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THE SOCIAL LOSS OF DYING PATIENTS

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Inevitably, a social value is placed on a patient, and that value has much to do with the impact on the nurse of his dying and, frequently, on the care he receives. So the authors have discovered in a study they, with a nurse faculty member, Jeanne Quint, are making of hospital personnel, nursing care, and dying patients at the University of California Medical Center. A clear recognition by the nurse of the evaluating she does can help buffer the impact and make it easier for her to determine nursing needs objectively.

When a patient dies, a nurse feels a loss. In fact, she may experience three kinds of loss. One may be personal loss. Some nurses become involved with patients for such very personal reasons as friendship, similiar age, or transference. A second kind is work loss—fighting to save a patient, then losing him. The third kind is the subject here—social loss.

In our society we value people, more or less, on the basis of various social characteristics: for example, age, skin color, ethnicity, education, occupation, family status, social class, beauty, "personality," talent, and accomplishments. Each dying patient embodies more or less of these social characteristics, each to a different degree. The total of the valued social characteristics which the dying patient embodies indicates the social loss to family, occupation, and society on his death.

Nurses tend to react to this degree of social loss with relatively consistent sadness, distress, and efforts at care. Their reactions are most noticeable on wards that have large ratios of high social loss patients (for instance, pediatrics) or low social loss patients (for instance, geriatric wards in state hospital). However, one can see it virtually any place in which patients die.

A clear recognition of her social loss appraisal may well help a nurse to avoid inequitable attention to different types of dying patients.

CALCULATING SOCIAL LOSS

Perhaps the single most important characteristic on which social loss is based is age. Americans put a high value on having a full life. Dying children are being cheated of life itself, a life full of potential contributions to family, an occupation, and society. They are a loss to the coming generation. By contrast, aged people have had their share of life; they have made their contributions to family, occupation, and society. Their loss, while felt, will be less than if they were younger. Patients in the middle years are in the midst of a full life, contributing to families, occupations, and society. Their loss is often felt as the greatest, for they are depended on the most. It is tragic to see dying a young woman who is married to a devoted husband, charming, educated, and who has three young children. A nurse told us, "I feel most involved with mothers." Or, "I was very involved with a young man who died with rapidly advancing carcinoma. He had a wife, our age, who was a nurse and who had a baby just before he died. He was to be an x-ray technician."

Thus, age is a gauge for a patient's actual and potential social worth. As a gauge, it becomes a baseline for judging in combination other factors. For example, education is more important for calculating the social loss of a middle-year adult than a child or an aged person, since in the middle years education is most put to use.

Age is an apparent characteristic, as are such others as beauty and charm, social class, or skin color. But the nurse must learn about certain other characteristics a patient has—talent, accomplishments, family status, occupation, and education. The

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longer a nurse works around a dying patient, the more likely she is to learn of his occupation, accomplishments, talents, fame, and family status. Further, she is more likely to learn the degree to which his loss will matter to occupation and family. Family members of dying patients visit frequently, and over time the degree which the patient will be missed after death becomes clear.

This learning usually becomes a collective operation among nurses, as they frequently share their variously discovered facts about the patient. A product of this sharing of information can be consensus among ward nurses about the social loss of the patient. However, consensus does not have to occur, since nurses with the same information can vary in their appraisals of social loss. Lack of consensus is most probable when some of the social loss characteristics of the patient are at odds—as in the case of an elderly man with a very important job, but with no family to care for.

PATIENT'S SOCIAL LOSS STORY

As nurses learn more about the social characteristics of a patient, and learn more about the degree of social loss involved in both apparent and learned characteristics, they continually balance out these factors. Thus, over time, a story is in continual development about the patient as factors are added, adjusted, and subtracted; we term this the patient's social loss story.

This story, then, is a product of the nurse-patient relationship carried over time, which in many cases can be months or even years. Obviously, on some wards which keep patients only a short time—such as premature infant nursery, intensive care unit, emergency—there is only a short social loss story. On these wards nurses may act and feel mainly on the basis of apparent characteristics. They have little time to learn about their patients' other social characteristics.

As the social loss story develops, it becomes an entity apart from the patient, though its calculus may better mirror the patient's potential social loss. The story is told to other nurses almost as if no patient were really involved. It is very sad to hear a story of a young boy run over by a streetcar, or a woman with three children who is dying. It is sad whether or not the patient is himself currently cheerful. Nurses thus react to the dying patient's social loss story as well as to the patient himself. A prime source of this separation is the generic basis of the social loss story: valued social characteristics, which are themselves something apart from any one person.

The social loss story gains an historical aspect as nurses learn more of the past meaning of the patient's present characteristics. They learn where a patient is from, what he has been doing and, therefore, what loss his death will be for family, occupation, and society. For example, it is a great loss when a medical student dies of cancer, and this loss is increased when nurses learn the young man had decided to be a doctor in his early teens like his famous father. Similarly, it appears a loss when a dentist is dying, but this loss is somewhat reduced when it is learned that he has spent the last few years of his life hustling marijuana on skid row. The loss of a premature infant may not seem so great when it is discovered that the mother had already lost three premies and did not fully expect this one to live either.

The historical and present aspects of social loss stories derive their meaning from the anticipated future. Thus the story spells out the loss for family members, to occupation, to society—all of which remain to go on without the dying person. In some cases, so the story may say, a family will fall apart without the father's paycheck, or a business will collapse, or a nation will feel the loss of a VIP. In other cases, such as the adolescent who, in a wild car drive, kills himself and four others, or the Mexican farm worker with cancer, little social loss may be anticipated by nurses. (In the adolescent's case, some nurses may feel a social gain!) For projections into the future, a nurses' imagination easily fills in details.

Social loss stories terminate or stop developing in various ways. For low social loss patients, they may scarcely begin before nurses lose interest. Typically the story stops at a patient's death, because the body is disposed of and the family disappears. With this egress of people all further news of the patient ends, and very few nurses check on what happened afterwards. They become caught up in the care of new patients. The story may also stop when a patient becomes comatose and family visits taper off. In this instance, social death has set in for patient, family, and nurses, and may last for days, weeks, or months before physical death finally occurs. The story may also stop in cases of lingering illness when family members have accepted the coming loss and grieved as much as humanly possible.

Sometimes the story goes on after death. This occurs in the case of a surprise death which does not allow enough time beforehand for story development. After the death the staff members sit around and hash out, with what little information they have among them, the social loss of the patient. Story development after death can also occur when family members return or send letters to the nurses, telling what has happened since the patient's death. Some striking stories are never forgotten among nurses; the relating of the story brings out again, and perhaps develops further, the social loss involved. One such striking case is that of a nurse, with one child, who let herself die from a nonsterile abortion in order to protect, it was assumed, her lover and the abortionist.

IMPACT OF SOCIAL LOSS

The principal impact of social loss on nurses is on their feelings. Low social loss patients may hardly bother them; high social loss patients can be very upsetting. The secondary impact of social loss is on patient care. Low social loss patients tend to receive minimal routine care. In some few cases, low social loss patients may receive less than routine care. For example, at peak hours on emer-

gency wards, when the staff must engage in split-second priority decisions concerning attention and treatment, low social loss patients can easily be forgotten for several minutes.

High social loss patients often receive more than routine care. Extra "good will" efforts are made to talk with them, to keep up their spirits, to make them comfortable, and to watch for sudden changes in their condition However, if the high loss of such a patient is too upsetting for the nurses, he may find himself, like the low social loss patient, receiving only routine care.

Many conditions serve to balance off the effects of social loss on nurses. An important one is the use of standard "loss rationales" to reduce being upset in the face of low or high social loss. People dying from a Friday night knife fight, or the adolescent on the verge of death who has killed others in a wild car drive, have their low social loss reinforced by an "it's their own fault" rationale. That rationale helps to stifle excessive efforts or minimize feeling upset by the tragedy. Being upset at the death of high social loss patients, such as the young mother or father, is typically reduced by rationales to the effect that "It was a blessing he passed on, he was in such pain." Old age rationals are "He had a full life," "He had nothing more to live for." The typical rationale for the loss of premature babies is "He probably had brain damage and couldn't have a (socially) useful life." Or for dying children, "You wouldn't ask him to suffer any longer, would you?" "Don't you think he is happier?" Thus these loss rationales—based on social worthlessness, having a full life, enduring pain, and defects pointing to no potential for a normal life—provide "good reasons" for discounting the impact of high social loss patients or accepting lack of concern with low social loss patients.

Some dying and deaths are not readily handled by loss rationales. It is hard to give good reasons for the accident or the surgery that considerably reduced a patient's life. What emerges are reasons that may increase the distress of social loss. One nurse said in the case of surgery, "I think I feel worse if I know that the patient might have done all right without surgery. They may have lived. Especially a young person. If I cannot explain it to myself, then I feel worse about it. If I can't make an explanation for someone dying, it seems irrational." In such cases, the death is senseless, and the impact consequently greater.

The greater the number of social loss factors the patient embodies, the greater will be the impact of his death on his nurses. For example, the death of a young man is probably less likely to be upsetting than that of a young man with a wife, children, and a highly respected profession. A low social loss factor can cancel the effects of high social loss factors, such as our skid-row dentist or the case of brain damage which renders impossible future contributions to society.

Various properties of the wards also affect the impact of social loss on nurses. On wards where many patients die, nurses can get accustomed to seeing repeatedly the same degree of social loss. This reduces its impact. In contrast, the surprise death of a mother on a ward which seldom has dying or death can have a very strong social loss impact on nurses. Closely associated with frequency of death on a ward is the type of ward patient. For instance, the same frequency of death on a geriatric ward is easier to take than on a pediatric ward. Some wards are filled with lower class patients, other with middle class or upper class. Still others cater to no particular type of patient.

Another property that changes the effects of social loss is the patient's length of stay on the ward. On wards which generally keep patients for a very short time, the impact of social loss is mainly based on apparent characteristics. On wards with slow turnover, the impact is based also on learned characteristics and on the resulting story development, as the balance of loss factors changes. It is difficult to generalize which conditions lead to greater impact. Some nurses who find it difficult to face death and dying on cancer wards, where patients linger for months, many take it much more easily on ICU, where patients either die or leave within a few days. Closely linked with length of stay is the pace of nurses' work. The quick turnover wards tend to keep the nurses very active with intensive care, which is a buffer to the impact of social loss. On the slow turnover wards, the nurses may dwell on the social loss of their patients.

IMPORTING VALUES

Is nurses' response to social loss professional? We do not believe this response is a result of professional training, skills, or attitudes. Indeed, becoming upset in the face of high social loss may hinder the professional requirement of composure in the face of dying and death. Variations in patient care based on social loss also hinder the professional ideal of treating all patients in accordance with their medical needs. The morale of a dying patient needs to be maintained irrespective of, say, his social class or "personality."

Thus we believe that nurses are responding as human beings born into our particular society—a response not necessarily in conflict with professional responses, but not falling within the group of professionally prescribed responses. Nurses import into the hospital the values of our society and act accordingly.

Can or should importing social values into the hospital be professionalized? This is difficult to say. It goes on; it cannot be stopped. But what surely can be done is to become deliberately aware of the importation so that responses to social loss will not hinder professional requirements of composure and care. If understanding the impact of social loss will help a nurse maintain her composure in the face of dying, she will not be forced to avoid patients whose tragic plight is just too much to take. She can also offset some of the untoward effects of social loss evaluation by realizing that socially important dying patients are not the only ones who sorely need extra efforts of good will.