent planned for. Family and friends will have had a chance to spend time with the patient and become involved in care. Affairs will have been put in order, at least partially. And the grieving process will have started well before the end. In these respects then, cancer deaths are often “better” deaths, emotionally speaking, than the largely unforeseen and abrupt deaths from other causes.

But this doesn’t mean they will be easy. If the various pieces of bad news about disease progression come in a rush, as is sometimes the case, shock-recovery, grieving, and learning the ins-and-outs of cancer and its treatment are all mixed up in a jumbled wad, ripe with potential for retrospective guilt and blame. Even if hearts have been poured out to each other in the brief month or two following diagnosis, the death occurs before anyone is truly reconciled to what is happening. On the other hand, if the bad news is spaced out over long intervals, we patients and families show an amazing ability to adjust our feelings back to almost normal. We go about rebuilding on the slopes of the volcano – what else can we do? – only to find ourselves devastated once again when the latest scans prove frightening. Fear and grief are not the only result. Each new disappointment necessitates changes of plans. “Roller coaster ride” is the expression often used.

No, we won’t be going to Colorado this summer after all.

Yes, we will try that extreme clinical trail that the doctor has mentioned.

Yes, we should get the patient out of that upstairs bedroom and down on the ground floor where she can get around better.

No, we're not ready for hospice, and yes, she does have a will...I think.

This issue of the newsletter is devoted to those of you who have not yet reached the rocky end of this road, but who know that this is one of the very possible outcomes of your or your loved one's current disease. More than any one piece of advice, patients and caregivers need a general image of what to expect, both emotionally and practically, so that they can begin to make wise adjustments. I confess from the start that this is the hardest newsletter I have yet written. It is emotional, there is too much to say on any given point, and it has been tough organizing the range of points coherently.

Recommended reading: Other than personal experience, the greatest help that I've found in forming an adequate image of what to expect is that garnered from the many little case histories that appear in books on end-of-life situations and concerns. Here are several good collections mixed with other pertinent works.

- *Dying Well*, by Ira Byock. One of the best and most informative books on end-of-life needs available.
- *The Needs of the Dying*, by David Kessler. Stories, advice, pithy wisdom from a long time hospice worker and student of Elisabeth Kübler-Ross.
- *Taking Time for Me*, by Katherine L. Karr. Takes on the issues of high stress caregiving with contributions from eight women and one man who have been immersed in it.
- *Pebbling the Walk*, by Steve Reed (recommended in an earlier issue on caregiving).
- *Final Gifts*, by Maggie Callanan & Patricia Kelly. The special awarenesses of the dying as witnessed by two hospice workers.
- *Patrimony*, by Philip Roth. The famous fiction writer gives us a stunning autobiographical account of caring for his dying father.
- *Advanced Breast Cancer* and *Holding Tight, Letting Go* by Musa Mayer. Both quote extensively from patients and families living with the disease; deaths are described and discussed.
- *Dare to Forgive*, by Edward M. Hallowell. Excellent straight from the shoulder advice. The cases he deals with are not easy ones; some are heartbreaking.
- *Home Care Guide for Cancer*, Peter S. Houts, editor. The handiest book on home symptom management that I have come across.

Needs and concerns, some lists. An initial pass at laying out the needs of the dying and their caregivers can be made by excerpting from lists that appear in three of the books mentioned above. "The needs of the dying," comes from David Kessler's book by that title, while the "The stresses of the caregiver" are taken from Katherine Karr's *Taking Time for Me*. The first is, to my mind, a bit too idealized, while the second is a bit too grim, but they serve to stimulate thought. The final short list is from Ira Byock, specifying the five most important things people should be able to say to each other as the end nears.

The needs of the dying

- The need to be treated as a living human being (i.e. not talked about in the third person by the bedside, especially as funeral arrangements are being discussed)
- The need to maintain a minimal sense of hopefulness, however changing its focus may be
- The need to be cared for by those who can maintain a sense of hopefulness, however changing that may be
- The need to express emotions about death in one's own way (i.e. not be coerced into unwelcome sob sessions, on the one hand, or forbidden to show sorrow/anger openly on the other)
- The need to participate in decisions concerning one's care
- The need to be cared for by compassionate, sensitive, knowledgeable people
- The need for continuing medical care, even though the goals may change from "cure" to "comfort."
- The need to have all questions answered honestly and fully
- The need to seek spirituality
- The need to be free of physical pain
- The need to express feelings about pain in one's own way
- The need to understand the process of dying
- The need to die in peace and dignity
- The need not to die alone
- The need to know that the sanctity of the body will be respected after death

The stresses of the caregiver

- The physical stress of meeting another's needs for help in the activities of daily living (The "ADLs" include bathing, dressing, toileting, preparing and eating food, and some movement from place to place)
- The multiple, seemingly endless demands on time, energy, and money
- The loneliness and isolation of the job
- The inability to structure time for oneself in the face of continuous demands
- Family misunderstandings and frictions
- Loss of privacy
- Loss of friends and social contacts
- The emotional strain of living in an atmosphere of sickness, decline, and impending death
- The deadening weight of the days, months, years filled with arduous, repetitious responsibilities for which there can often be no thanks or appreciation
- Being the recipient of anger and hostile behaviors which dependency behaviors can create and/or the abusive and erratic behaviors caused by brain damage in infirm family members

The five most important things to be able to say

- Please forgive me.
- I forgive you.
- Thank you.
- I love you.
- Goodbye

Listing needs in terms of the caregiver's point of view vs. the patient's, or in terms of emotional vs. practical, breaks things apart in an artificial way. Byock's list reminds us that any of the individual concerns that appear in the other two lists are enclosed within a larger 'relational' concern. The concerns of patient and caregivers, for instance, are often quite fused. Caregivers usually want to be as sensitive as possible to the patient's needs, while patients have a strong interest in attuning to their primary caregivers. Each party is anxiously watching the other.

Emotional needs and practical needs also defy easy separation – the one has a way of becoming the other. If there is no one around to bring the bed-ridden patient a glass of water, the patient will be suffering not just thirst but helplessness and abandonment as well. Indeed, a call for a glass of water is often simply a call for reassurance. By the same token, an emotionally overloaded caregiver can easily forget that water must be brought, or feel resentful when the symbolic call for reassurance comes. What we are tackling when we talk about end-of-life concerns is really a wholistic relational situation. It is this relational situation I would like to highlight in this newsletter.

Getting a care team together.



Support teams for cancer patients often begin to shape up at the initial diagnosis. For most patients, close relatives form the core: spouse, children, parents, siblings, in-laws. Often a cloud of personal friends, old family friends, church ladies, and less close relatives hover around the edges. At the beginning there seem to be many eager hands.

But things change over time. Patients whose successful treatments have allowed them to extend their lives appreciably may find, when crunch time comes, that many of these originally eager people no longer feel in such a heroic mood. Some have been caught up in other life situations. Some have

drifted away because they weren't put to much use when they originally offered, while others discovered early on that their fantasies of how to relate to a cancer patient (and people do have such fantasies!) were not fulfilled by this particular situation.

Even under the best of circumstances, e.g. a large dutiful family, the final team that will hang in till the bitter end, often suffers from short-handedness and time scarcity. This is because nowadays very few families are composed of people with time on their hands all living close to one another. And hired caregivers do not come cheaply – think \$14-\$18/hour for the less skilled; \$20-30 for a skilled nurse.

Distressingly, health insurance and medicare benefits do not cover the “custodial” part of care for the terminally ill, that is, the assistance with activities of daily living, and the being-on-hand. (Though medicaid patients may tap into some limited home support for this). Even hospice is unable to offer this part of the service, except partially and intermittently through volunteers. Usually it is too late, and also quite expensive, for the patient to enter “assisted living.” Some people have long-term care insurance policies, but typically these require that the patient foot the bill for the first 90-120 days in the skilled nursing facility, and usually by the time a cancer patient is sick enough to need skilled nursing, she/he does not have 90-120 days. What to do?

For people with serious care shortages and less than robust financing, options center around organizing more volunteer help. For long-time church members or long-time community organization members (e.g. The Moose, Kiwanis, etc), these associations can be a significant resource. It is even possible to interest certain churches and associations in one's care even if one has not been a member previously. Certainly worth investigating.

Lately, our area has seen the introduction of Project Compassion, a movement specifically dedicated to improving care at the end of life. You may contact them by phone at 919 402/1844 or 919 402/1843. A support team leader should be available to help you begin to organize a network of supporters. While most of these will be recruited from your own larger network, some may be volunteers who have signed on with Project Compassion through their volunteer program.

Many of the principles of Project Compassion can be found in a book we frequently recommend, *Share the Care*, by Cappy Capossela and Sheila Warnock. This is a handbook on organizing a support team for the seriously ill. While oriented to the educated professional class who understand appointment calendars and can read things like medical histories, their general approach can be modified in a variety of ways to fit the patient's circumstances. It is full of heartening examples.

If, as is fairly often the case, home care for a dying person proves unfeasible and the family must have the patient placed in a skilled nursing facility, the care team still has an important role to play in visiting, monitoring, and

improving communication between nurses and patient. Some nursing facilities have arrangements to permit hospice workers to take over important aspects of symptom management. In other nursing facilities, the staff takes on this responsibility. Often a prior consultation with hospice will help to clarify which facilities in your area have the best reputation in regard to care for the terminally ill. Remember, however, that even in the best of facilities, nurses are looking after a number of patients at once and the care can become spotty. Visits and monitoring will be essential to the patient's comfort.

The bond between the dying and their caregivers.



Whatever the composition of the care team, and wherever the location of the care, the dying and their caregivers come to be bound together in a process of grieving, rejoicing, coping, and saying goodbye. Each side has needs that only the other can meet: the patient to be treated as a whole person, and to be sensitively cared for; the caregivers to feel they are meeting the patient's needs and to savor the remaining days of his or her company.

The principle anxieties of the patient center around the physical rigors of approaching death, the humiliation of being a burden to loved ones, and the specter of being promptly forgotten once dead. The anxieties of caregivers are more varied because they are often trying to make a living while this is going on, and often deep in their own process of grieving. But in terms of the care relationship, their principle anxieties tend to arise from anticipated guilt. They don't want to look back and feel they did a poor job of caregiving, said or did something insensitive, or in some way hastened the loved one's death. Among relatives and life-long friends, both sides also worry about missed opportunities to resolve old hurts or reaffirm mutual love.

Patients often need to be reassured that caregiving is something the caregivers *want* to do, either out of love, or from a personal sense of mission. For some grieving caregivers, it will be their primary solace during this sad time. And caregivers need to be told, periodically, how much they are appreciated.

Care teams mesh well with hospice, and hospice should be on the case by the time full time care becomes an issue. Some hospices, such as Duke Community Home Health & Hospice, offer a temporary in-patient respite care option for the dying when the usual caregivers are, for whatever reason, unavailable. In the meantime, visits from the hospice nurse, doctor, social worker/counselor, pastor or volunteer offer opportunities for collective

problem-solving when stresses build up. And it is the mission of any hospice service to manage, and teach caregivers to help manage, the needs of the dying listed above. I advise Duke clients to consult their social worker for a recommendation to the best hospice in their area.



Bringing others in, keeping others out.

The introduction of hospice raises the point that a sort of cocoon tends to form around the dying person and the primary caregivers, and either or both may resist outside intrusion, even when this comes in the form of help. Hospice workers and other health care professionals can often recall situations in which a dying patient wore out his wife or a lone offspring by rejecting all temporary substitute helpers, or worse, when an inadequate caregiver selfishly barred access to the patient even as the situation deteriorated miserably. It is not uncommon, especially when parents are attending a dying young person, for all outsiders – even those once welcome – to be suddenly ejected as the end draws near. I won't speculate as to why cocooning is such a strong dynamic in some patient-caregiver bonds, but only advise readers to be aware of the tendency. Often a mediating party can be found, a pastor or a long-trusted family friend, who can facilitate a necessary intrusion, such as the introduction of hospice or home health care.

There are other ways in which the cocoon suffers violation, at least in the eyes of one party or the other. One involves the sudden strong need on the part of the patient to not depart this world without having made a contribution to others in the community or to a cause. Dying persons often become generous to charities that they previously ignored, or struggle to find a home for personal papers and objects that they deem to be of eventual historic interest. The heirs to the patient's estate (who are also often among the caregivers) may need to come to terms with some reduction in their inheritance if the patient's wishes are to be honored in this regard. Fortunately most such wishes do not seriously impact the inheritance.

The patient is also the party most likely to suddenly reach outside the inner circle toward a salvational outsider, sometimes a new doctor, often an alternative medicine guru, sometimes a religious leader, sadly sometimes a con artist. This may be a signal that the patient feels him/herself surrounded by too much pessimism, but just as often it is an attempt simply to explore any remaining options before giving in to the disease. The salvational outsider does have a therapeutic role to play: one of giving the patient an advisor all her/his own with whom private feelings may be aired. Except when the outsider is an obvious exploiter or is giving damaging medical advice, it usually works to tolerate the intrusion.



Living in sacred time.

Joanne Lynn, in *Handbook for Mortals*, cites an unnamed Catholic monk who said that all religion is about one thing – death, and trying to make sense of it. Anyone who visits an assortment of care groups tending the terminally ill will notice that something that sounds like religion, whether or not it comes from a specific creed, has assumed a presence in the group. One of the books recommended above, *Final Gifts*, put together by two hospice nurses, deals with the special awareness that some dying persons exhibit as the end draws near, awareness that can give those who attend to it a glimpse of the beyond or a transforming insight into family relationships. These moments enter into the "culture" of that particular care team. It is often the case that many little happenings take on a heightened, and healing, significance during end-of-life vigils.

The role of organized religion in end-of-life situations will be immense in some families, only lightly touched upon in others, but the dying and the grieving both typically seek spiritual resolution in some manner. When a unity of spiritual feeling and practice emerges, and it can do so in surprising ways, patients and care team members will gratefully speak of this period as "living in sacred time."

Given the diversity of modern culture, however, it is best to anticipate that not all the parties involved will be on the same page, spiritually speaking. If, instead of unity, subtle or not so subtle dominance contests have erupted, it might be well to call in pastoral counselors skilled at mediating these issues. Hospice pastors and social workers are usually well acquainted with these dilemmas.



The conspiracy of sunshine.

A rather different idiom that often installs itself in a group is the idiom of eternal optimism. We were all brought up to think that if everybody continuously claps their hands, Tinker Bell will live. But is there any truth to this? While no studies have shown a direct effect of mood level on cancer itself, mood level has a palpable effect on the people around you and cheerful patients tend to have bigger, better support teams than gloomy patients. Better support teams, in turn, mean better care and physical monitoring, and these factors can indeed prolong life.

But there are benign and not so benign versions of the mandate to "think positive!" In the case of my dying former classmate and friend, Mary, her

many visitors easily fell into a tacit acceptance of her utterances such as "When I get well, we will...[do whatever]," or "I'm really feeling fine, despite appearances." This was because everything else in her behavior pointed to a reasoned acceptance of her approaching death. Her seemingly unrealistic remarks were essentially her way of saying, "I've cried enough already, we don't have to go there."

It is quite different when family members draw visitors aside and warn them against giving any hints of the direness of the situation. Is this coming from the patient, one has to wonder, or is it part of a group conspiracy to keep up false cheer? Virginia Morris, in *Talking about Death Won't Kill You*, writes:

In the early stages of an illness, when there is much information and emotion to digest, denial and unrealistic optimism are not bad. But too often that optimism becomes a pattern, an obsession, and finally, a lie. The lie is planted without malice, but once it is established, no one dares uproot it. The patient is not healed by this lie... He is not uplifted or bolstered by it. Instead he is isolated. Silenced. Shut off.

Patient isolation is not the only problem in such cases. Friends and relatives may find themselves inhibited in expressing deeper feelings, sometimes even in visiting (!) because this may show an alarming level of concern. When everyone is busy acting like nothing is the matter, no emotional work gets done.

Certainly the best, and often the only party that can break through this impasse is the patient's doctor, though it may take prodding by a family member to get the doctor to speak. When the words "hospice" or "end of life" come from the doctor's mouth, the spell is usually broken, and open grieving may finally become acceptable.

The stages of grief.

Elizabeth Kübler-Ross's famous stages of grief - denial, anger, bargaining, and acceptance - don't actually come in stages. Any of the four may appear at any point in the one's journey toward the end, then give way to a different one days, or even minutes, later. So another subtle imperative that tends to settle into the culture of the care team - that everyone move in lockstep through a set pattern of emotional responses - should be set aside. The only pattern that should give alarm is having one party or another stuck in a particular response, be it a grieving response or any other (fear, self pity, maniacal hilarity, woodenness) because this too shuts off opportunities for emotional resolution and sharing.



Forgiveness.

Forgiveness is never easy - the natural grain of human nature seems to run more toward revenge than forgiveness. But if there is ever a time when it is easier, it is when one party to the situation is soon to depart this world. David Kessler writes,

In the end, our diseases stop spreading, our hearts no longer beat, and our minds cease thinking. So do our fights, grudges, and judgments end. Whether we like it or not, our part of the quarrel will be over, for we will no longer be here. The dying understand this intuitively, which is why they often have a meeting with forgiveness. To forgive does not mean to accept bad behavior. When we forgive, we release ourselves from the binds of hates and hurts.

Some dying persons, by relinquishing long-standing anger, become almost transformed in personality for the brief period of life remaining. True, most of us aren't ever going to change our personalities. But the degree to which retained anger and bitterness can distort a person is worth pondering. If you or someone in your care team is wrestling with a tough forgiveness situation, a good resource is Edward Hallowell's *Dare to Forgive*.

Things to watch for and understand.

Last minute gyrations: In entering into the lives of the terminally ill, the thing that has made me grit my teeth the most are the wild reorganizations that some patients insist upon as it becomes more real to them that they will, indeed, die. I'm speaking of a point where they still have strength left, and fight. Otherwise they would not propose some of the things they propose. Heading the list is, Let's Move House! There may be some realistic grounds for wanting to move. The current housing may be hard to negotiate physically, too remote from caregivers, or not big enough to house a caregiver. But often there are unrealistic elements to the perceived solution. Many people, for instance, think that an Assisted Living facility is the answer, not realizing that there are long waiting lists for all of the good facilities and that the "assisted care" level does not encompass end-of-life care. In other words, another move would eventually be necessary. Occasionally, a person, looking for an elusive quality such as "peacefulness" or hoping for the care of an elusive relative, winds up in a situation even more remote from real help than they were before.

Some of the acceptable solutions I have seen involved the patient being taken in by a relative or friend who was committed to their care and *knew what that care would involve*. But I have seen unknowledgeable rescuers become overwhelmed by the patient's needs shortly after taking them in. My advice to patients and families coming to grips with a need for change of space is to do an intake interview with hospice to find out what hospice considers realistic. (One need not enter the hospice service quite at that point.) Often a somewhat deficient current home is better, and certainly cheaper, than a leap into the unknown. Money that would be spent on a move can be spent on making that current home less deficient.

If there is danger or a care deficiency at home and the need for a move does become urgent, the patient's doctor may recommend admission to the hospital. After 72 hours in the hospital, it becomes the prerogative of the hospital to determine to where the patient will be discharged, and the Patient Resource Manager takes over the job of locating an appropriate nursing facility. (A Patient Resource Manager can be found on every floor of the Duke hospital.) This recourse relieves families of decisions that may have been dividing them and it gives the patient a way out of an inadequate care situation. Your doctor is the person to consult about this.

The burned out caregiver: A patient who is bedridden or who has grown disoriented or prone to falling becomes a giant baby in your care. Some of you remember how difficult the baby was, but at least he/she was (a) portable and (b) not the object of sorrow. Oh, and (c) the baby is never embarrassed by your care. With a terminally ill patient those three advantages disappear. Being a caregiver for the terminally ill is stressful, and being a sole caregiver is an invitation to burn-out.

The warning signs of caregiver burn-out include irritability, sleep disorder, depression, drinking and self-medicating, over- or under-eating, poor concentration, trembling, feeling out of control, neglecting own health, compulsive behavior, rudeness, and suicidal thoughts!



The best ways to ameliorate the stress are sharing the care more widely, joining a caregiver support group, and "taking time for me," i.e. having periods of rest and recuperation, perhaps supplemented with exercise, meditation/prayer, outings with old friends, visits to grandchildren, or any form of activity that highlights enjoyment and lightning up. Your loved one is not going to feel worse by your feeling better.

The patient's sense of timing. Frequently the patient seems to know better than the caregivers, even the medically experienced caregivers, when the end is very near. He or she may request that an event, such as an anniversary, be moved up in time; or that something planned for near the end, e.g. a farewell phone call, a move to the hospice facility, be implemented immediately. There is usually no harm in following the patient's wishes when this is feasible. What is difficult is interpreting such wishes if the patient is disoriented and states them in an elliptical way. Callanan and Kelly's *Final Gifts* provides many good

examples of how such wishes get stated.

Questions about death itself: Some patients, while they are still well enough to have such discussions, begin to wonder aloud what death will be like - meaning spiritually, not simply physically. While none of us has the answer, it is often a great comfort to enter into speculative discussions nonetheless, centering on positive formulations. Religious teachings will be the main resource for some people. Others may wish to consult books about near-death experiences such as the famous *Life after Life* by Dr. Raymond Moody, or the Christian examination of this phenomenon, *Embraced by the Light* by Betty J. Eadie and Curtis Taylor.

Suicidal thinking: Most terminally ill patients do not voice suicidal wishes, though many admit to having pondered the subject. Studies have shown that those who do voice such interests are usually expressing anxiety over something unstated. Common anxieties are being a burden to loved ones, fear of uncontrolled pain, or depression over abandonment. Sometimes the stated death wish is simply a statement that the current situation is intolerable. Certainly the pain concern can be adequately dealt with in almost every case, and reassurances by caregivers can overcome the burden anxiety. At present, there is no good remedy for real abandonment.

Occasionally there are patients who, for some time, have been announcing and even detailing their personal suicide plan, one that they expect their loved ones to help them implement. Often it is necessary to point out to the patient that he/she is asking the other party to violate the law. It is of interest that in Oregon, currently the only state where assisted suicide is legal, the patient and his/her caregivers often never get around to putting the carefully worked out plan in motion. It has served all along as a sort of reassurance that an uncontrolled and messy death can be avoided; but there are other ways of providing this reassurance, such as good hospice care.

The fed up patient: We should distinguish suicidal thinking from a similar situation that often arises when the patient is very close to death. This is the patient who repeatedly voices how fed up she is with the situation. "I've had enough of this," "When will this be over?" and, especially in disoriented patients, "Just take me home," are frequently the phrases heard. My experience concurs with what other caregivers tell me: these complaints usually do not arise until about the last week of life. Attention to comfort levels and reassurances about comfort are in order here. The patient who wants to "go home" might be comforted by hearing that she/he will soon be home.

The over-nurturing caregiver: It is also appropriate at this point to give up the struggle to nourish and hydrate the patient since alimentary functions become increasingly unhelpful and unpleasant to the patient whose organs are beginning to fail. Here we will often run up against the caregiver who is anticipating guilt over not having done all that was possible to keep the patient alive. It may need to be stressed that these nurturing behaviors are distressing rather than helping the dying person, and that there is a fine line between helping someone live and prolonging the agony of dying. A more fitting form of nurturance when death is near is for caregivers to gently give the patient

their permission to "let go". There is an excellent pamphlet called "Hard Choices for Loving People," that caregivers might want to consult on these issues. At Duke, it is available through the Palliative Care Service, the Patient Education Program, or the 9th Floor Oncology Unit.

The patient who can't "let go": Obviously time will eventually cure the problem of the patient who seems to be clinging too hard to life. But this is often an indicator that he or she feels unreconciled about something. Try to figure out what it is. The difficulty again is that of interpreting elliptical utterances. One patient cited by Callanan and Kelly, kept saying, "I can't find the feed for the horses!" A close family member realized what needed reconciling, and with this reconciliation, the patient let go. (It had nothing to do with horses.) Typically, it is the person most familiar with the patient who is the best interpreter of strange death-bed utterances.

Religious and ritual practices, when acceptable to the patient, are often a great help in smoothing the patient's transition to the other side. I have witnessed a number of situations where the patient passed away shortly after a prayer vigil or a group bedside ritual. In one case, the Native American friends of the dying woman, who had no clue the end was so near, arrived miraculously at her bedside at midnight one night and set about chanting and drumming. The patient passed away quietly while the chanting was in progress.



"Did an angel whisper in your ear,
And hold you close and take away your fear,
In those long, last moments?"
-Lucinda Williams

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