

Care at St. Christopher's

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A volunteer nurse's assistant describes, from a personal point of view, her work on two wards at St. Christopher's Hospice, Sydenham, England from October 1978 to February 1979. A brief description of the Hospice, her on-the-job training and, in more depth, a sample morning on a ward, give an impression of the character of this work and the care given.

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WRITING from the standpoint of a volunteer, a person from a foreign country working in an English Hospice, a worker who is only there two days a week, clearly brings a limited picture of what St. Christopher's is like. My training and experience had been as a teacher, a wife, a mother and graduate student nearing completion of an MA in Psychology at Portland State University in Oregon. We were to be in London for a winter sabbatical, and I wrote ahead to Sheila Hanna, director of Volunteers at St. Christopher's, to see if they would take me on as a volunteer nursing assistant. I'd heard Dr. Saunders speak in Portland five years ago, and realized this might be the best chance I'd have to learn what this particular kind of nursing care could be, and how people best live at the very end of their lives.

Sheila Hanna visited with me, as she does with all prospective volunteers, showed me around, found something about what I hoped to do, and made an estimate of what she thought I could do. When she called me after our first visit, I was assigned to a nurse on a ward for a morning of training. We made beds, gave baths, and generally did the work of the day as I learned where things were kept and absorbed the patterns of the way care is given. From then on, October through February, I worked one day a week on a women's ward, one on a men's ward.

St. Christopher's has four main wards built over each other: Rugby, Alexandra, City, and Nuffield. Rugby, on top has only single rooms, but the others consist of sixteen beds in four bays, and two "side wards" (single rooms) at the end. This gives eighteen single-bed rooms with a bed total of sixty-two. Curtains draw around each bed, but the walls between the bays don't even go all the way to the ceiling; they are really partitions. The bays on a ward attach to each

other along the sides, with windows along one side and the doors to the hallway on the other. Across the hallway runs the kitchen, three bathrooms, treatment room, sister's office, sluice, conversation room (a small living-room for talking with families) and storage. The whole feeling is very open.

In another wing, Drapers' Wing, are rooms for the "frail elderly" who are unable to take care of themselves at home, but who can still do a good deal for themselves, can come in to the dining-room, and are relatively well. The lower floor, where these two wings join, holds the main kitchen, the dining-room, staff lounge, social workers', chaplain's, PT and OT offices and chapel, and leads to the Outpatient Clinic. The clinic receives outpatients, and is also the place where weekly meetings are held to keep the Hospice staff up on discharged patients who are being seen at home by "domiciliary care" nurses.

The third side of the U holds administrative offices, the Department of Clinical Studies, and doctor's offices. Tucked into one of the bends of the U lies the children's playschool for children of staff: they join their mothers for lunch in the dining-room. From all parts of the Hospice you can often see the children out riding their trikes in the central garden and playing with their two teachers around the fountain pool. Occasionally, they appear upstairs, at the end of a ward, on their way to watch a children's television program.

Admissions meeting is held every morning at ten. Matron, one social worker, an OT staff member, and several other people, read over the applications. The chief criterion is that the person be in the very latter stages of life with cancer. A few patients with longer expectancy, such as someone with motor-neurone disease, are admitted, but most people are there for a few days or a few weeks. The median stay in 1979 was fourteen days, the average, twenty-five days.

There is a steady effort to support each member of the nursing staff. There is always the feeling that one may sit and talk with a patient, commit oneself to compassionate, friendly, human contact, without concern over saving time in a busy day or protecting oneself from distress when that person dies. There is a

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wide variety of attitudes among the patients. In conversations with one very elderly woman, I heard an affectionate, pleasant recalling of a long life she knew was coming to an end very soon. With other patients, there was every kind of feeling — hope that things would get better, humor, anger. Every few weeks there are staff meetings on each ward with the consulting psychiatrist, and weekly open meetings include doctors, social workers and sisters, or charge nurses. The doctors and the social workers stay in close touch with staff patients and families. Matron keeps a close watch, coming around with particular attention to a ward group of nurses, if several people have died on a weekend for instance.

Describing a morning on Alexandra ward may give some idea of how the work goes on. Coming out by train from Victoria Station, I walk up the hill from Penge East to Lawrie Park Road, and arrive a little after 8:30. Pat and Bernie are just collecting last tea cups. Patients doze in their beds. The nurses are all sitting in Sister's office just finishing report, going over what's happened during the night and plans for the day.

Donning my thin, vinyl apron over a rosy-colored, volunteers' smock, I start to care for dentures, brush teeth, sometimes just give a mouthwash with an anti-fungal, refreshing solution — done after every meal. I find I'm teamed with Rose for the morning. By the time we have finished mouthcare, others have started running baths, or are giving bed-baths. Whenever possible, even if the bed has to be wheeled into the bathroom, a person is given a hot bath in one of the three big bathtubs. Sometimes two of us would lift a patient first up to the end of the tub, feet in, then all the way in. Some patients can manage to get in and out on their own with just an arm. With others, we use the Hoyer lift from the wheelchair or the bed.

Amount of time in the tub varies. Mr. Holcombe stayed in for twenty minutes this morning, dozing, well bolstered by big sponge rubber pads. We're giving him the first bath so he'll be ready to go down to chapel at 10:30. His ostomy bag doesn't need changing today; his arm is in a sling.

Sister groups staff nurses, nursing auxiliaries and volunteers, six or seven of us, into twos, and assigns each pair four or five patients. Annie Morrison seems close to dying, so someone sits with her all morning. We give her a freshening, gentle wash, clean her mouth out, explain what we're doing although she may not hear us. She is breathing very heavily, not conscious. Mark, a volunteer from the Church Army, comes around with the menu for lunch. When it's completed, he'll telephone it down to the main kitchen.

There will be an admission this morning in the bay we're working on, so we make up the admission bed. While I finish washing Mrs. Beeson, Rose takes the bed down in the elevator to be waiting at the entrance door. The bed has two hot water bottles, warming it; the top covers are not tucked in, just turned under on themselves. Matron, or one of the Sisters who

sometimes takes Matron's place in doing admissions, will meet the person at the door and come up to the ward with patient and family.

Rose and I take our break about mid-morning, twenty minutes downstairs for a cup of tea in the lounge which is a friendly place. No member of the "hierarchy" goes in, so the staff can be free to grumble if they want to, but the OT and PT are there, as well as social workers, and nursing, kitchen and office staff.

There are no visitors around on the wards today because this is Monday. Families are asked not to come and to take a day off, unless the patient is very ill or has just been admitted over the weekend.

When we've finished all the baths and beds, I take a turn sitting with Miss Morrison. She doesn't have any family; Sister would have called them by now and they would be here. I talk with the patient in the next bed. Miss Morrison's breathing becomes irregular, stops for a little while, starts again. A nurse comes by and stays. We stand and wait. The breathing stops altogether. She dies. We pull the curtains around the bed; the nurse goes and gets the prayer cards from Sister's office, and we kneel down by the side of the bed and say aloud, together, those beautiful prayers for the dying from the Anglican service. We straighten the bed, and tell the other three people in the bay that she has died. Mrs. Barnard says, as I tell her, "Oh, I'm sorry," and adds, "She's been very bad these last few days." We wheel Miss Morrison in her bed down the hall to the treatment room.

The juxtaposition of the everyday goings-on, with death so recently occurring, is always striking in a way and at the same time perfectly natural. Between the time that Miss Morrison died and the time we make her ready for the morgue, we go and serve lunch. The lunch cart comes up in the elevator, the hot food very hot, in serving dishes, the plates warmed and ready on the cart. If the person we're taking food to needs to be fed, we'll stay and feed that patient, however much he or she feels like taking. Soon the dessert cart starts around closely followed by the tea cart. Then it's time for the 1:00 drug round. Sister or one of the staff nurses does that, helped by an aide or a volunteer.

After lunch, Sister assigns two of us to do the last offices for Miss Morrison. We wash her, do her hair, clean her nails, make her bed clean, pack the orifices and make her ready for the morgue downstairs. Rather than have a stranger do these things, St. Christopher's tradition is that they be done by people who have known and cared for the patient while alive. We list her belongings, and take her, still in her bed, along the hall again, down in the elevator to the basement, where we use another hoist to put her body in the cold vault. The light is on inside, and we can see the faces of people we've known—quiet, cold and peaceful. We talk a little in the elevator going back up, about what it feels like to be doing that, about other things, too.

A doctor has been on the ward most of the morning, visiting with patients, asking them exactly how things

are, doing some examinations. She has spent considerable time with Sister, talking over each patient, deciding on any changes. There are four doctors working full time at the Hospice, but we see mainly two on this ward.

In the five months that I was there, I didn't see any IVs. There is no routine of TPR. I did help with some procedures such as bladder washouts, catheterizations, dressing changes, standing by to hold things, fetching something forgotten, holding the patient's hand. Ostomy care we usually did at bath times. Pressure sores were not a serious problem except once in a while when someone would come in with a bad one. To avoid them, there was lots of rubbing with "oil and spirit" lotion at bath time and other times, shifts of position, ripple cell mattresses and so forth. We didn't raise or lower beds, since the beds aren't made that way. Everyone had *lots* of pillows, and there was a canvas sling from the head of the bed that could be strapped out at different angles. Most people sat in their chairs some of the time.

The physical therapist came every morning and the hairdressers came to the women's wards about once a week. Ladies can have a wash and set, the wash in the end bathroom, the set and dry in the treatment room. If someone wasn't out from under the dryer yet, when lunch came we'd keep it hot till she was ready.

Once in a while, there was a patient whose vomiting couldn't be brought under control. It caused distress for the staff because it was so uncomfortable for the patient and so rare. Almost all the patients were on morphine by mouth, except for the few who were on diamorphine by injection when they could no longer take anything by mouth. Except for those within a few hours of death, everyone was quite alert, ready to converse, involved and aware of what was going on around them. Visitors with children came in and out. People got their mail and newspapers, and sometimes went down to the St. Philip's room to paint, see a film, or went to the bar which was open on Thursdays.

So the weeks went on. I felt somehow that I'd come home, that I'd found something that I'd had once but lost. Since for most of us, the "laying out" of our grandmothers and grandfathers is something that some stranger does, we don't have that chance to see life through quite to its end. I learned a great deal about myself, and before I left I knew that this was something I liked doing and could do well. I learned, especially from trying to describe it to friends, why this kind of work isn't "depressing," that taking care of people *with* other people who are also working gently, efficiently, lovingly, is anything but depressing. Sad sometimes, but full and rich.