Time of Death: The End of Patient Care?

Arguments towards a Continuity of Care

Objective

Have a greater awareness for, and feel better equipped to, respond to needs that may arise both for patients and their families after patients have died.

Case Study

- Unidentified trauma patient - suspected to be brain dead
- Transferred to the ICU (escalation of care)
- Testing confirms brain death - still unidentified
- Transferred to the morgue (de-escalation of care)
- Family requesting to see patient in the morgue

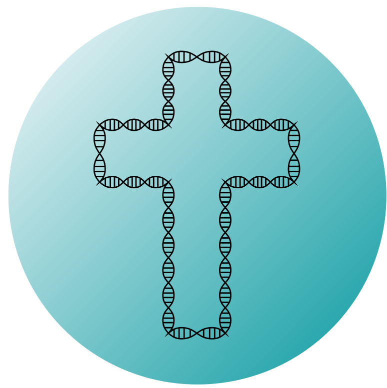
Medicalization of Death

- Communal practices
- Burial and Viewing Rituals at home
  - "...the death of a man altered the space and time of entire social groups and communities..." (Ariés, 559)
- Both where patients are viewed and where they die has been centralized to one space – the hospital.

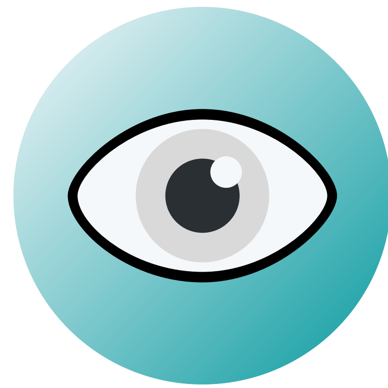
Death now happens within the sanitized process of hospital institutions. Death is "out of sight, out of mind."

CARE NEEDS AFTER DEATH

Autopsies



Bereavement



Body Viewings

Funeral Arrangements

Organ Donation

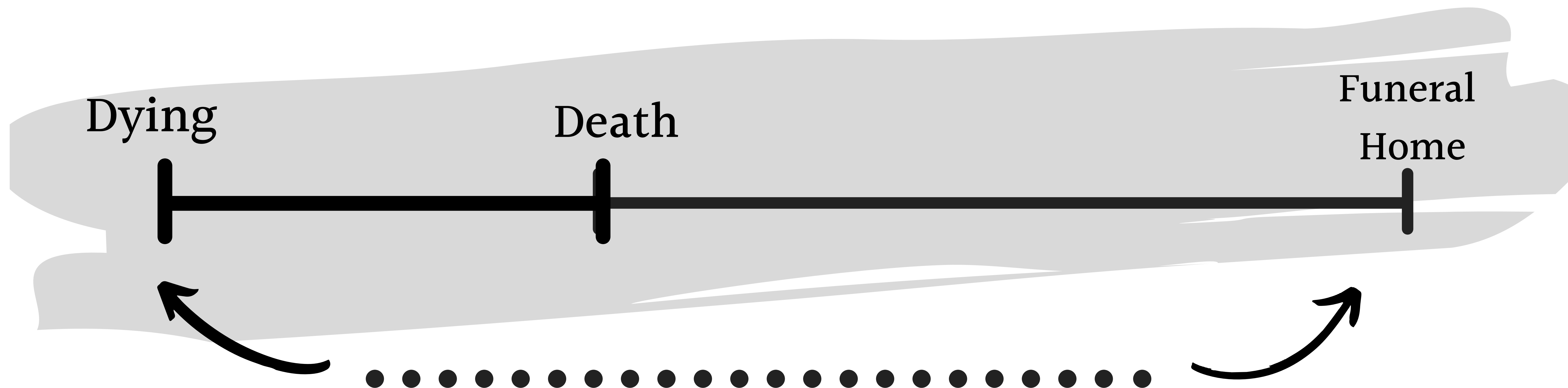
Cultural Rituals

Coroner

Death
GAP IN TIME= GAP IN CARE
Funeral Home

"The process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care."
– The American Academy of Family Physicians

What is "Continuity of Care?"



C O N T I N U I T Y   O F   C A R E

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Barriers to Continuity of Care:

1. Loss of personhood: Is a dead body still my patient
2. Death's threat to medicine's rescue scheme: Death at the margins.
3. Lack of documentation: Where medical care stops.

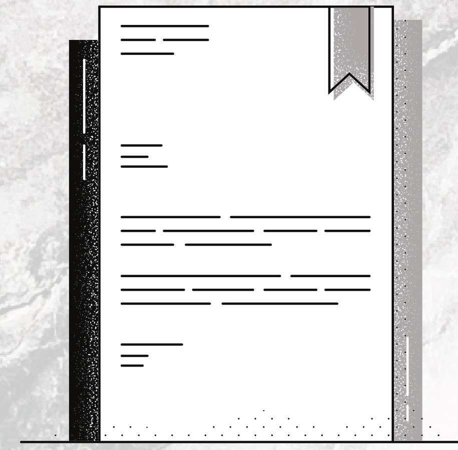
Open Opportunities for Change: When a Patient Dies

The Land of the Living: Move dying and dead patients from the ghetto of hospice and the morgue and "return their needs squarely back to the land of the living." (Chapple,9)

Patient Autonomy: Deceased patients still require the professional obligation for dignity and respect. Most tangibly done by honoring family wishes.

Spatiality: Consider the ways in which space contributes to meaning and memory. Make this an informed consent/refusal process.

Open Opportunities for Change: While Patients are yet Living



Document Preferences/Values:
Studies show that patients who have a Living Will are less likely to die in the hospital. (Degenholtz et. al, 2004)

Awareness for Religious Traditions in your Community

Gather Stakeholders and Assess your Hospital Policy

No one really specializes in dead patients. And yet, this does not prevent questions about deceased patients from emerging and needing to be answered.

Concluding thoughts on trauma case

What would you have done?

OPERATIONAL QUESTIONS:

What is a reasonable amount of time to wait for family to arrive? Are there other beds available?

BODY VIEWINGS. SHOULD WE DO THEM?

- Golden Rule is misapplied here.
- Make this an informed consent/refusal process.

Although there may not be medical care, in the strictest of definitions, to provide to deceased patients, there is yet care by medical providers that should be offered.

Sources:

Ariés, Philippe. The Hour of Our Death. Translated by Helen Weaver. New York: Oxford University Press, 1981.

Chapple, A, and S Ziebland. "Viewing the Body after Bereavement Due to a Traumatic Death: Qualitative Study in the Uk." BMJ 340 (2010): c2032. https://doi.org/10.1136/bmj.c2032. https://www.bmj.com/content/bmj/340/bmj.c2032.full.pdf.

Chapple, Helen Stanton. No Place for Dying: Hospitals and the Ideolody of Rescue. New York Routledge, 2016. 2010.

Degenholtz, H. B., Y. Rhee, and R. M. Arnold. "Do Living Wills Affect the Setting Where People Die in the United States?". Article. Annals of Internal Medicine 141, no. 2 (2004).

Horsley, Philomena. "Death Dwells in Spaces: Bodies in the Hospital Mortuary." Anthropology & Medicine 15 (08/01 2008): 133-46. https://doi.org/10.1080/13648470802122040.