Hospital staff members tend to experience increased anxiety when they have to look after a dying patient. This results in the routine technical aspects of physical care being emphasized more than the emotional needs of the patient. Instead of spending time to listen to the patient, the staff members find themselves avoiding conversation with the patient or trying to turn the thoughts of the patient away from death.

When the patient feels that the hospital personnel are uncomfortable in discussing the fatal nature of his illness, the patient himself gradually erects his own communications barrier and withdraws from important relationships. Unable to cope with their own painful feelings of loss, the friends and family members also tend to withdraw from intimate communication.

This process of gradual mutual withdrawal or disengagement and the conspiracy of silence are most distinctive. It diminishes the patient’s capacity to live. Unable to verbalize his thoughts and feelings, the patient loses the opportunity to let his positive feelings for others to emerge. Loneliness is the greatest burden of the dying patient.

What is needed is that the patient should be helped to die in peace, dignity, and with acceptance—not with anxiety, restlessness, feelings of guilt, or a sense that life is unfinished.

There is no rule of thumb as to whether the patient should be told all that the doctor knows or thinks about the patient’s condition whether he is dying or whether he is sure to recover.

Staying with the patient emotionally is the most important thing. The level of intimate communication should be maintained so that the patient may feel really free to share whatever thoughts or feelings he/she has.

Neither trying to hide anything, nor hurrying to tell the whole truth for which the patient may not be ready. If the patient is inclined to “be prepared for the worst”, his/her wish should be satisfied.

We may speak of six stages though which a patient passes in facing the prospect of death.

1) shock—that death although ultimately inevitable should be so near
2) denial—refusal to accept disbelief in what is happening, projecting this fear to others, trying to reassure the family
3) sense of guilt—regarding errors that might have brought on the fatal situation or over horrible feelings towards others, envy or jealousy to those who will continue to live, anger at oneself or the doctor
4) bargaining—O God give me some more time and I will be good, settling accounts, flashback memories
5) depression—fear, anxiety for dependants, what will my daughter do etc.
6) acceptance—resignation, peace of mind

For the staff there seem to be five stages of caring:

1) preparing the patient to die
2) preparing the family and the staff for the patient’s death
3) facing the situation where there is nothing to be done except to wait
4) the emotional support of the last hours
5) the actual death and what is to be done after that