

## Lay Summary

### Doing Death and Doing Diversity in Nursing Homes

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## 1. Background

It is getting more and more common in Western societies that old persons are dying in nursing homes. This is in one part due to the general trend to maintain individual autonomy as long as possible, and to transfer persons to institutional care as the utmost option chosen. On the other hand, due to cost explosions in health care, hospitalizations are reduced to a minimum, and therefore, aged and terminally ill patients are cared for as long as possible in nursing homes. As a consequence, homes for the elderly are increasingly becoming institutions of dying, while the institutions themselves still lack full recognition of this role. At the same time, Swiss policy and specialized institutions are elaborating Palliative Care conceptions and guidelines that also reach nursing homes. Within the frame of Swiss Palliative Care provision, the latter are, according to policy, supposed to provide so-called 'general palliative care services'. However, conceptions and guidelines propose an ideal of a 'good death' focused on dignity, autonomy and self-determination, which is difficult to fulfill in old-age long-term care. One reason for this lies in the high probability of physical and mental restrictions at old age, another in the insufficient use of advance care directives and the resulting needs to interpret on behalf of dying residents. Complying with the expectations of Palliative Care ideals would require an early onset of discussions on dying and substantiated biographical clarifications in the nursing home, so that staff members would be able to take decisions when the dying person is not in a position to communicate his/her wishes and needs anymore. Respecting the will of the nursing home resident is expected to be at stake in manifold everyday activities and decisions. Therefore, repeated negotiations of what is to be done in what manner to provide for a 'good' end-of-life and death are requested. This is not only the case when nursing home residents are physically or mentally restricted in expressing their will, but also in a more general way: Differences in gender, class, religious beliefs, migrant background, language or other issues of diversity request that the resident's needs, habits and wishes at the end-of-life be negotiated between resident, his/her family and professionals. If the possibilities of communication with the resident and/or his/her family are restricted, questions of how to interpret what would be nearest to the resident's will and who would be the best person to speak on behalf of the resident become of central importance. We therefore suggest that dealing with diversity is an integral part of living, working and dying in nursing homes.

In our research project, we used the sociological concepts of 'doing death' and 'doing diversity' to stress the fact that significances are constructed in everyday interactions and practices at the end-of-life. In this sense, death and diversity are constructed in concrete situations in the nursing home life, i.e., they are 'done'. Or, in other words, there is no 'doing death' or 'doing diversity' without the actors who are involved in the daily interactions around death and dying.

## 2. Goals and research questions of the project

The project 'Doing death and doing diversity in nursing homes' aimed at exploring how diversity is structuring end-of-life in Swiss nursing homes. It specifically investigated how nursing homes deal with migrant residents. Following a Grounded Theory approach, we consider social processes to be the basis of any phenomena in a research field. Observing such processes helps to explore how 'doing death' while 'doing diversity' is done in everyday practice, i.e. in interactions between residents of migrant background and professional caregivers involved (often of migrant background themselves). This means that death and dying were conceptualized as a product of activities and relationships between individuals, groups and institutions, while migrant 'doing death' was expected to be particularly negotiable because of the potentially wider frame of diversities (e.g. diverse religious or cultural practices, special needs at the end-of-life).



Our research furthermore focused on modes of community building within the nursing home (i.e. among residents, between residents and institutional actors and among institutional actors) and on modes of reciprocity and social support associated with it. It was studied if community-based concepts of elder care (such as migrant-specific, segregative departments or household-like, integrative departments) do bring about specific modes of community in everyday life. If so, the research project intended to explore how these modes of community also produce specific exchange relationships at the end-of-life in the nursing home and if these modes can be regarded as producing socially more embedded forms of 'doing death'.

Thus, we concretely focused on the following research goals:

- 1) Exploring the constitution of 'doing death' in Swiss nursing homes with reference to increasing diversity in society, with a specific focus on migrant diversity.
- 2) Developing analytical key categories for 'good death'-practice within nursing homes.
- 3) Providing innovative knowledge for science, policy, service development, and training of professional caregivers.

### 3. Methods

Data collection: The project chose an open ethnographic research strategy that followed the principles of Grounded Theory. Ethnographic research builds on participant observation of everyday practice, combined with several additional procedures of data collection (i.e. interviewing, document collection, focus group discussions etc.). It is thus an adequate mode of data collection on social phenomena that cannot be easily put into words and therefore cannot (only) be grasped by solely asking questions. Since death and dying are expected to be something one does not talk about easily and, if so, talking about it tends to be normatively affected, participant observation of implicit practices is a central source to understand processes of 'doing death'. 'Doing diversity' similarly is a field where normative assumptions and fears of 'not saying the wrong things in order not to discriminate' are at stake.

Field sites: The project selected two organizations of long-term elder care (nursing homes) in order to approach its research issues. Participant observation served to study 'doing death', that is to say it explored how dying is 'done' in concrete everyday settings of interaction among the actors who are present in nursing homes. The main research focus was laid on the institutional actors who are permanently present in the field of study, i.e. the nursing staff members and the residents. Furthermore, the study also considered other actors who are only temporarily present, such as medical specialists, general practitioners, religious specialists, morticians, family members, friends and other visitors, as far as they were taking part in 'doing death'. The concrete fields of research included 1) a segregative, group specific ward for residents of so-called Mediterranean migrant background, which emphasizes common (in this case migrant) characteristics (i.e. 'doing migrant community'), 2) community-based household-like wards, which group residents together randomly in a household community (i.e. 'doing community'), and 3) integrative wards combining individual housing with public facilities for all residents, holding a considerable number of residents with migrant background without offering them specific services (i.e. 'doing individuality'). We conducted the study in two institutions, which were equal in size (approximately 120 to 130 residents), in two cities of the Canton of Bern. Nursing home A is organized as a set of autonomous households, including a migrant-specific household. Nursing home B is organized as a hospital-like set of wards holding single and double rooms.



Data analysis aimed at formulating key categories of 'doing death' while 'doing diversity' at the same time. Thereby, special interest was laid on problematic processes ('conflicts') in everyday interactions to learn more about how diversity is dealt with in concrete situations of dying. Further, we aimed at exploring if specific forms of community are emerging and producing distinct modes of dying. Finally, we studied what elements might be of relevance in formulating nursing home specific guidelines of palliative care and how positively valued forms of exchange (resident/caregiver relationship, resident/resident relationship) might be integrated. Identifying key situations and key categories of 'doing death' was achieved by iteratively analyzing the collected data (extensive field notes and interview transcriptions) during the whole process of field research. Data collection and analysis were following the principles of Grounded Theory by a) continuously coding the data (open, axial and selective coding), and by b) formulating concepts and verifying the relevance of each concept (considering its attributes, conditions, interactions and consequences). In doing so, data analysis aimed at developing interpretational categories that contribute to the formulation of theory that is literally 'grounded' in empirical data. Coding and analysis of data were supported by atlas.ti software.

#### 4. Results

'Doing death' and 'death work': Entering the nursing home as a nursing assistant and thereby being introduced to the field from the professionals' perspective, the findings of our study take the focus on professional 'doing death' as a starting point. In both nursing homes included in our study, 'doing death' proved to be strongly defined by the institutional framework (e.g. general nursing home guidelines, daily routines) and the agencies of the professional actors working within it. We, therefore, concentrated on the professional 'death work', the routinized practices of caregivers who are employed by the nursing home and who are involved in dying trajectories as part of their daily work in the institution. In other words, although 'doing death' is understood as an interactional process involving residents, relatives and other relevant actors, professional caregivers are in our field of study the actors with the largest scope of action (i.e. agency) and the main power to define and shape the practices of 'doing death'. In the nursing home setting, professional 'death work' is to a very high degree done by qualified nursing staff members and nursing assistants. Other professional 'death workers' such as doctors, spiritual specialists, social workers, therapists, morticians, etc. are less involved.

The residents' part in 'doing death' is characterized by the specificities of dying in very old age, by generational characteristics and by the context of the nursing home as a semi-public space (i.e. quasi-private for residents, quasi-public for staff and visitors). Slow dying trajectories with unspecific causes and unclear progresses are common. Advanced care directives such as a 'patient's will' are still not very common, and aged-related impairment and weakness leave residents with a rather limited scope of action when it comes to dying. Active self-determination by residents is uncommon.

Further actors who are (temporarily) present in the nursing home such as relatives, fellow residents or volunteers (which are all informal actors opposed to the professionals) are left in a secondary role in 'doing death'. Even though living in the institution themselves, fellow residents are generally not taking over an active part in 'doing death' because of the widespread institutional practice of transferring (supposedly) dying residents from the semi-public space (i.e. shared facilities such as dining hall or TV room) to the private space of individual rooms (an exception are twin rooms, where the room neighbor is usually more involved in 'doing death'). The involvement of volunteers in 'doing death' was not very common (and if so, it was often limited to sitting at the bedside) in the two nursing homes and seemed to be subject to either the initiative of the professional caregivers or of relatives. The role of relatives in 'doing death' is to a cer-



tain extent also subject to the guidance of professional caregivers, e.g. with respect to when/how relatives are informed and what they are asked to contribute to the dying trajectory. In most cases they are asked to be present but not to be 'too present' in the dying trajectory of their relative, meaning they are expected to stick to their role as first proxies who accompany the dying process but who do not disturb the professionals' 'death work' routine. Striving to fulfil their institutionally defined tasks and duties, of which 'doing death' is just one part, professional caregivers do have a considerable scope of action in 'doing death', but are nevertheless obliged to comply with the rules of the institution and the care needs of fellow residents. Compared to other institutions professionally handling end-of-life care, the nursing home seems to be characterized by a way of 'doing death' oriented towards the ideals of Palliative Care, but in a very pragmatic and ready-to-use manner (e.g. omitting suffering by choosing an adequate medication and increasing surveillance). Furthermore, although palliative orientations seem to have profoundly diffused throughout the institution of the nursing home, there are also curative orientations still present (predominantly among younger or less qualified staff), and they may in some cases collide.

'Doing diversity' and 'doing community': To investigate how diversity issues matter in institutional 'doing death', we primarily focused on migration related diversities, which were studied both in the integrative and the segregative settings of living and caring for migrant residents. Findings were then contrasted with observations regarding other dimensions of diversity (such as gender, socio-economic status, religion etc.). Attention was also put on possibly emerging tendencies of 'doing community' in the sense of social embeddedness of 'doing death'. With regard to how diversity generally matters in nursing home 'doing death', it especially seems to be necessary to negotiate the resident's individual needs and wishes when new residents enter the nursing home. Diversity issues are in this context debated with respect to integrating the new residents with their specific characteristics and needs into the nursing home everyday life. Collective ways of 'doing diversity' in the sense of constructing liable communities within the nursing home were, however, not very common: neither wards nor household units seem to specifically foster community building among groups of residents. Socializing among residents or between residents and professional caregivers in general followed the logics of single interpersonal relationships based on individual preferences and reciprocity (see below), or it popped up in the form of ad-hoc community building, e.g. distinguishing between 'the fit' and 'the frail'.

However, 'doing diversity' in the form of 'doing difference' is explicitly at stake in the segregative Mediterranean ward. 'Doing difference' on the Mediterranean ward mainly serves the purpose of establishing the segregative mode and legitimizing its specific status within the organization ('doing community' as 'doing minority' and claiming recognition for this minority status). Thus, practices on the Mediterranean ward are characterized by occasionally performing sameness/otherness to construct borders between the Mediterranean and other wards of the nursing home. This may for example be the case when menu planning is questioned for not being truly Mediterranean, or when the residents of the Mediterranean ward overtly leave as a group to join a collective social event of the organization. Furthermore, interactions on the Mediterranean ward are characterized by stressing similarities to family life both in discourses and practices. Third, achieving understanding is a central issue in Mediterranean care, which not only means speaking the same language, but also involves understanding and being understood. The latter is also relevant in end-of-life care in old age more generally (e.g. regarding dementia, or self-determination in dying trajectories). Overall, the practices of 'doing diversity' on the Mediterranean ward are characterized by highly situational and contestable practices of explicitly 'doing difference'. Based on our results, we argue that the contested practices involved in running a Mediterranean ward seem to go along with repeated reflections of all institutional actors (not only the ones working on the Mediterranean ward) about diversities and differences and how to deal with them in old-age end-of-life care in a nursing home. Combined with the observations



that collisions and crises were less explained with reference to group characteristics in the nursing home running a segregative Mediterranean ward than in the nursing home offering integrated care, we suggest that the structural segregation of some residents seems to go along with 'institutionalizing reflexivity'. This is to say that the organization is experienced with debating sameness/otherness and that this experience may also foster the 'diversity fitness' of the organization.

As far as 'doing community' is concerned, our data on the Mediterranean ward have shown that there are only slightly increased practices of 'doing community' among residents and professional caregivers compared to the other, integrative wards. 'Doing community' occurs situationally and is most frequently related to 'doing sameness/otherness', i.e. performing the difference of the Mediterranean ward as opposed to other wards. However, our field of research demonstrated another peculiarity with reference to 'doing community', which was associated to the Mediterranean ward: the role of the local 'migrant community'. Having been involved in the establishment of the segregative ward as a pressure group, the local migrant organizations kept being involved, mostly by providing rather extensive volunteer work, as well as spiritual support. While being highly appreciated, the intensive involvement of the 'migrant community' was also used as a mode of informal social control and pressure on the staff of the ward (e.g. by gossiping about the inappropriateness of the kind of Mediterranean care provided by the staff). Thus, we might conclude that the extensive involvement of the migrant community on the Mediterranean ward both entails chances and challenges. Thus, we suggest that a regular monitoring of roles and limitations of volunteer work in institutional long-term care settings is necessary to manage the threat of transgressions inherent in intense involvement of volunteering communities.

Concerning the concrete dying trajectories and the practices of 'doing diversity' involved in it, our results show no specific emphasis on diversity issues. Instead, rather strong normalizing practices of professional 'death work' were visible. This is also the case on the segregative Mediterranean ward. However, in both nursing homes and all types of ward, 'doing death' may be heavily contested by diversity issues when notions of what a 'good death' is are divergent (i.e. if residents or relatives disagree with the practices of nursing home 'death work' and its implicit notions of 'good death', see also below) and when the involved agents fail to negotiate and achieve a shared notion of 'good death'.

'Good death': In contemporary palliative care, the concept of 'good death' focuses on the ideal of an autonomous dying person, cared for under a specialized biomedical authority. Transferred to the nursing home context, characterized by long-term basic care for the very old under conditions of scarce resources, the notion of 'good death' is broken down into ready-to-use, pragmatic elements of daily routines. Both routinized professional 'death work' practices and unclearly defined informal practices of 'doing death' by relatives seem to refer to often poorly reflected and sometimes conflicting frames of reference on what a 'good death' should be like. These unspecific notions of 'good death' do, however, comprehensively shape actions and decisions involved in 'doing death'. This is especially at stake in dying from old-age related weaknesses, where progresses are unclear, opportunities for concrete negotiations on divergent notions of a 'good death' are rare and where decisions are to a large extent subject to interpretations. In this context, collisions may arise, both between professional caregivers and relatives and among caregivers. These collisions may roughly be sketched as negotiations between curative and palliative actions, but also involve debates on what actions serve or hinder palliation in what sense. Increasing diversity, e.g. with respect to migrant background, may also (but does not necessarily have to) increase divergence of notions of a 'good death' and of expressions of acting 'on behalf' of the dying person. Organizations that are experienced in negotiating diversity (e.g. by running segregative departments) may be more capable to handle such collisions when it comes to a concrete dying trajectory, as our analyses propose, since differences are constant-



ly subject to negotiation in organizations running both segregative and integrative wards, beginning with a resident's entrance to the nursing home. Organizations focusing on integrative residency may, on the other hand, tend to postpone negotiations on diversities and differences to incidents of conflict that typically arise during dying trajectories and thus may be forced to negotiate in an ad hoc and less reflected manner. This may lead to stereotyping ascriptions of wishes or needs that are divergent from the nursing home routine, e.g. as being 'difficult' or 'burdensome'.

'Doing reciprocity and exchange': In a highly individualized and market-guided society, liquidating modes of transactions, or, in other words, the immediate repayment of assistance or material goods received, is stressed in nearly all societal realms. Elderly people in need of assistance often face the fact that reciprocating the support they receive becomes challenging. As a consequence, feelings of debt may arise, especially when receiving seems to outweigh giving in an extreme way. Such feelings may also be evoked in nursing home residents, despite the fact that repayment is done by paying the institution for the care provided to them. However, reciprocity in the sense of 'giving and giving back' in turn is not only an economic rule of exchanging goods and services in a market-guided society. With reference to an anthropological model of exchange, it is also a social practice of individuals who replace an immediate repayment by non-material goods or services that will be provided in turn. Reciprocating support or goods in this sense leads them to establish long-lasting informal relationships, and this is, as anthropological theory has elaborated, a fundamental base of community-building. The nursing home as a setting of long-term care, where staff and residents typically spend months or years together before a resident dies, offers the necessary surroundings to build informal relationships. Despite scarce economic and personnel resources and clearly defined rules (e.g. the staff member is being paid for the care services he/she provides to a resident), this setting also permits professional caregivers and care receivers to engage in non-liquidating transactions, where 'giving back' consists of loosely defined, often immaterial gestures of high individual value that lead to further investments into the relationship. For residents, on the one hand, being able to exchange immaterial goods with their caregivers (e.g. showing and receiving signs of affection) may add to their relationship a level of familiarity, which is usually reserved for friendship or family ties. We can, therefore, say that informally exchanged goods may influence the resident's feelings of imbalance between giving and taking. That is to say, imbalance tends to be perceived as less burdening. Additionally, residents, often confronted with an increasing loss of their own social environment outside the nursing home, take the opportunity to construct new social bonds with their caregivers which may reduce feelings of loneliness. For staff members, on the other hand, engaging in informal exchange relationships with some residents may reduce disturbances in the daily care routine, benefiting from the higher level of familiarity with the resident's habits and needs. It can also improve job satisfaction for those staff members who appreciate the interpersonal or social dimension of their work as a caregiver. However, the death of a resident can make additional strategies necessary to cope with loss and grief.

In both integrative and segregative organizational structures, the relationships between caregivers and care receivers are of great importance for the modes of 'doing death' in the institution. Our results show that these care relationships need to be considered from a two-pronged approach: they consist of formal parts and informal parts (as described above). Informal relationship parts between staff members and residents are established individually by choice of the actors, depending on their preferences, experiences and the concrete situations involved. Contrary to our first assumption, they do not occur predominantly within a certain organizational structure (as e.g. the Mediterranean ward), but develop on any type of nursing home ward observed. The study further shows that nearly all professional caregivers and care receivers in the observed nursing homes engage in such informal relationships and that they mostly invest immaterial goods in reproducing them. However, there is a wide spectrum from a sporadic 'giving and giving back' to



vast investments of e.g. time resources, which lead to relationships of unique importance. Moreover, our data demonstrate that informal parts in care relationships gain special attention during dying trajectories. Confronted with the passing away of one of 'their' residents, staff members seem to be especially eager to 'do' a dying process which in their perception corresponds to the image of a 'good death' (e.g. not to let the person die alone). In this sense, reciprocity practiced in informal exchange relationships may become a substantial category for the practice of 'good death' in nursing homes.

In order to understand core elements of exchange and their significance within care relationships at the end of-life in the nursing home, we elaborated three categories of transactions (i.e. investments), all of them are immaterial and predominantly invested within the informal relationships between professional caregivers and care receivers:

- A) Experiencing and showing emotional involvement (e.g. affection in everyday life, during dying trajectory, after death). Signs of affection are selectively exchanged between caregivers and care receivers both in everyday practice and in the context of acute dying (i.e. the very last days and hours of life). They are of high value when establishing and maintaining an informal part in a caregiver-care receiver-relationship as they serve as a reassurance for further investing into the relationship.
- B) Selectively sharing personal information (e.g. delicate or 'precious' biographical information). 'Keeping a secret' may play a strong role in establishing and reproducing an informal relationship based on trust and confidence.
- C) Spending extra time (typically invested by staff members during dying trajectories). What is most impressing here is the fact that time, considered from the liquidating perspective, is a very scarce resource in the everyday routine (staff members are always confronted with time pressure in their daily routine). Integrated into a non-liquidating interpretation of relationship, however, time becomes a negotiable matter (e.g. 'I do not care if I have time, I just take my time!')

To sum up, 'permitting affection and emotional involvement', 'sharing personal information' and 'offering extra time' are categories of transactional goods which are often invested to establish and maintain informal relationship parts between residents and staff members and which in the context of acute dying tend to be accumulated in order to prepare to the coming rupture which is the death of the resident. Looking back to our initial research question concerning the establishment of specific communities within certain nursing home organization models, we can state that, according to our results, small communities based on non-liquidating exchange relationships may develop spontaneously and individually, depending on the specific preferences and circumstances. They develop in all three types of organizational models observed and between singular actors or small groups of actors, including both caregiver-caregiver, caregiver-resident, and in singular cases resident-resident relationships. However, we found no evidence that a certain organizational model (type of housing) leads to the construction and reproduction of larger communities among residents or other groups of actors in any of the nursing homes (e.g. the community of the residents of a specific ward).

'Doing community' as described with reference to the Mediterranean ward has to be seen in a slightly different context. Although the Mediterranean department is repeatedly 'doing community' in the sense of 'doing sameness/otherness' (i.e. performing borders between the Mediterranean department and other departments, for example by overt kissing and hugging between residents and caregivers while explaining this to the observer as a characteristic of 'us Mediterranean people'), it is doing so with reference to an already existing societal community (migrant community) and the host society. Thus, one might say that a pre-existent notion of 'community' is performed, but this does not seem to contribute to the formation of new communities within the nursing home. Furthermore, while the outside community of reference for the



Mediterranean department, the Italian migrant community, seems to be broadly involved in everyday nursing home life, it has been almost completely absent in dying trajectories. This is in concordance with our observation in both nursing homes and all types of organizational models that dying happens in the quasi-private sphere of the resident's room and bed with little to no participation of other residents or actors from outside the nursing home.

## 5. Significance of the results for science and practice

### Science:

Our research opens up a myriad of potential further research issues. E.g., with regard to applied research, intervention studies could be initiated aiming at the exploration of practical implementations that could be derived from our results described above. Intervention studies could thus focus on supporting professional caregivers and organizations in optimizing their 'death work' and their capability to adequately address diversities both among care receivers and the professional teams. Considerable potential furthermore lies in promoting a wider understanding on informal parts in care relationships in different settings and in exploring ways to make them visible and valuable as a field of unpaid work in our society. Further research could also focus on the transferability of key findings to other settings of professional 'death work', e.g. conceptualizing the potential of informal parts in care relationships to enhance quality of care in hospital settings or in general palliative care (family doctors, outpatient nursing etc.). Another possibility would be to focus on the relatives' role in 'doing death' and to develop interventions providing relatives with a more concrete part in 'doing death' (e.g. by negotiating ways of getting involved in end-of-life care).

There are also several basic research topics worth pursuing, such as the theoretical transfer of exchange theory to palliative care in general, and especially to nursing care, which holds considerable potential to be expanded to debates on care economies in a broader sense. Another topic worth further investigation on both a theoretical and empirical level is the issue of diversity specific care, e. g. with respect to dementia care or care offered by religious organizations, and explorations of how such forms of care affect professional care work (especially nursing care). There is further potential to promote concepts of professional care such as 'transcultural competence' or 'patient centered care' in order to enable care provision to be more diversity sensitive in general. With regard to the issue of segregating residents on the basis of supposed common features (e.g. 'common' migrant or religious background), the observation that segregating residents within an integrated organization might enhance institutional 'diversity-fitness' should be more thoroughly investigated in order to test their potentials for organizational development.

### Practice:

Doing Death: Considering the fact that 'doing a good death' is the product of interactions between actors who all relate to their own attitudes and experiences and aiming at the policy goal of providing equal access to palliative care to all members of society, the implementation of well-reflected palliative care concepts should be improved and standardized in nursing homes. That is to say, (1) palliative care concepts should be part of vocational and advanced training, (2) they should be made accessible via ready-to-use guidelines and/or easy-to-reach opportunities to discuss issues (e.g. with nursing experts or colleagues having specialized expertise) during (conflicting) situations of concrete dying and (3) they need to be part of post mortem vessels of reflection in order to improve quality assurance for future residents.

Doing Diversity: Regarding organizational structures (i.e. integrative vs. segregative), our results point to the insight that both elements - 'doing community' and 'doing individuality' – are meaningful for the institutional end-of-life. When one element is structurally embedded, our results point to the necessity to mon-



itor the other element very carefully, e.g. via easily accessible instruments of reflection in the daily nursing home routine. For example, in segregative wards, where sameness needs to be orchestrated in everyday life, it may be more important to monitor the recognition of individual needs and beliefs of residents and their families in daily life as well as during dying trajectories. Or, as integrative wards focus on individuality, the implementation of specific measures to reflect on (supposed) group-specific diversities in situations of conflict may be advisable.

Doing Reciprocity: As in any other institution of long-term care, informal relationships seem to be essential when actors are doing a 'good death'. Therefore, these relationships have to be made visible. That is to say, they need to be recognized as a valuable resource within the institution and need to find societal recognition. Applying our findings to a wider care context offers a new possibility to monitor quality of care by providing the basis for tools to reflect care relationships at the end-of-life in institutions. Doing so, it is important to discuss the described coping strategies that are relevant for staff members who appreciate maintaining strong informal ties to their residents. Informal social ties are therefore a basic structural element of dying in nursing homes, and they should not be discussed as additional elements but as constitutive characteristics of the field.

