autumn 2017

# spotlight

for today's Christian nurses & midwives

- talking about death
- sudden death: lessons for life
- student groups for nurses and midwives

spotlight
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# inside

# editorial

Death and dying are not popular topics of conversation, and are not usually the preferred topics for magazine articles or books. Sadly, not only is death a part of life, but as nurses (and unfortunately, sometimes as midwives too) it is part of our day-to-day workload. We are forced to confront our own mortality as we work with dying patients and their relatives.

I (Steve) remember the first patient I had to 'lay out' as a student. It was the first time I had seen someone die – indeed the first person I had ever met who had died, so insulated from death had my life been at that time. I was struck by the profound mystery that where once there had been a human person, now there laid just a lifeless shell.

The great mystery and wonder of the Christian faith is that we serve a God who, in Jesus, once was a dead body lovingly laid out to rest by those he had known in life. This mystery became both deeper and more wonderful when three days later he was once more a living, breathing person again. A person who had conquered death, and promises the same resurrection life to all who follow him.

The great privilege and challenge of our profession is that we get to serve people at the gateways of life – birth and death. The wonderful hope we have as Christians is that we know that death is not the end. We have good news of hope that goes beyond this life into a new heaven and earth where we will forever dwell in God's presence (Revelation 21).

In this edition, we explore the challenge and opportunity we have as we care for the dying. Tracey and Rob share their professional experiences in palliative care and dealing with sudden death in a trauma unit. We look at how we start conversations about death and dying with our patients and their families, breaking the last taboo. Above all it is about how we, in the face of death, reflect and communicate the real hope that we have in Christ.

**Steve Fouch, CMF Connections Manager**
Steve worked in community nursing in South London, before working for several years with a Christian HIV and AIDS home care team in the city.

**Pippa Peppiatt, CMF Head of Nursing**
Pippa trained as a nurse. She has planted a church for students with her husband, set up a charity for street kids in Uganda, and has been a Friends International Student Worker.

# talking about death

**Steve Fouch** reflects on why we can find it so hard to talk about death and dying

About 15 minutes into Alexander Payne's 2011 film *The Descendants*, Matt King (played by George Clooney) walks calmly into the hospital room of his comatose wife, Elizabeth. He closes the door gently and then proceeds to excoriate her for controlling and messing up the lives of everyone around her.

This powerful scene follows on from Matt's discovery that Elizabeth is not only in an irreversible coma, but that she has made a living will that means life support would be terminated in the next few days. It left him the responsibility of breaking the news to family and friends that they only had days to make their last farewells. As the film unfolds it becomes apparent that the couple had not talked properly about any matters of importance for years, let alone what their dying wishes might be.

A report from the Dying Matters Coalition[1] suggests this is far from a fictitious. Only 29% of Brits have let a loved one know their funeral wishes and only 21% have discussed any other plans or wishes for their end of life care. Less than a third of us have even made a will. Death was always one of the great taboos of British conversation, along with sex and religion. It seems that not much has changed. We can portray death on the big and small screens but cannot talk about our own mortality. *The Descendants* is one of the few Hollywood films I have ever seen that deals with death and dying in such an honest and realistic manner.

The real problem is that we tend to assume death is a future issue, not something relevant in the here and now. Recently my wife and I had a phone call from the husband of a former colleague to tell us the tragic news of her death. In her mid-forties, with teenage children, she was struck down with little warning. As Benjamin Franklin allegedly pointed out, there are only two certainties in life: death and taxes. While the super-rich can find ways to avoid the latter, neither wealth nor virtue ultimately spares any of us from the former!

Or, as the *Book of Common Prayer* reminds us, 'in the midst of life, we are in death'. Grim as this sounds, it reminds us that we must be mindful that we are fragile and mortal beings throughout our lives.

Atul Gawande's book, *Being Mortal* (review on page 23),[2] explores the way healthcare avoids dealing with death. We so easily postpone the inevitable at the cost of quality of life, and avoid discussing what people really want or value as they face their last months and weeks of life.

Health professionals are often reluctant to address death with some patients – not least because our primary business is saving life. This includes a reluctance to talk about instances where we have decided that no further major interventions are appropriate (so-called 'Do Not Resuscitate' orders).

However, right from the start of my nurse training back in the 80s, we were taught that dying is part of life, and that part of our role as nurses was to care for the dying. The Royal College of Nursing has continued to campaign for more training and support for members to be able to deliver the best end of life care.[3] We have a long way to go, but the professions are beginning to address the issue.

## Christian hope and dealing with death and dying

How well do Christians in the UK grapple with death? Well, as a litmus test, when was the last time you heard a sermon on death, heaven and hell, future hope and the fleeting nature of our lives? My guess is seldom if ever (though I would be very happy to be proved wrong). I certainly cannot recall the last time I heard such a sermon in my own church.

Yet Scripture is replete with wisdom and hope in the face of our certain mortality. The psalmists call upon God to 'Teach us to number our days that we may get a heart of wisdom'.[4] The philosopher of Ecclesiastes counsels us that 'It is better to go to a house of mourning than to go to a house of feasting, for death is the destiny of everyone; the living should take this to heart'.[5] This is not morbid or depressing resignation, nor grimly fatalistic realism. Rather it is holding in tension the reality that 'all flesh is grass',[6] while looking forward to the resurrection of the dead and the coming of a new heaven and earth.[7]

As Paul puts it, what we go through here on earth are passing and momentary troubles that presage a greater glory.[8] This is the reality that we learn to hold on to and rejoice in as Christians. As health professionals this helps us have courage to talk about death with others, because once we learn to live with that tension within ourselves, we learn not to fear discussing it with our patients.

I recently turned 50. Depending on which set of statistics you refer to, based on gender, ethnicity, social class and UK region, I can say with some confidence that I am more than 'halfway through this journey of life'.

Confronting my own mortality has been an important part of my life in recent years. It has been of immense help to have the chance to talk, reflect and pray with friends and family.

Knowing the hope I have in Christ, alongside my own experiences as a nurse who has worked in palliative care, and in the conversations with loved ones, my own death holds less fear and more hope than it once did.

You, however, may be at a different stage in your journey. A conversation would be a good place to start.

## Resource


*Facing Serious Illness* is a guide for individuals, pastors and health professionals on a Christian approach to end of life decisions.[9] This CMF publication aims to help Christians to address end of life issues with health professionals, family, friends and their church.

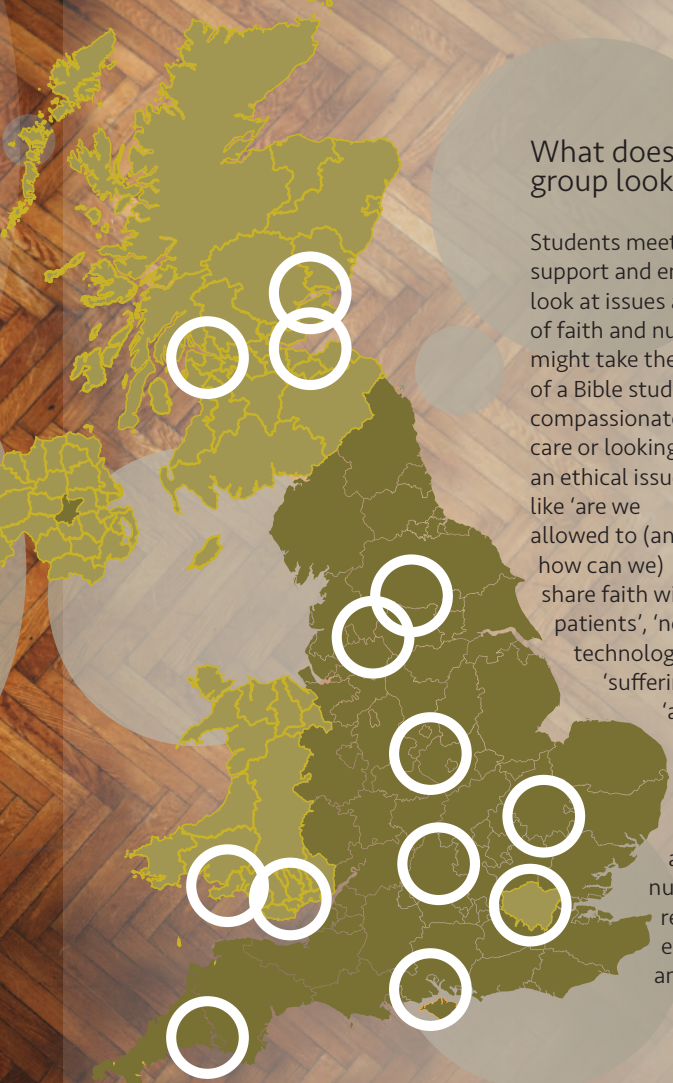

Dying Matters
*bit.ly/2tzkGBN*

1. Millions leaving it too late to discuss dying wishes. *Dying Matters* 12 May 2014 *bit.ly/2rHTkNK*
2. Gawande A. *Being Mortal: Medicine and What Matters in the End*. New York: Metropolitan Books, 2014
3. *rcnendoflife.org.uk*
4. Psalm 90:12
5. Ecclesiastes 7:2
6. Isaiah 40:7
7. Revelation 21:1-8
8. 2 Corinthians 4:16-18
9. CMF and LCF. *Facing Serious Illness: Guidance for Christians towards the end of life*. London: CMF, 2015 *bit.ly/2rHZDAZ*

‘When you come together…
let all things be done for building up’
(1 Corinthians 14:26)

# CMF student groups

**Pippa Peppiatt** looks at local groups across the UK



## What does a local CMF nursing group look like?

Students meet once a month, usually over food, to support and encourage each other, to pray, and to look at issues at the interface of faith and nursing. This might take the form of a Bible study on compassionate care or looking at an ethical issue like 'are we allowed to (and how can we) share faith with patients', 'new technologies', 'suffering' or 'abortion'.

'I have loved being in a CMF group this year, being with others who know exactly what it's like to be a Christian and a student and a nurse, with all the challenges that brings. Looking at key things like keeping our faith and compassion strong has been so helpful...'
**Becky, 2nd year nursing student**

We aim to deepen the spiritual life of nursing and midwifery students, empower them to examine and apply Scripture as it relates to nursing, and equip them by providing resources and speakers on relevant ethical issues. It's a chance to share and pray for each other; we also aim

to link them with local Christian nurses and midwives, who can mentor and pray for them.

## In order to start a group:

We need to know that there are several Christian student nurses and midwives at that university who want a group, and in particular at least two students who have the enthusiasm (and reliability!) to be student Reps. We provide resources, Bible studies, and even speakers for the group so leading it is made as easy and as time efficient as possible. If you want to explore starting a group at your university, please contact Pippa on *pippa@cmf.org.uk*

'I am so thankful that the opportunity arose for us to start a CMF group for nurses and midwives in Southampton. CMF provides us with the chance to discuss topical/ethical issues, ask questions about what we've seen on placement, get prayer for our busy/stressful workload, and be equipped to share God's love in our workplace.'

**Lara, 3rd year midwifery student**

## Currently groups are set up in:

- Cambridge
- Cardiff
- Dundee
- Edinburgh
- Glasgow
- Leeds
- London
- Nottingham
- Oxford
- Plymouth
- Southampton
- Swansea

plus an integrated student nurses and medics group in Manchester.

We're looking into starting student nurse groups in Belfast, Brighton, and Bristol in the autumn, but are also open to considering other universities where there is enthusiasm for one to start.

# upcoming events


A three day course over three Saturdays

23 September
21 October
25 November
6 Marshalsea Road, London SE1 1HL


London & South East conference
4 November
6 Marshalsea Road, London SE1 1HL

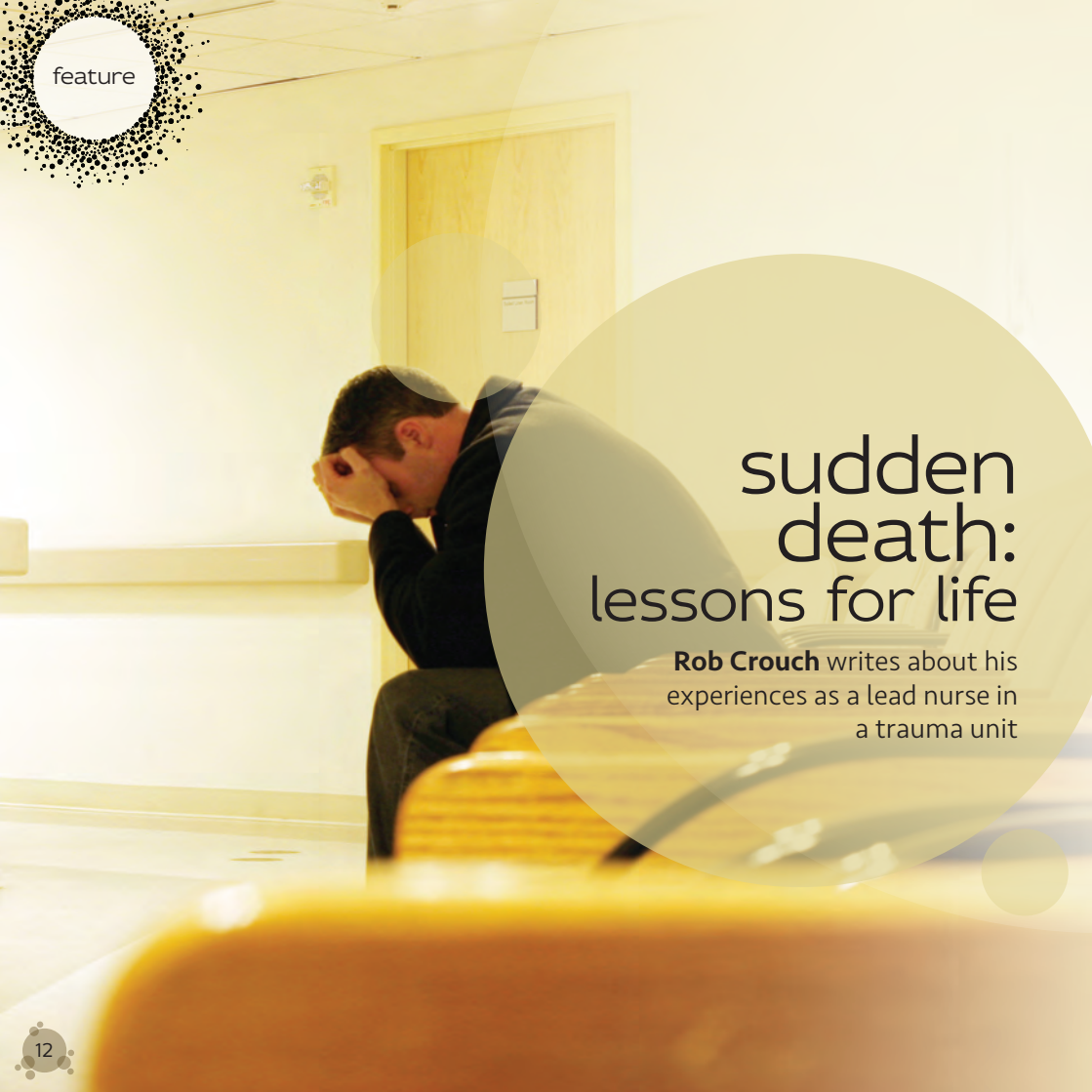
Scotland conference
3–5 November
The Green Hotel, Kinross


A one day course on sharing faith: *bit.ly/2tMNSVY*

Saturdays
London – 14 October
Cambridge – 21 October
Newcastle – 11 November
Southampton – 11 November

## www.cmf.org.uk/nurses/events

for further details and online booking



# sudden death: lessons for life

**Rob Crouch** writes about his experiences as a lead nurse in a trauma unit

Sudden death. Though not uplifting, it's nonetheless an important topic to consider from a Christian perspective. The events of the last few months – the terrorist atrocities in both Manchester and London together with the tragic Grenfell tower fire – bring the issues into stark relief. In my professional life, working with a Helicopter Emergency Medicine Service (HEMS) and in an Emergency Department, I am sadly well acquainted with sudden death.

I have often been asked 'Do you get used to dealing with sudden death?'; the answer is both yes and no. Yes, because you develop strategies to help you manage challenging situations and delivering the worst news. No, because I don't think you can ever get used to the raw human grief that cascades from loved ones when they hear those irrevocable words that their child, parent, partner, brother, sister or important other has died, particularly when it is unexpected.

Over the years the sense of injustice and anguish often associated with sudden death is, I have to admit, an area that has caused me to struggle with my faith – indeed I spent ten years in a spiritual wilderness seeking to answer the question, 'How can I have faith in a God of love when I see such anguish and pain?' I will come back to the question later. Along this journey a number of observations have helped me in my faith and in my limited understanding of sudden death.

## Reflections on sudden death

### Humans as spiritual beings

It took me a while to rationalise that death is an absolute transition. At the point of death, when the last breath has been taken, the person is gone – replaced by the empty shell of a former life, devoid of spirit. Breath, of course, is fundamental to life. In biblical terms the Hebrew word *ruach* means wind, breath or spirit of God, the Holy Spirit (*pneuma* is the corresponding Greek word). *Ruach* is also used in reference to human spirit or breath. Similarly, soul appears to be a deeply spiritual part of us.[1] Often in the scriptures, references to soul are linked to heart, anguish, rejoicing, yearning and finding rest. It would seem that it is the part of our inner being where we relate to God. Simply, in the departure of the spirit, the person is no longer present but standing before God; all that is left is the redundant physical body.

In 2015, there were

**529,655**

deaths registered in England and Wales in 2015

**5.6%** increase compared with 2014

Infant mortality rate

**3.9** deaths per **1,000** live births

In 2015, there were

**6,188**

suicides recorded in the UK

**75%** WERE MEN

## Transition from body to person

Another question is whether there is a feeling of detachment during resuscitation. Again my answer would be both yes and no. On the one hand, there is little cognitive space to consider 'who' it is you are resuscitating; you have a job to do. Whilst resuscitating, the individual seems to have no context. Yet, on the other hand, you soon become aware of the individual's context, whether in the pre-hospital field when you suddenly become aware of belongings that connect them to people or places, or in the hospital context when you meet their next of kin. Then the individual becomes a person, with context, family, life and purpose.

The exception is the resuscitation of colleagues or their relatives. It is difficult to detach yourself when you know the person or are connected to them. This presents unique challenges professionally and emotionally.

Perhaps the strangest phenomenon in the last decade is the connection to the individual's wider life made through their phone. It is now common for an individual's phone to be ringing whilst you are resuscitating them, or after they have died. The phone bears the caller's identification, the parent, partner or significant other, who will soon be confronted by a starkly different reality. It is a moment of connection that is both tangible and surreal.

SUICIDE
+
SELF-INFLICTED
INJURIES
+
ACCIDENTAL
INJURIES
are the leading causes of death among children and young adults

1-4 figures based on ONS 2015 [2]
*bit.ly/2uZyojt*

In 2015, there were
1,732
reported road deaths, a
45% reduction over the last decade

Reported road casualties in Great Britain: main results 2015, Department of Transport, bit.ly/2u7rylv

## Suicide

Death by suicide is increasing. Suicide and injury or poisoning of unknown intent is the leading cause of death for both males and females from age 5–34, for males it remains the leading cause of death until the age of 49. [2] It is the area of sudden death I find most challenging.

Sadly, I have often been engaged in resuscitating young males who have ended their life by hanging. It is the saddest thing to have to inform relatives of their deaths. The mental anguish that drives individuals to take their own lives must be intolerable; the devastation and psychological 'injury' to the loved ones is often considerable.

Tragically, I have a number of clinical colleagues who have ended their lives by suicide. It is a stark reminder that as healthcare professionals we are not immune to mental illness. Indeed, we are at considerable risk. It is incumbent upon us all to be aware of our own wellbeing and mental health, and importantly those around us. I draw comfort from the Psalms (Psalm 31, 42 and 43 for example); so often the psalmist cries out to the Lord in anguish, often expressing feelings of utter despair or depression and the Lord answers. We can rely on God at these times of extreme challenge.

This is one of the greatest privileges as well as challenges of my job: to be there at times of absolute devastation and provide what comfort I can.

## Lessons for life

### Keep short accounts

I have lost count of the times that loved ones have mentioned their regret on parting on poor terms. The issue, which caused an argument and one party leaving before resolution, is often so trivial in the greater scheme of life. Their lives have changed forever by the sudden death of their loved one. So often their grief is made worse by the feeling of guilt and regret, the parting words perhaps sharp or cutting, negative rather than affirming, were the last words shared.

Ephesians 4:26, 'In your anger do not sin: do not let the sun go down while you are still angry, and do not give the devil a foothold' resonates in these situations. This small principle is one I have tried hard to adopt in my Christian life, I try not to let situations where I have been wrong, or been wronged, fester.

### Comfort those who mourn

This is one of the greatest privileges as well as challenges of my job: to be there at times of absolute devastation and provide what comfort I can. For the individual who has died there is little more that can be done; the focus now is on those who cared for them. I think by now I have witnessed every possible reaction to sudden death: anger, denial, verbal and physical outbursts, laughter of disbelief and overwhelming grief to name a few. I will never get used to that rawness of human reaction we so often see. This is testament to the power of love and relationship between humans, again to me evidence of spiritual roots of connection.

I am always struck by the passage in scripture where Jesus wept at the death of Lazarus.[3] He knew that he would raise him from death, and yet he wept with those who mourned. I have witnessed many senior colleagues weep with those who mourn in the resus room. Of course, uncontrollable grief would not be appropriate, but there is something important about human connection and sharing sadness even when you have not known the person.

Providing comfort and human connection can be difficult depending on the nature or circumstances of death. For example, we are sometimes treating both the perpetrator of an alleged crime and the victims. I have often had to remind myself that the individual is made in the image of God and dearly loved by him.

Perhaps some of the most challenging times have been supporting people who are on their own as they die. Holding the hand of a person who is dying is perhaps one of the greatest privileges of our roles. There are individuals who have no significant other to be with them at such a poignant time; just a legal guardian to inform of their passing. As the church should we, could we, do more?

## Celebrating individuals

I have attended a number of funerals of friends, colleagues and children of colleagues. Some died suddenly, others after short illnesses. Whilst these have been celebrations of life, there is a tangible difference between those who died who were known to have a faith and those who did not; a difference in their sense of hope and finality.

I am always struck by the words of affirmation shared, of admiration and value made clear in the eulogies and stories told. Did those individuals know how much they were loved and celebrated? Do people really know what we think of them and how we value them? Certainly my experience of the fragility of human existence has driven me to be clearer in my affirmation of others, expressing what they mean to me. There are numerous references to building others up in the Bible. [4]

The challenge for us is to ask whether those around us know how they are valued and loved. Tell them.

## Making sense of sudden death

As I alluded to at the beginning of this article, unanswered questions about suffering and sudden death caused me to question my faith. The suffering and pain seemed juxtaposed to the concept of a loving God who is in control of the world. At the end of those ten wilderness years, I concluded that rather than these concepts being incongruous, it is only through faith in a God of love, one who is in control of this world that you can make any sense of sudden death or draw any comfort from it. For without faith one is left with no hope and no sense of purpose, just a sense of futility that this fragile human existence is all that there is – if that were the case what would be the point in life?

Job, who suffered extraordinarily, often asked God 'Why?'; he never got an answer. I have become comfortable with knowing that there are many questions that won't be answered in

this life; in other words I am more comfortable with those 'grey' areas that questions in life raise.

Am I still saddened by sudden death? Does it still trouble me? Yes is the simple answer, but I draw great comfort from two Bible passages in particular:

*For I am convinced that neither death nor life, neither angels nor demons, neither the present nor the future, nor any powers, neither height nor depth, nor anything else in all creation, will be able to separate us from the love of God that is in Christ Jesus our Lord.* [5]

We have hope that we will see those who have been separated from us by death.

*Brothers and sisters, we do not want you to be uninformed about those who sleep in death, so that you do not grieve like the rest of mankind, who have no hope. For we believe that Jesus died and rose again, and so we believe that God will bring with Jesus those who have fallen asleep in him.* [6]

And hope for the future – a new heaven and new earth:

*Look! God's dwelling-place is now among the people, and he will dwell with them. They will be his people, and God himself will be with them and be their God. He will wipe away every tear from their eyes. There will be no more death or mourning or crying or pain, for the old order of things has passed away.* [6]

Dealing with death is a reality in our roles as healthcare professionals, how we respond to it and how it affects each one of us will be different. Considering sudden death and learning from it has been part of my journey, I hope these reflections, in some small way, might help as you face life's challenges ahead.

1. *gotquestions.org bit.ly/2siYxb2*
2. Office for National Statistics. Statistical Bulletin: Deaths registered in England and Wales. *ONS*; 2015 *bit.ly/2tEt0DS*
3. John 11:17-37
4. 1 Thessalonians 5:11; Hebrews 10 24-25
5. Romans 8:38-39
6. 1 Thessalonians 4:13-14
7. Revelation 21:3-4

elective report

# end of life care in Kampala, Uganda

**Hannah Hawksley** and **Arabella King** report on their nursing elective working at a hospice

We spent seven weeks on our nursing elective working with Hospice Africa Uganda (HAU)[1] in Makindye, on the outskirts of Kampala. HAU cares for patients living with, and dying from, cancer and HIV/AIDS during the terminal stages of their illness. The role of HAU is to provide entirely holistic pain and symptom management in an accessible and affordable way.

Patients are visited in their own homes by a team consisting of a doctor and two nurses, who may be accompanied by an occupational therapist and a patient support worker. Hospice in Makindye serves an area of 20km in and around Kampala from a base in the village, but also has branches in Hoima and Mbarara, and works across the continent teaching and training health professionals and churches about end of life care.

During our time as part of the Hospice team, we gained new clinical knowledge but also learnt so many valuable lessons from the amazing people we met and cared for. Every home visit was memorable, but some hold special significance for us. One afternoon we drove out in a four-wheel-drive to the Najeera district to review Mary. Mary was 59 and had been living with cancer of the cervix for many years. Her poverty, lack of access to healthcare and the fact that she lives out 'in the sticks' meant that her cancer had spread rapidly and she now has metastases to her bladder and pelvis. Despite her pain and reduced mobility, Mary crawled out to meet us at the entrance of her one-room house. Although unable to communicate with her in her native tongue of Luganda, her warm smile and excitement at seeing us was touching.

She welcomed us into her home and, giggling, pointed first at us and then at a TinyTears baby doll, one of her few possessions. By this point we'd learnt the meaning of the word 'mzungu' (white person), which Mary exclaimed with enthusiasm. Over the next few weeks we got to know Mary better and realised that language barriers were no issue for God. We followed Mary's request to pray with her in English and she spoke to us in Luganda, knowing full well that neither of us understood 99% of her words.

During our care of Mary, we also learnt more about the role of traditional and herbal medicine, which Mary's family were keen to employ in her care. Even though Mary used both drugs supplied by the Hospice and the herbal alternatives from her family, we became conscious of the fact that ultimately her trust was in God, and she was patiently waiting to be free of her cancer after this earthly life. Mary taught us something of hope in the face of adversity – not hope for an immediate cure, but a knowledge born of faith that she could be healed in God's time, not ours. We became acutely aware that our English obsession with time-keeping and punctuality reflected the typically Western 'time is money' mentality that drives our society. We quickly learned that Ugandans place a different emphasis on time, which prompted us to reassess our priorities and perspectives.

In another village outside Kampala, Helen's family were coming to terms with the devastating effects of AIDS. Helen was emaciated and bed-ridden. Cryptococcal meningitis had blinded her and Kaposi's sarcoma left her struggling to breathe. Helen's mother cradled her daughter in her arms and spoon-fed her in the same way she did with Helen's baby daughter, who was now

dependent on her grandmother. This stoical woman had left her own home in the west of the country to nurse her daughter through a disease which many people would prefer to run away from. However, Helen's HIV/AIDS status did not compromise the way she was cared for – her mother stayed with her as the meningitis made her slip in and out of consciousness. She told us: 'we must praise the Lord for these days we have with her here'.

Helen's family were an example of the unity and dedication that so many Ugandan families show when a family member falls ill. Family-centred care is very important in Uganda. When a patient joins the Hospice programme they become a part of the Hospice family too. This was especially significant for patients whose family members were unable to stay with them throughout the day or night.

Nicholas was one such patient, suffering from advanced Burkitt's lymphoma. He was just 14-years-old: lonely, frightened and embarrassed by his disfiguring tumour. He lived in one room, with only a radio for company as his parents were both forced to work long hours to earn enough for his family, and his brother could only visit for short periods each day. HAU met Nicholas' physical needs, providing him with pain relief and meeting his requests for mango juice when his sense of taste was impaired by the cancer, making even fresh water taste foul. However, Nicholas' doctors and nurses also provided him with spiritual comfort, taking time to pray with him and share Bible passages, with the aim of lessening his fear of death. Hospice truly was feeding Nicholas' body and soul. We were both inspired and motivated by this aspect of spiritual care (which is so frequently overlooked in our practice), and returned home feeling better equipped to meet such needs of our patients in the future.

We left Uganda covered in red dust, with our emergency first-aid kit still intact, encouraged and uplifted by our experience.

**Arabella** and **Hannah** were student nurses who were supported by CMF and the Medical Missionary Association on their elective placements.

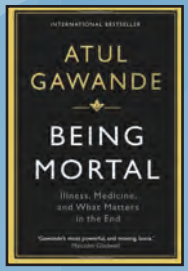
This review was originally published on the CMF website under Elective Reviews – Uganda bit.ly/2srEat7

1. *www.hospice-africa.org.uk*

# Being Mortal

## Illness, Medicine and What Matters in the End

## Atul Gawande




Metropolitan Books
2015, £6.99, 296pp
ISBN 9781846685828

Reviewed by Rebecca Parsonson, clinical medical student in Cardiff.

This review was originally published in *Nucleus*, May 2016

The inevitability of old age and death is rarely spoken; yet it is of utmost importance in modern medicine. Death has become a medicalised, clinical experience; no longer black and white. Medicine often falls short when providing care for the frail and dying. Secular American surgeon Atul Gawande begins 'I learned a lot of things in medical school, but mortality wasn't one of them'. He gives insight into non-Christian perspectives of mortality.

Using personal clinical encounters along with his own family and friends, Gawande illustrates changes in attitudes to old age and dying. Early chapters explore the aging process and its end in dependence on others. Idealistic aims of assisted living and nursing homes are challenged, and alternative models of ensuring elderly people live autonomous, fulfilled lives are suggested. The second half of the book begins with the shocking story of 34-year-old Sara, pregnant, and with metastatic lung cancer. Her example highlights clinical striving to prolong lives at any cost, avoiding difficult end-of-life conversations. He concludes medicine should strive for 'wellbeing', described as 'what people live for'. Even as Christians, mortality and dying are difficult subjects. *Being Mortal* identifies issues to consider, but does not give many answers to these questions. Would this be different from a Christian perspective?

interview

# on the frontline

**Tracey** is a specialist acute oncology nurse with experience in palliative care

## What area of nursing or midwifery are you in?

I have been qualified now for 24 years and 23.5 of those years have been in the field of oncology and palliative care. Wow – it sounds a lot now I have counted it up! Mostly this has been in the hospital environment but I worked as a community palliative care nurse specialist for six years.

## Why did you choose this specialty?

I had no idea what I wanted to do when I qualified as I didn't have any specific experience in cancer care as a student. I was actually looking after a nurse who worked in a well-renowned cancer hospital (during my first ever set of nights as a student nurse) and on talking to her she suggested I think about oncology nursing as she thought I would be good at it! I moved into this field pretty quickly post-qualifying and the rest is history, as they say.

## What motivates you in your job?

Making a positive difference to someone who is probably at one of the worst times in their life. A kind word or gesture makes such an

impact on patients and their families. Sounds a bit clichéd but being 'a light' in someone's darkness is such a privilege. Even though I no longer work in community palliative care, I have chosen specialist areas in oncology caring for those patients who have incurable cancers with a short prognosis attached (lung and pancreatic most recently). The importance of knowing when to say something to a patient and when to be a silent, supportive presence cannot be underestimated.

## What does a typical day look like?

Every day starts with a quiet personal prayer on the way to work that I would do no harm but be a 'light' in someone's darkness. My current role is in acute oncology and this means that no day is the same. It's a bit like working in an A&E with just cancer patients attending. I assess and manage cancer patients undergoing treatment (and often those who are no longer able to manage treatment) in person on the unit or via telephone triage (liaising with community teams and GPs). I love learning and still learn new things every day; there are lots of unique side-effects of cancer treatments, especially with the more novel immune therapies that keep me on my toes!

## What are the particular challenges about your job?

Lots of people say to me that working with cancer and death on a daily basis 'must be a hard job'. It can be sad and sometimes impacts on my home life. I have a very understanding husband though and a good hug can work wonders! It can be particularly hard when someone's death is more traumatic and doesn't go as you or they would want it to – in those times all you can do is hang in there and know that God is in control. He is the God of all comfort who never leaves nor forsakes us.

## What are the particular blessings of your job?

It is such a privilege being 'with' and caring for patients and families who are affected by cancer. Knowing that you made a difference to them in a particularly bad time can make your job awesomely satisfying – when by God's grace you made a positive difference to a patient and their family.

Another blessing is seeing patients come in incredibly sick but smiling and feeling a little better by the end of the shift.

## How did you find the transition from student to qualified nursing?

A bit stressful to be honest as I was in charge pretty quickly on my first ever job. Keeping your head, holding on to what you have learnt and staying safe is paramount!

## Any advice for student nurses and midwives reading this?

Yes, lots! However this is probably the most important lesson I have learnt: I am a person as well as a nurse. I remember my mum saying to me when I was about to start my training that 'I was too soft to be a nurse' as I cry (a lot)! I seem to have a rather overactive empathy chip in my brain as well as overactive tear glands! It's just me and being emotional is part of who I am. When I did the 'care of the dying course' 23 years ago, crying with patients or their families was severely frowned upon and seen as an incredible 'weakness';
I remember a tutor reprimanding me when I confessed to her that I was fearful of being emotional when I saw someone who was sad. She asked me 'who are you crying for – the patient or yourself?' This worried me and to this day, I never forgot what she said to me. It challenged me and I thought I needed to change who I was to be a cancer nurse.

I felt I needed to find a way of holding back and not showing patients or their families that I cared about them or what they were going through. Now I am not saying it is appropriate for the nurse to be the one needing the comfort of a dying patient's family by any means (because if you are completely falling apart this is not at all appropriate).

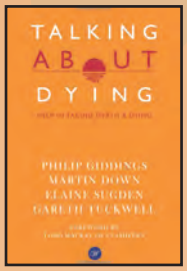
Yet, when someone dies or something incredibly sad happens, having a nurse with you who can be vulnerable and empathetic is one of the most comforting and special moments. I have always treasured this memory when my nurse cried with me when I suffered a significant loss and I think that attitudes to crying and showing empathy need to change. Showing compassion is not a fault, it should be part of who we are.

## What can we pray for you?

For daily strength to keep positive in today's NHS. For daily energy and that I remember Jesus is with me in all I do, think and say.

# Talking about dying:
## help in facing death & dying

Philip Giddings, Martin Down, Elaine Sugden, Gareth Tuckwell

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Reviewed by Steve Fouch, CMF Connections Manger

Sex and politics have become mainstream, but death remains as the last subject which we do not talk about. That, according to the authors, 'simply will not do'. In reality, many people faced with life-limiting illnesses do want to talk, but are either afraid to or just do not know how to broach the subject. This pithy little volume is an attempt to help break down some of those barriers.

Written from an unashamedly pastoral Christian perspective, *Talking about dying* is a helpful starter. It addresses a wide range of issues, from planning funerals and other arrangements, to starting conversation about your own death or someone else's. It also looks at miscarriage and still birth, sudden death, suicide and talking to children. It even manages to explain the gospel succinctly in a chapter on what comes after death. Each chapter is short, with practical follow up reading and resources.

Very much aimed at the concerned layperson, this book could be a useful tool for training church or chaplaincy pastoral visitors. Given that death is universal, however, it is probably worth reading by anyone and everyone.

# BIBLICAL LEADERSHIP

## FOR NURSES AND MIDWIVES

Leadership is vital in the health service, and there are plenty of courses for nurses and midwives on being leaders in the workplace. However, while secular models of leadership have much to teach us, they do not spring from a biblical, God-centred worldview.

This course seeks to equip and empower Christian nurses and midwives in biblical values to enable them to transform their teams, workplaces, organisations and communities.

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