20

Dying, Death, and Hospice

1. Discuss the stages of grief

Death can occur suddenly without warning, or it can be expected. Older people or people with terminal illnesses may have time to prepare for death. A **terminal illness** is a disease or condition that will eventually cause death. Preparing for death is a process that affects the dying person's emotions and behavior.

Grief is deep distress or sorrow over a loss. It is an adaptive, or changing, process and usually involves healing. Dr. Elisabeth Kübler-Ross studied and wrote about the grief process. She theorized that dying people share a common grief process. Her book, *On Death and Dying*, describes five stages that dying people and their families or friends may experience before death. These five stages are described below. Not all people go through all the stages. Some may stay in one stage until death occurs. Others may move back and forth between stages during the process.

Denial: People in the denial stage may refuse to believe they are dying. They often believe a mistake has been made. They may talk about the future and avoid any discussion about their illnesses. They may simply act like it is not happening. This is the "No, not me" stage.

Anger: Once people start to face the possibility of their death, they may become angry. They may be angry because they think they are too young to die. They may be angry because they feel they have always lived a healthy lifestyle and have always taken care of themselves. Anger is a normal and healthy reaction. Even though it may be upsetting, the caregiver must try not to take anger personally. This is the "Why me?" stage.

Bargaining: Once people have begun to believe that they really are dying, they may make promises to God or a higher power, care providers, or others. They may somehow try to bargain for their recovery. This is the "Yes me, but..." stage.

Depression: As dying people become weaker and their symptoms get worse, they may become deeply sad or depressed (Fig. 20-1). They may cry or become withdrawn. They may be unable to perform simple activities. They need additional physical and emotional support. It is important for caregivers to listen and be understanding.

Fig. 20-1. *A person who is dying may become depressed and withdrawn. The home health aide should give extra emotional support to these clients.*

Acceptance: Peace or acceptance may or may not come before death. Some people who are dying are eventually able to accept death and prepare for it. They may make arrangements with attorneys and accountants. They may arrange with loved ones for the care of important people or things. They may make plans for their last days or for the ceremonies that may follow their death. At this stage, people who are dying may seem emotionally detached.

These stages may not be possible for someone who dies suddenly, unexpectedly, or quickly. Caregivers cannot force anyone to move from stage to stage; they can only listen and be ready to offer any help a person needs.

2. Describe the grief process

Dealing with grief after the death of a loved one is a process as well. Grieving is an individual process. No two people will grieve in exactly the same way. Clergy, counselors, or social workers can provide help for people who are grieving. Family members or friends may have any of the following reactions to the death of a loved one:

Shock: Even when death is expected, family members and friends may still be shocked after death occurs. Many people do not know what to expect after the death of a relative or friend and may be surprised by their feelings.

Denial: It is easy to want to believe that everything will quickly return to normal after a death. Denying or refusing to believe they are grieving can help people deal with the initial hours or days after a death. But eventually it is important to face feelings. Grief can be so overwhelming that some people may take years to face their feelings. Professional help can be very valuable.

Anger: Although it is hard to admit it, many people feel angry after a death. They may be angry with themselves, at God, at the doctors, or even at the person who died. There is nothing wrong with feeling anger as a part of grief.

Guilt: It is very common for families, friends, and caregivers to feel guilty after a death. They may wish they had done more for the dying person. They may simply feel that he did not deserve to die. They may feel guilty that they are still living or that they are relieved.

Regret: Often people regret what they did or did not do for the dying person. They may regret things they said or did not say to the person who has died. Many people have regrets for years.

Relief: People may feel relieved that the person who has died is no longer suffering. They may be relieved that they no longer have a responsibility (emotional, physical, or financial) regarding care.

Sadness: It is very common to feel depressed or emotionally unstable after a death. People may suffer headaches or insomnia when they cannot express their sadness.

Loneliness: Missing someone who has died is very normal. It can bring up other feelings, such as sadness or regret. Many things may remind people of the person who died. The memories may be painful at first. With time, those who survive usually feel less lonely, and memories are less painful.

3. Discuss how feelings and attitudes about death differ

Death is a very sensitive topic. Many people find it hard to discuss death. Feelings and attitudes about death can be formed by many factors:

Experience with death: Someone who has been through other deaths may have a different understanding of death than someone who has not.

Personality type: Open, expressive people may have an easier time talking about and coping with death than those who are very reserved or quiet. Sharing feelings is one way of working through fears and concerns.

Religious beliefs: Religious practices and beliefs affect a person's experience with death. These include the process of dying, rituals at the time of death, burial or cremation practices, services held after death, and mourning customs. For example, some Catholics do not believe in cremation. Orthodox Jews may not believe in viewing the body after death. Beliefs about what happens to people after death can also influence grieving. People who believe in an afterlife, such as heaven, may be comforted by this belief.

Cultural background: The practices people grow up with will affect how they deal with death. Cultural groups may have different practices to deal with death and grieving. Some groups have meals and other services but say very little about a person's death. In other cultures, talking about and remembering the person who has died may be a comfort to family and friends (Fig. 20-2).

Fig. 20-2. *Looking at photos and sharing stories about a person who is dying or who has died is one way family and friends may grieve.*

Learning Objective 9 in this chapter contains more information about different practices relating to death.

4. Discuss how to care for a client who is dying

Caring for a client who is dying should focus on meeting physical needs, as well as providing comfort and emotional support. Promoting independence is important.

Guidelines: Client Who Is Dying

- **Diminished senses**: Vision may begin to fail. Reduce glare and keep room lighting low. Hearing is usually the last sense to leave the body, so speak in a normal tone. Tell the client about care that is being done or what is happening in the room. Do not expect an answer. Ask few questions. Encourage the family to speak to the client but to avoid subjects that are disturbing. Observe body language to anticipate a client's needs.
- **Care of the mouth and nose**: Give mouth care frequently. If the client is unconscious, give mouth care every two hours. The lips and nostrils may be dry and cracked. Apply lubricant, such as lip balm, to lips and nose.
- **Skin care**: Give bed baths and incontinence care as needed. Bathe perspiring clients often. Skin should be kept clean and dry. Change sheets and clothes for comfort. Keep sheets wrinkle-free. Giving regular skin care and repositioning the client often is important to help prevent pressure injuries.
- **Pain control and comfort**: Clients who are dying may be in pain. Pain relief is critical; observe and report signs of pain to the supervisor immediately. Clients may be connected to a patient-controlled analgesia (PCA) device. A PCA device is a method of pain control that allows patients to administer pain medication to themselves. They press a button to give themselves a dose of pain medication. Report any complaints of pain or discomfort to your supervisor immediately. Because some clients may not be able to communicate that they are in pain, observe body language and watch for other signs (Chapter 14) (Fig. 20-3).

Fig. 20-3. *Observing body language is important to help identify when a client is in pain.*

Frequent changes of position, back massage, skin care, mouth care, and proper body alignment may help. This type of care is discussed more in Chapters 12 and 13. Body temperature usually rises. Many clients are more comfortable with light covers. However, fever may cause chills. Use extra blankets if clients need more warmth.

- **Environment**: Display favorite objects and photographs where the client can easily see them. They may provide comfort. Play music if the client requests it. Make sure the room is comfortable, appropriately lit, and well ventilated. When leaving the room, place a call signal within reach, even if the client is unaware of his surroundings.
- **Emotional and spiritual support**: Clients who are dying may be afraid of what is happening and of death. Listening may be one of the most important things you can do for a client who is dying. Pay attention to these conversations. Report any comments about fear to your supervisor.

People who are dying may also need the quiet, reassuring, and loving presence of another person. Touch can be very important. Holding your client's hand as you sit quietly can be very comforting.

Do not avoid the dying person or his family. Do not deny that death is approaching, and do not tell the client that anyone knows how or when it will happen. Do give accurate information in a reassuring way. No one can take away a person's fear of death. However, your supportive and reassuring presence can help.

Some clients who are dying may also seek spiritual comfort from clergy. Provide privacy for visits from clergy and others. Do not discuss your religious or spiritual beliefs with clients or their families or make recommendations.

Take the time to sort out your own feelings about death. If you are not comfortable with the topic, clients will feel it. Speak to your supervisor if you need resources to help you deal with your feelings.

Advance Directives and Medical Orders

Advance directives and medical orders were introduced in Chapter 3. Advance directives allow people to choose what medical care they want or do not want if they cannot make those decisions themselves. A DNR order tells medical professionals not to perform CPR. DNR orders may be written for a person who has a terminal illness, a person who almost certainly will not be saved by CPR, a person not expected to live long, and/or a person who simply wants to let nature take its course.

If a client has an advance directive in place, the HHA may be asked to continue to monitor vital signs, such as temperature, pulse, respirations, and blood pressure, and to report the readings to the supervisor. Comfort measures, such as pain medication, will continue to be used. However, depending on what the advance directive states, performing CPR or any extraordinary measures may be prohibited, no matter how the vital signs have changed or declined. Extraordinary measures are measures used to prolong life when there is no reasonable expectation of recovery. When a person with a DNR order stops breathing or the heart stops, she will die unless the heart or breathing restarts on its own. This is not likely to happen. By law, advance directives and DNR orders must be honored. Home health aides must respect each client's decisions about advance directives.

5. Explain legal rights for clients who are dying and describe ways to promote dignity

Home health aides can treat clients with dignity when they are approaching death by respecting their rights and their preferences. These are some legal rights to remember when caring for people who are dying:

The right to refuse treatment. Home health aides must remember that whether they agree or disagree with a client's decisions, the choice is not theirs. It belongs to the person involved and/or his family. HHAs should be supportive of family members and not judge them. The family is most likely following the client's wishes.

The right to have visitors. When death is close, it is an emotional time for all those involved. Saying goodbye can be a very important part of dealing with a loved one's death. It may also be very reassuring to the person who is dying to have someone in the room, even if the person does not seem to be aware of his surroundings.

The right to privacy. Privacy is a basic right, but privacy for visiting, or even when the person is alone, may be even more important now.

Other rights of a dying person are listed below in *The Dying Person's Bill of Rights*. This was created at a workshop, *The Terminally Ill Patient and the Helping Person*, sponsored by Southwestern Michigan In-Service Education Council, and appeared in the *American Journal of Nursing*, Vol. 75, January 1975, p. 99.

I have the right to:

- Be treated as a living human being until I die.
- Maintain a sense of hopefulness, however changing its focus may be.
- Be cared for by those who can maintain a sense of hopefulness, however changing this might be.
- Express my feelings and emotions about my approaching death in my own way.
- Participate in decisions concerning my care.
- Expect continuing medical and nursing attentions even though "cure" goals must be changed to "comfort" goals.
- Not die alone.
- Be free from pain.
- Have my questions answered honestly.
- Not be deceived.
- Have help from and for my family in accepting my death.
- Die in peace and dignity.
- Retain my individuality and not be judged for my decisions, which may be contrary to the beliefs of others.
- Discuss and enlarge my religious and/or spiritual experiences, whatever these may mean to others.
- Expect that the sanctity of the human body will be respected after death.
- Be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death.

Guidelines for how home health aides should treat dying clients and their families with dignity include the following:

Guidelines: Treating the Client Who Is Dying with Dignity

- G Respect the client's wishes in all possible ways. Communication is extremely important at this time so that everyone understands what the client's wishes are. Listen carefully for ideas on how to provide simple gestures that may be special and appreciated.
- G Do not isolate or avoid a client who is dying. Enter his room regularly.
- G Be careful not to make promises that cannot or should not be kept.
- G Continue to involve the client in his care and in any activities that are happening in the house. Be person-centered.
- G Listen if a client wants to talk but do not offer advice. Do not make judgmental comments.
- G Do not babble or be especially cheerful or sad. Be professional.
- G Keep the client as comfortable as possible. Tell your supervisor immediately if pain medication is requested. Keep the client clean and dry.

- Assure privacy when it is desired.
- Respect the privacy of the family and other visitors. They may be upset and not want to be social at this time. They may welcome a friendly smile, however, and should not be isolated either.
- Help with the family's physical comfort. If requested, get them coffee, water, chairs, blankets, etc.

6. Define the goals of a hospice program and identify guidelines for hospice work

Hospice care is the term used for the special care that a dying person needs. It is a compassionate way to care for people who are dying and their families. Hospice care emphasizes a holistic, person-centered approach. It treats the dying person's physical, emotional, spiritual, and social needs.

Hospice care can be given seven days a week, 24 hours a day. It is available with a doctor's order. Hospice care may be provided in a hospital, at a special care facility, or in the home (Fig. 20-4). A hospice can be any location where a person who is dying is treated with dignity by caregivers.

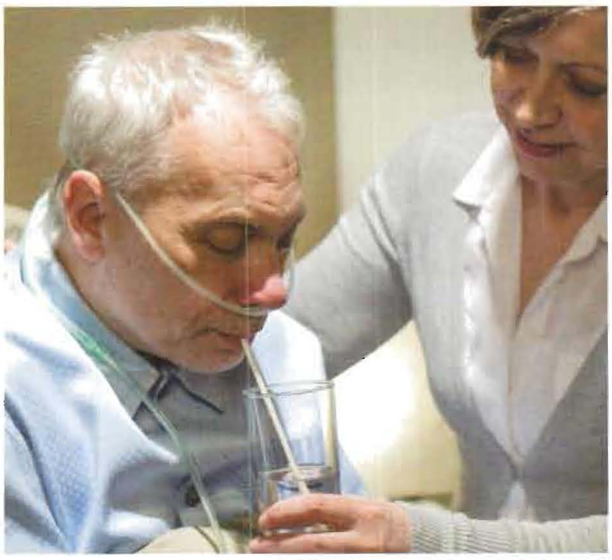

Fig. 20-4. *Hospice care can be provided in any setting where a person who is dying is treated compassionately by caregivers.*

Any caregiver may provide hospice care, but often specially trained nurses, social workers, and volunteers provide hospice care. The hospice team may include doctors, nurses, social workers, counselors, home health aides, therapists, clergy, dietitians, and volunteers.

Hospice care helps meet all needs of the client who is dying. The client, as well as family and friends, are directly involved in care decisions. The client is encouraged to participate in family life and decision-making as long as possible.

In home care, goals include a focus on the client's recovery, or on the client's ability to care for herself as much as possible. In hospice care, however, the goals of care are the comfort and dignity of the client. This type of care is called palliative care. **Palliative** (*PAL-ee-ey-tiv*) **care** is a type of care given to people who are dying that emphasizes relieving pain, controlling symptoms, and preventing side effects and complications. Palliative care is also given to people who have serious, chronic diseases, such as cancer, congestive heart failure, and AIDS.

Focusing on pain relief, comfort, and managing symptoms is different than providing regular home health care. HHAs will need to adjust their mindset when caring for clients in hospice.

Clients who are dying need to feel independent for as long as possible. Caregivers should allow clients to retain as much control over their lives as possible. Eventually, caregivers may have to meet all of the client's basic needs.

Family members or friends who are caregivers for the person who is dying will appreciate help. The home health aide is providing them with a break. This kind of care is sometimes referred to as **respite** (*RES-pit*) **care**. The HHA must be aware of the feelings of family caregivers. She can encourage them to take breaks and take care of themselves but should not insist that they do so. Many want to do all they can for their loved one during his or her last days. The HHA should observe family caregivers for signs of excessive stress and report signs to the supervisor.

Guidelines: Hospice Care

- **G** Be a good listener. It is hard to know what to say to someone who is dying or to her relatives and friends. Most often, people need someone to listen to them (Fig. 20-5). Review the listening skills discussed in Chapter 4. A good listener can be a great comfort. Some people, however, will not want to confide in their caregivers, and you should never push someone to talk.

Fig. 20-5. *Being a good listener can be a great help to a person who is dying.*

- **G** Respect privacy and independence. Relatives, friends, religious leaders, or others may visit a client who is dying. Make it easy for these difficult visits to take place. Stay out of the way when you can. Do not join in the conversation unless asked to do so. Clients who are dying can have some independence even when they need total care. Let the client make choices when possible, such as when to bathe, whether to eat, or what to eat or drink.
- **G** Be sensitive to individual needs. Different clients and families will have different needs. The more you know what is needed, the more you can help. Some clients need a quiet and calm atmosphere. Others appreciate a cheery presence and might like you to make small talk or stay close by. If you are not sure what you can do to help, ask someone.
- **G** Be aware of your own feelings. Caring for people who are dying can be both physically and psychologically draining. Know your limits and respect them. Discuss your feelings of frustration or grief with another care team member.
- **G** Recognize the stress. Realizing how stressful it is to work with clients who are dying is a first step toward caring for yourself. Talking with a counselor about your experiences at work can help you understand and work through your feelings. Remember, however, that specific information must be kept confidential. A supervisor may be able to make a referral to a counselor or support group.
- **G** Take care of yourself. Eating right, exercising, and getting enough rest are ways of taking care of yourself. Remember that caring for your emotional health is important too. Talk about and acknowledge your feelings. Take time to do things for yourself, such as reading a book, taking a bubble bath, or doing another activity that you enjoy. If you are a religious or spiritual person, these needs may be met by attending religious services, reading, praying, meditating, or just taking a quiet walk (Fig. 20-6). Meeting your needs allows you to best meet other people's needs.

Fig. 20-6. *Taking care of yourself, including eating right, drinking plenty of water, and relaxing, is a way to help you tend to your own needs while caring for people who are dying. Exercise, meditation, prayer, and reading are also ways to meet your needs.*

- **G** Take a break when you need to. Find 10 minutes to sit down and relax or stand up and stretch. Doing this may be enough of a break in some situations. There may come a time when the demands of hospice care are too great. You may need to request a change of assignment from your supervisor. Do not feel guilty about doing this when you need to.

Hospice Volunteers

According to the National Hospice and Palliative Care Organization, over 1.4 million people received hospice services in 2016. Hospice volunteers go through a training program to prepare them for hospice work. The volunteers provide a variety of services. These include caring for the home or family of a dying person, driving or doing errands, and providing emotional support. The organization's website, nhpco.org, contains more information.

7. Explain common signs of approaching death

Death can be sudden or gradual. Certain physical changes occur that can be signs and symptoms of approaching death. Vital signs and skin color are often affected. Disorientation, confusion, and reduced responsiveness may occur. Vision, taste, and touch usually diminish. However, it is generally acknowledged that hearing is often present until death occurs.

Common signs of approaching death include the following:

- Blurred and failing vision
- Unfocused eyes
- Impaired speech
- Diminished sense of touch
- Loss of movement, muscle tone, and feeling
- A rising or below-normal body temperature
- Decreasing blood pressure
- Weak pulse that is abnormally slow or rapid
- Alternating periods of slow, irregular respirations and rapid, shallow respirations, along with short periods of apnea, called **Cheyne-Stokes** respirations
- A rattling or gurgling sound as the person breathes (which does not cause discomfort for the dying person)
- Cold, pale skin
- Mottling (bruised appearance), spotting, or blotching of skin caused by poor circulation
- Perspiration
- Incontinence (both urine and stool)
- Disorientation or confusion

When death occurs, the body will not have heartbeat, pulse, respiration, or blood pressure. The eyelids may remain open or partially open with the eyes in a fixed stare. The mouth may remain open. The body may be incontinent of urine and stool. Between two and six hours after death, the muscles in the body become stiff and rigid. This is a temporary condition called ***rigor mortis***, which is Latin for *stiffness of death*. Though these things are a normal part of death, they can be frightening. The home health aide should inform the supervisor immediately to help confirm the death.

8. Describe postmortem care

Postmortem care is care of the body after death. It takes place after the client has been declared dead by a nurse or doctor. Home health aides must be sensitive to the needs of the family and friends after death occurs. Family members may wish to sit by the bed to say goodbye. They may want to stay with the body for a while. They should be allowed to do these things. HHAs should be aware of religious and cultural practices that the family wants to observe. Home health agencies will also have different policies about postmortem care. HHAs should follow their agency's policies and only perform assigned tasks.

Guidelines: Postmortem Care

- G After death, the muscles in the body become stiff and rigid. This may make the body difficult to move. Talk to your supervisor if you need help performing postmortem care.
- G Bathe the body. Be gentle to avoid bruising. Place drainage pads where needed, most often under the head and/or under the **perineum** (*payr-i-NEE-um*) (the genital and anal area). Be sure to follow Standard Precautions.
- G Check with the family about how to dress the client and whether to remove jewelry.
- G Do not remove any tubes or other equipment. A nurse or someone at the funeral home will do this.
- G If instructed to do so, put dentures back in the mouth and close the mouth. You may need to place a rolled towel under the chin to support the closed mouth position. If this is not possible, place dentures in a denture cup near the client's head.
- G Close the eyes carefully.
- G Position the body on the back with legs straight and arms folded across the abdomen. Place a small pillow under the head.
- G Once the body has been removed, strip the bed.
- G Open windows to air the room, as appropriate, and straighten up.
- G Arrange personal items carefully so they are not lost.
- G Document according to your agency's policy.
- G Ask family members or friends how you can be of help. If you are working with a hospice program, you may be asked to answer the phone, make coffee or a meal, supervise children, or keep family members company. Do not leave the home until the client's body has been removed or until your supervisor says you may leave.

Organ Donation

Organ donation is the removal of organs and tissues for the purpose of transplanting into someone who needs them. Organ donors can be people who have recently died or living people. If a client has designated himself an organ donor after death, specific policies and procedures will need be followed. Some organs must be taken from the body very soon after a person dies. HHAs should follow their supervisor's instructions regarding special preparations or transport.

9. Understand and respect different postmortem practices

When caring for those who are dying, home health aides will also interact with families and will witness many different responses to the death of a loved one. Dealing with the loss of a loved one is a monumental task that people face in different ways. It is a process that may begin with the diagnosis of a terminal illness and may not end until years after the loved one's death.

There is no right or wrong way to grieve. A person's initial response to the death of a loved one may be due in part to her cultural or religious background, or it may simply be how that person deals with death. What is important is that when people respond differently than a home health aide would, it is the HHA's professional duty to respect their responses.

When a death has occurred, some people may respond quietly, with very little obvious emotion, while others may be very vocal. Depending on the preferences of the family, the body may be removed very quickly or the family may wish for the body to remain for some time while people say goodbye, pray, or perform necessary religious rituals. Many cultures forbid leaving the body of the deceased alone. In some cultures and religious traditions, the body must be buried promptly, either on the day of death or within a certain period immediately after. An HHA should not be alarmed if this happens or judge the practices of the client's family.

A home health aide may be invited to attend a funeral or other ceremony following the death of a client. As someone who has cared for the deceased person, the HHA may be grieving as well (Fig. 20-7). If she wants to attend the service, she should check with her supervisor first to make sure it is appropriate. It is important to respect professional boundaries.

Fig. 20-7. *Home health aides should allow themselves to grieve. They will develop close relationships with some clients. It is normal for them to feel sad, angry, or lonely when clients die.*

Just as responses to death vary widely, funeral and burial practices vary from culture to culture and region to region. In some cultures, the family and friends of the deceased person hold a *wake*, or a watch over the body before burial. Traditionally the wake was held in the deceased person's home, and the body was present. Modern wakes may take place at a funeral home. There may be singing, eating, drinking, and storytelling at a wake. The mood is not necessarily sad or somber. A *viewing* is a period of time during which a deceased person's body may be visited by mourners. Viewings may be combined with a celebration of the person's life (as in a wake) or may simply be a time for mourners to pay their quiet respects.

Funerals or memorial services may also involve the display of the dead person's body. This is typically called an open casket funeral. The body will have been preserved for burial (embalmed) by a mortician (a person whose job it is to arrange for the burial or cremation of the dead) and may be dressed formally or in clothing dictated by the person's family, culture, or faith. Some cultures or religious traditions forbid the display of a dead body, and for some it is simply a preference that the body not be displayed. At a closed casket service the casket, or coffin, is present, but it is closed so that the body is not visible.

When a body is not buried in a casket, it may be cremated. Cremation is the burning of a body until it is reduced to ashes. Being cremated may be what the deceased person wanted for personal reasons, or it may be dictated by some religious traditions. An urn, or container for the ashes, may be displayed instead of a casket at a funeral or memorial service.

Natural burial (sometimes called green burial) is another option. The body is wrapped in a shroud (cloth) or put in a biodegradable casket. The body is not embalmed and is placed in the ground to allow for natural decomposition.

Funerals and memorial services may be held in a place of worship or at a funeral home. They may be held in a family home, at a park, in a restaurant, or at any location that has personal significance. Services may involve readings of religious scripture and prayers or of philosophical excerpts. Many include eulogies, or speeches made in honor of the deceased. Friends and family members may share moving, memorable, or humorous stories about the person who died. Spiritual leaders may offer words of comfort or remembrance. Some funerals are followed by a procession to the place of burial. Often only those closest to the deceased take part in the burial. In some cases, memorial services are entirely separate from the burial, and the deceased person's body is not present at all. A luncheon or reception often follows the service.

Services may incorporate elements of the dead person's religious faith and culture. If an HHA is attending a service for a client who practiced a faith different from her own or who came from a culture different from her own, she should be respectful of the client's traditions.

The same is true of attending a service for a client who was an atheist (a person who does not believe in any higher power). Such services will not involve prayers, hymns, or any religious rituals.

No matter what rituals or services take place after a person has died, home health aides should not be judgmental or make critical comments. They should be respectful and professional.

Chapter Review

1. Describe one behavior a home health aide might see at each stage of grief.
2. Describe five possible feelings/responses in the grief process.
3. How would you describe your personality type? What helps you work through difficult feelings like those associated with grief?
4. What are some of the ways an HHA might provide emotional and spiritual support for a client who is dying?
5. What measures may help a client who is in pain?
6. List three legal rights to remember when caring for the terminally ill.
7. What is the focus in palliative care? How does it differ from the usual care HHAs provide?
8. Why is it important for an HHA to be aware of her feelings as she provides hospice care?
9. What are three ways that an HHA can take care of herself when working in hospice care?
10. Which sense is generally present until death occurs?
11. What is postmortem care?
12. What is a wake?
13. What is cremation?