South American Publishing

SAP Community and Interculturality in Dialogue. 2023; 3:118
doi: 10.56294/cid2023118

REVIEW

Death: between the individual and the social

La muerte: entre lo individual y social

Xiomara Carranza Jimenez[1], Jeanette Choque Vargas[1], Patricia Rafaela Soledad Ortega Medina[1], Soledad Maidana Victoria[1]

[1]Universidad de Buenos Aires, Facultad de Medicina. Ciudad Autónoma de Buenos Aires, Argentina.

Cite as
Carranza Jimenez X, Choque Vargas J, Ortega Medina PRS, Maidana Victoria S. Death: between the individual and the social. SAP Community and Interculturality in Dialogue. 2023; 3:118. https://doi.org/10.56294/cid2023118

Publication History
Submitted: 25-08-2023
Revised: 01-11-2024
Accepted: 01-01-2024
Published: 02-01-2024

ABSTRACT

This paper discusses the concept of death and its various types, focusing on how death affects terminally ill nurses. The importance of understanding and managing emotions related to death in nursing practice is explored. Types of death such as natural, apparent, sudden, violent, suicide, homicide, accidental death, and assisted suicide are discussed. The paper reflects on the universal fear of death and how this fear can influence the pursuit of achievement to counteract distress, often leading to an anxious race against time without enjoying achievement. The importance of recognizing and addressing death-related fears and emotions in nursing staff to provide high quality care to terminally ill patients and their families is highlighted. It is highlighted that, despite the inevitability of death in nursing practice, nursing professionals are not always emotionally prepared to deal with death. It is mentioned that the dying process not only affects nurses in their professional lives but also impacts their personal lives. The need to provide adequate support and resources to help nurses cope with the complex emotions associated with the death of patients is highlighted. In conclusion, this paper highlights the importance of addressing the issue of death in nursing practice, recognizing the need for emotional support and training for nursing professionals. The need for more compassionate and dignified care in the process of caring for terminally ill patients is emphasized.

Keywords: Death; Nursing; Emotions; Terminal Care; Emotional Support.

RESUMEN

En este artículo se aborda el concepto de la muerte y sus diversos tipos, centrándose en cómo la muerte afecta a los profesionales de enfermería en pacientes terminales. Se explora la importancia de comprender y manejar las emociones relacionadas con la muerte en la práctica de enfermería. Se discuten tipos de muerte como la natural, la aparente, la súbita, la violenta, el suicidio, el homicidio, la muerte accidental y el suicidio asistido. El artículo reflexiona sobre el miedo universal a la muerte y cómo este miedo puede influir en la búsqueda de logros para contrarrestar la angustia, a menudo llevando a una carrera ansiosa contra el tiempo sin disfrutar de los logros. Se destaca la importancia de reconocer y abordar los temores y emociones relacionados con la muerte en el personal de enfermería para proporcionar atención de alta calidad a pacientes terminales y sus familias. Se resalta que, a pesar de la inevitabilidad de la muerte en la práctica de enfermería, los profesionales de enfermería no siempre están preparados emocionalmente para lidiar con la muerte. Se menciona que el proceso de la muerte no solo afecta a los enfermeros en su vida profesional sino que también impacta en sus vidas personales. Se subraya la necesidad de brindar un apoyo adecuado y recursos para ayudar a los enfermeros a afrontar las complejas emociones asociadas con la muerte de pacientes. En conclusión, este artículo destaca la importancia de abordar el tema de la muerte en la práctica de enfermería, reconociendo la necesidad de apoyo emocional y capacitación para los profesionales de enfermería. Se enfatiza la necesidad de una atención más compasiva y digna en el proceso de cuidado de pacientes terminales.

Palabras clave: Muerte; Enfermería; Emociones; Atención Terminal; Apoyo Emocional.

© 2023; The Authors. This Open access article is distributed under the Creative Commons Attribution 4.0 license (https://creativecommons.org/licenses/by/4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

INTRODUCTION

In this paper we will first talk about the concept of death, we will also mention some types of death, and finally, we will focus more on how death affects the nursing professional in terminal patients.[1]

We are going to base ourselves on authors based on various publications, who describe that for the nurse the death of a patient is a complex and drastic event in her life, presenting in the professional feelings of sadness, helplessness or anger, among others.[2] The dying process is not isolated from the sociocultural context of the patient or the professional. Improvements are required in the professional competence of health agents to face the final stage of life since there is not enough preparation at the emotional and care level, because dying has not been sufficiently addressed, and what the nurse feels has not been taken into account.[3]

DEVELOPMENT

Death: between the individual and the social

Death is the inevitable companion of life; it is its final stage; it can occur at any age, suddenly or after suffering a long illness; it is not an instantaneous phenomenon but a natural process, not only biological but also psychosocial, in which a large number of vital acts are extinguished in such a gradual and silent sequence that generally escapes simple observation. Death is the universal event par excellence that, in a certain way, confers intensity and value to life, which, according to Kubler, allows one to shape a more conscious life, to be more responsible for one's existence and to mature more intensely.[4]

The end of life can occur in different ways: naturally or by the action of an agent outside the person, a severe illness or even because someone, voluntarily or unconsciously, has ended his own life or that of another individual.[5]

Types of death:

1. Natural death: it has practically always been believed that people who reached old age died simply because they had been born at a certain age. Since the individual had already lived a long time, sooner or later, it was time for him to go to the next world. This type of death was called natural death. Today, we know that all deaths occur for a reason, even if we do not always know it. If an older adult dies, it is not because the clock of life has run out but because there has been something in their organism that has failed, something typical in older adults whose natural defense mechanisms have deteriorated with time. To indicate this, the term "natural death" is still used since nobody dies for no reason; everything has a cause.[5,6]
2. Apparent death: Sometimes, although very rarely, it happens that the organism momentarily loses all its vital functions, a phenomenon called catalepsy. Technically, it is said that the organism is alive, but it appears not to be so because it has entered a transitory state, which in appearance makes anyone believe that the person is dead. The individual who has entered this curious state can be reanimated using different medical procedures.[7] This event, which nowadays is known to happen, was not known in the past since, in the absence of autopsy techniques and devices that monitor vital functions, it was believed that, after seeing a person who gave no signs of life, they were considered deceased. The entire funeral procedure was initiated, burying or burning them alive.[8]
3. Sudden death: It is the one in which the individual dies without apparent cause or disease or who is not suspected to die in the short term. This type of death is characterized by being unexpected and rapid, occurring in newborns, and there is also a risk of sudden death when the person is over forty years of age.
4. Violent death: Violent death is considered when the cause of death is entirely unrelated to the body's functioning.
5. Suicide: Suicide is the situation in which an individual voluntarily ends their life.
6. Homicide: Homicide is the act by which a person deliberately takes the life of another person.
7. Accidental death: Accidental death is the situation in which the deceased has died as a result of something external to their body, but there has been no intention or willfulness on the part of the person who handled the object, if any.
8. Assisted suicide: Assisted suicide is the type of death in which a person is provided, intentionally and with the necessary knowledge, with the means needed to end their life, including advice on lethal doses of medication, prescription or supply of drugs. It is the patient who voluntarily ends their life.

Despite knowing that someday we will have to die, the death of a loved one is a terrible event, complicated to accept, which affects us. When the link with the deceased person is broken, the suffering is so great that the foundations of the self, of human existence and our deepest beliefs are questioned, affecting in a meaningful way the essential family and social relationships.[9] Fear of death is universal because human beings fear the unknown. In this sense, the inexplicable fear of death can manifest itself in an excessive eagerness to obtain achievements that counteract this anguish, and the person undertakes an anxious race against time without enjoying his achievements because he lives pending to obtain the maximum possible.[10] While it is true that death is a complicated reality to understand today, it is even more so because, in the era of the globalized world, the illusion that we will live for many years is fostered. The denial of the reality of death is nurtured. Our ancestors lived in a world where the death of people and animals was experienced as something natural. People died at home, surrounded by their loved ones and their "things" (their bed, their room, their scent). Nowadays, when accompanying the corpse in the funeral parlors, which is the place where the rituals of the wake are practiced, relatives and close friends stay only hours and then go home and return for the burial. This fact makes the wake to be wrapped in a halo of coldness and detachment.[11]

Individual attitudes towards death and related aspects such as pain, grief or suffering can condition how nursing professionals deal with death and thus establish the treatment they provide to terminally ill patients and their families. We speak of patients with

a terminal illness to refer to death foretold. However, there are occasions when death occurs unexpectedly and suddenly, leaving a great void in those of us who are still in this earthly dimension.[12]

This becomes important if we consider that death occurs daily in nursing practice, especially in critical care areas, since they are the ones who directly face death and the agony of others; they are also the ones who will most directly experience this situation for two reasons: the first is that the patient's death makes them aware of their end and of the losses they have suffered throughout their lives, and secondly because they are the ones who spend the most hours day after day with the patient.[13]

These experiences can be harrowing, so it is likely to appear to a greater or lesser degree, anxiety, uneasiness and insecurity since death today seems more like a technical failure than an event in the life cycle of all living beings, which can sometimes result in inadequate care and attitudes of rejection, flight or insecurity, even facing their fears of death.[14]

Nursing professionals are not accessible from the influence of emotions and feelings generated by witnessing the death of a patient since the primary role of the nurse is to provide care to healthy or sick people, to achieve the maintenance or recovery of health, and in the particular case of a terminally ill person, to care for him/her so that he/she may have a dignified death. Such care requires attitudes, knowledge and skills that must be acquired and perfected in the process of disciplinary training.[15] It is indisputable that addressing the attitudes and emotions of nursing professionals is extremely necessary since they are aspects that can influence the quality of care. Therefore, the objective of this study was to explore the attitudes of nursing personnel working in critical hospital areas toward the process of patient death.[16]

Reflection

Nursing professionals are the ones who remain in continuous contact with the patient and his family both at birth and at death since both events occur in health institutions. However, the process of death is not easy.

The death of patients is often painful or complex; the care of human beings is a fact of much complexity and full of connotations at the biological, psychological and social levels that must be taken into account in the training of nursing staff and clinical practices. However, we must find a serene and balanced attitude to relieve our feelings of tension and, at the same time, meet the needs of the patient.[17]

It is essential that the nursing professional is aware of and accepts his or her fears about death, as these influence his or her actions and behavior when facing a terminal patient. Moreover, sometimes, it is challenging to create a correct attitude toward death because many components affect it. For the nurse, facing dying is a painful process and difficult to accept. However, professional training in the health area seems to be focused on the value of technology and science, forgetting the importance of the nurse's care under empathic human relationships that allow him/her to recognize his/her coping strategies in the face of death, and thus maintain correct attitudes in order to contribute to the care of the terminally ill patient and his/her family in a more effective way and with higher quality.[18]

Nurses caring for patients at the end-of-life express nervousness, helplessness, uncertainty, guilt or frustration. They also feel angry or frustrated when the patient dies or when they perceive that the patients' families are suffering and reflect that their performance could be better. Nurses manifest multiple emotions even in critical care units, where many deaths occur. The fact that nurses feel that they could not have done more to make the patient better or prevent the patient's death increases feelings of sadness, depending on their relationship with the patient. Witnessing the pain of the patient and the suffering of family members at the death of their loved one is an unforgettable experience.[19]

Although death is considered a part of the human life cycle, nurses are not sufficiently prepared on an emotional level to cope with death or to deal with the feelings that occur during this process. Moreover, intensive care professionals may feel like novices or beginners because of the emotional impact of being involved with terminally ill patients and family members. As has been explained, the nurse feels helpless since this situation is over which he/she has no control despite all the efforts made. The dying process does not only affect the nurse in her professional life. Emotional reactions such as sadness, helplessness, feelings of loss or guilt also affect them. Nurses feel that it also impacts their personal lives because of the empathetic care they provide to patients and their families. Professionals seek support from their colleagues because they feel better understood than among friends and family members.[20]

We can thus affirm that the nurse's work goes beyond the technical and also concentrates on the human. However, the professional practice puts him/her in contact with the death of patients on an almost daily basis so that he/she learns to ignore or minimize the signs of personal suffering due to the loss of the patient because facing the emotional pain that the death of a patient could cause, together with the stress generated by the life he leads and the future that awaits him, exposes him to have to admit his fears, his vulnerability and his limitations, sometimes not even recognized by ourselves.

CONCLUSION

This work through research has allowed us to know in depth more about DEATH, how it affects the family members and the health personnel, and how nursing should intervene and help the family member to be able to cope with the grief since the process of caring for the end of life is not something simple for nursing.

In this process of bereavement, care in our health context is framed in cold care, where nursing and other health professionals have been governed by a practice based solely on protocols, tasks and procedures. Comprehensive care for the patient and the professionals themselves needs to be addressed.

We were also able to recognize that nurses do not have sufficient resources or support to provide more dignified care at the end of life, nor has there been an interest in listening to them and understanding what they feel or what they perceive in this end-of-life

process of the person they are caring for. Death, or the end of life, should cease to be a taboo subject in our professional context, and we should understand that it is just another stage of life. Therefore, the nurse must be listened to and supported since, as a human being, he or she may suffer.

REFERENCES

1. Fernández RM, Thielmann K, Bormey Quiñones MB. Determinantes individuales y sociales de salud en la medicina familiar. Revista Cubana de Salud Pública 2012;38:484-90.

2. Alizade M. Clínica con la muerte. Ediciones Biebel; 2021.

3. Rodríguez Herrero P, Gayarrolla Hormaechea F. Propuestas didácticas para una pedagogogía de la muerte desde la creatividad artística. REICE: Revista Iberoamericana sobre Calidad, Eficacia y Cambio en Educación 2012;10:86-96.

4. Araujo Hernández M, García Navarro S, García-Navarro EB. Abordaje del duelo y de la muerte en familiares de pacientes con COVID-19: revisión narrativa. Enfermería Clínica 2021;31:S112-6. https://doi.org/10.1016/j.enfcli.2020.05.011.

5. de Miguel JM. «El último deseo»: Para una sociología de la muerte en España. Reis: Revista Española de Investigaciones Sociológicas 1995:109-56. https://doi.org/10.2307/40183865.

6. Gómez Esteban R. El médico frente a la muerte. Revista de la Asociación Española de Neuropsiquiatría 2012;32:67-82. https://doi.org/10.4321/S0211-57352012000100006.

7. Marí-Klose M, Miguel JM de. El canon de la muerte 2000.

8. Jiménez Aboitiz R. ¿De la muerte (de)negada a la muerte reivindicada? Análisis de la muerte en la sociedad española actual: Muerte sufrida, muerte vivida y discursos sobre la muerte 2012. https://doi.org/10.35376/10324/979.

9. Arellano FH, 3175862, rn. El significado de la muerte. The meaning of the death 2006.

10. Alvarez A, Mohar A, Kraus A. En torno a la muerte. Una revisión y una propuesta. Rev invest clín 1997:151-61.

11. León C. A. La muerte y el morir. La muerte y el morir, 1980, p. 205-205.

12. Álvarez-Cienfuegos J. Sobre la muerte voluntaria. Recerca: revista de pensament i anàlisi 2004:111-23.

13. Cruz VP. La Conciencia de la Muerte Como Conciencia de la Vida. Thémata: Revista de Filosofía 2005;34:155-70.

14. Castillo M, Traverso G, Gainza Veloso Á, Aronsohn Falickmann S. La muerte: su sentido y significado a partir de un estudio de casos en adultos mayores. Thesis. Universidad Academia de Humanismo Cristiano, 2008.

15. Sola CF. Afrontar la muerte en Ciencias de la salud. Universidad Almería; 2012.

16. Bondar CI, Giordano M. Los estudios sobre la muerte y el morir: Reflexiones teóricas y estudios de caso. Avá 2017:07-12.

17. Rovaletti ML. La Ambiguedad de la Muerte: Reflexiones en torno a la Muerte Contemporánea. Revista Colombiana de Psiquiatría 2002;31:137-54.

18. Schumacher BN. Muerte y mortalidad en la filosofía contemporánea. Herder Editorial; 2018.

19. Duque AH, Medina L. De enterrados a fieles difuntos. Diálogos Culturales 2006:11-69.

20. Morir dignamente y eutanasia: en el corazon de la medicina 2021. http://www.scielo.org.co/scielo.php?pid=S0121-08072022000100702&script=sci_arttext.

FINANCING

No financing

CONFLICT OF INTEREST

None.

AUTHORSHIP CONTRIBUTION

Conceptualization: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Data curation: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Formal analysis: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Acquisition of funds: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Research: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Methodology: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Project management: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Resources: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Software: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Supervision: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Validation: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Display: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Drafting - original draft: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

Writing - proofreading and editing: Xiomara Carranza Jimenez, Jeanette Choque Vargas,Patricia Rafaela Soledad Ortega, Medina, Soledad Maidana Victoria.

https://doi.org/10.56294/cid2023118