Experience of the nursing professional with regard to death and the process of dying in intensive care units

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ABSTRACT

Objective: The objective of this research is to understand the experience of the nursing professional with regard to the death of a patient. **Methodology:** Qualitative, descriptive, and cross-sectional study. Seven nurses of the intensive care unit of a secondary care institution participated. To select the participants, a typological classification was constructed including age of the patient, duration of the relationship, experience regarding death processes, and age of the nurse. Data analysis was performed in an inductive-deductive way; the software Nvivo, version 7, was used. This research is in line with the Regulation of the General Health Act in the Area of Health Research. **Results:** The participants informed that the main coping strategies with regard to death and the dying process are emotional detachment, as well as seeking social support in religious and thanatology groups, and psychological help. Innate mechanisms are part of cultural capitals, while those acquired are usually taught at educational and health institutions. **Conclusions:** The dying process is determined by three types of important contextual stimuli: Age of the patient, nurse-patient relationship, and length of this relationship. Efficient coping processes were found in those nurses, who, within their professional preparation, thanatology courses were included. Main coping strategies found were: redefinition of death and emotional support through some type of religious belief.

Key words: Death; nursing care; nursing personnel (DeCS).

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Received: 27/01/2019
Accepted: 27/03/2019

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How to cite this article
Valle-Figueroa MC, García-Puga JA, Quintana-Zavala MO, García-Pérez Y. Experience of the nursing professional with regard to death and the process of dying in intensive care units. SANUS. 2019; (11): 19-31. [Access__ __ ___]; Available to:_____ .
month day year URL

INTRODUCTION

In the daily work of the health professional, especially in the ICU, dealing with the dying process and death of patients is a deeply stressful factor, whose consequence is emotional and physical strain[1] for said health professionals. Death is a natural part of life, and only during 2018, 14,916 deaths were recorded in hospital settings in the 72 municipalities in the State of Sonora, from which 8,747 were males, and 6,157 were females[2]. Main death causes were myocardial infarctations, chronic degenerative illnesses such as diabetes mellitus, and car crashes. But, regardless of the cause, any death is traumatic for the family and for the health professional, since they are usually unexpected or involve a long suffering process.

ICU form part of areas where patients experience a lengthy hospital stay and a significant number of deaths occur. Therefore, the nursing professional is forced to use tools that were received during his/her education in order to cope with such experiences[3-5]. From a social point of view, death is an issue more or loess disguised to some extent in everyday discussions of most people, who have to apply diverse coping mechanism in the face of such an event[1].

To understand this adaptation process to death, this research used the adaptation model of sister Callista Roy, which refers to the level of adaptation of a human being, understood as a point that is constantly changing and is comprised by focal, contextual, and residual stimuli that represent the standard of the range of stimuli that may the individual react by means of normal adaptation responses. Thus, adaptation is an interaction process, where feelings and practices, conditioned by beliefs, values, principles, and experiences, are expressed, which can be positive or negative for the persons[6, 7].

Innate mechanisms are embedded in the psyche, or genetics, of every person. These mechanisms allow that, in the face of stimuli, people build a form of life vision and respond to those stimuli. This is in accordance to what has been established within the Genetics Structural Theory, since subjects incorporate economic and cultural capital, this being understood as the significance meanings to any situation or object.

Related studies reveal that the experience of the death process that involves a patient, seen from the perspective of the nursing professional, is an event that can affect the nurse's personality, before which the nursing professional can take either a rejecting stand or a negativity stand, or it, that is, the experience the health professional has had regarding the death process, can help the professional in his daily tasks that involve the care provided to the health user in critical condition, and especially help the dying individual. However, this process can be conditioned by different situations, such as previous and own experiences regarding death, level of interaction between the nurse and the patient, and the construction of the meaning of death of every nursing professional[8-18].

Diverse studies have focused on quantitative aspects of the death and coping process, but the studies did not have an in-depth approach toward the impact that is produced by these experiences. Generally, these impacts produce stress, anxiety, absenteeism, or detriment of the quality of care. While from a quantitative point of view the situation is important, the number does not reflect the personnel's own experiences; thus, in this study the experiences regarding the death of patients are seen from the nursing point of view, and precisely from this perspective the following question is raised: what are the experiences of the nursing personnel in the face of the dying process and death of patients in an acute-care setting in a secondary care hospital?

METHODOLOGY

This was a cross-sectional, qualitative, and descriptive study because the experience to live the death process implies subjective knowledge of the participants, and cross-sectional because interviews were conducted at a specific point in time[19].

The selection of the participants was intentionally conducted. They are nurses who work, or worked, in the ICU of a secondary care institution. To select them, a typological classification was built with the following characteristics: length of the relationship with the patient (equal or longer than a week), age of the patient, prior experiences in the face of death, and age of the participant. The selection criteria for length of the relationship with the patient considered two groups: 1) A relationship of one week, and 2) a relationship of more than one week with the patient; for the experience in the face of death processes, it was considered: 1) if they had experience the process, or 2) if they had not experienced the process. With respect to the age of the patient, this was divided in: 1) Underage, and 2) of legal age; and finally, with respect to the age of the nurse, two age groups were considered: 1) Less or equal to 30 years, and 2) older than 30 years. Therefore, four typological groups were built in order to select at least one participant of each group who meet the criteria in each group.

Two elements comprised the instrument to collect the information: a) Personal data card, and b) semi-structured interview script. The socio-demographic data card included age, sex, labor seniority, academic level, thanatology training, and religious practices of the nurse.

The semi-structured interview script was based on focal and contextual stimuli of the nurse in the face of the dying process undergo by a patient.

For data collection, in the first place, the research protocol was submitted to evaluation to the Ethics and Research Committee of the Nursing Department of the Universidad de Sonora and once it had obtained a favorable opinion, it was proceeded to deliberately locate the study participants –based on typological criteria, that is, from direct contact, to subsequently request their participation;

once accepted, they were interviewed in the clinical areas, and during the time they had a chance to be interviewed. Verbal consent was requested from the participants in order to record the interviews.

With respect to the assessment of the demographic data, central and dispersion-tendency descriptive statistics was used. The qualitative information collected was recorded using an Olympus, Model VN-6200PC, digital voice recorder, to later on transcribe all of it using the software F4 and capture the interviews using the software Nvivo, version 7. Data were analyzed using inductive methods assessing the information given by the nurses interviewed.

This research adhered to the provisions established in the Regulation of the General Health Act in the Area of Health Research, which in agreement with article 17 it was considered as a safe research since only documentary techniques and methods through interviews were used.

In order to protect the identity of the participants, they are identified by codes rather than by their real names; however, the possibility that their real names appear in the research document was discussed, and the participants had no objections.

RESULTS AND DISCUSSION

Socio-demographic characteristics of the participants

Seven nurses participated in the study, who work in a secondary care hospital in Hermosillo, Sonora. Age ranged between 26 and 50 years, with an average age of 34.4 years. Three of them have their Bachelor's Degree; two have the Master's Degree; and two are specialists.

Innate Adaptation Mechanisms

One of the main mechanisms that are typically adopted by the nursing personnel, and especially during their first experience with respect to the death of a patient, is the use of the age of the patient to justify his death. In several societies, death often pose different meanings, and especially in western societies where older adults have lost value for the functionality of the social system, thus, collective imaginaries toward care typically change, when going from considering that the adult person had a high social value due to his experience for the functionality of the community, to consider him as a physical, emotional, and economic burden. By comparison, a high social value is assigned to children, and one indication of this is the time and resources that are used to make them productive people who allow social reproduction[20,21]. All the foregoing resulting from the idea of modern societies where production, instant gratification, and exclusion, mainly, prevail.

This aspect was seen in the case of the interviewee E1, who used this mechanism to reduce her grief in the face of death in function of the age of the patient.

> *... and yes, I felt, I remember, paralyzed, struck, first because it was the first time that one of my patients died, maybe, mmm I don't want to be nasty by saying that I wasn't sorry, but, that is, like, she was already an older woman, it is understandable, because of her age [...] (E1).*

Additionally, and as secondary strategy, the interaction with the user may generate a projection mechanism about the patient, and try to improve the quality of the care, as expressed by E2, who said that even though at first she felt "paralyzed, struck", subsequently, she was able to build a mechanism that reframed an empathetic feeling favoring the nurse-patient relationship[7].

> *[...] "We always think it can be our brother, our uncle. I know not all think this way, I know, each nurse has her own way of seeing things, but I do, personally, some times I think about the patient as if he were a relative of mine, and I try to give him comfort" (E2).*

Roy establishes that innate coping mechanisms are part of the human genetics, or humanism, stated using another semantic context. This can be seen in the response of E2, who stated that during the interaction mechanism with the patient she projects the situation toward the care of a relative; this differed with Gálvez, since, instead of showing detachment as a primary defense strategy, she showed greater empathy toward the patient[7,24].

Acquired Adaptation Mechanisms

Consistent with Roy, educational and health institutions set different strategies to help their members to ease their adaptation in the face of the death process. Resulting therefrom, the adaptation mechanisms acquired through courses and certificate courses that help the professional [24].

> *"The course I took on palliative care and thanatology have helped me a lot, sure, it helped, I see the author, that just to mention one example, we have the author, "the Ros", as her, who also suffered, and nothing, all her books, all her life, all that in some way, because she also passed through and transcribed it, then you say, well, why not, because one can see death as part of the life cycle, indeed" (E3).*

Social support through groups and courses that prepare the professional in the face of the death process, and the death of a patient, have been no doubt a key piece for the coping process of the nursing professional, as it was stated by E4, one of the nurses interviewed.

Primary Coping Strategies

Barriers

Detachment is among the main strategies implemented by the nurses in order to face the death process of a patient. The professional training processes are inscribed in the concepts of Field and Habitus introduced by Bourdieu[22]; these concepts state that cultural transmission of work forms are incorporated by nurses and operationalised in practice, which in the case of coping with suffering the trainers reinforce the idea of emotional detachment toward the patient. Although nursing is expressed as a good practice useful to establish a close relationship with the patients in everyday work, with respect to dying patients, detachment is noticeable, which allows not getting emotionally involved and, as such, avoid suffering resulting from the death of the patient.

> *"Professors always read us the Riot Act, that you should not get emotionally involved with the patient, not at all, which means that you are being professional" (E4).*

The former situation is contrasted in the comments stated by E5, for whom the interactions with the patient generate rapprochement that gives rise to emotional bonds, which are understood as a specific value given by the nursing professional to the patient, which increase during the care process and cause personal pain when the patient die.

> *"Ummm, I think that it was in that moment when I shut down, in order not to feel, that is how your mind shuts down, and that is, you do not have to feel, or, I don't know how to say that, it is just you are not affected, that is to say, since I didn't know the patient, I didn't say anything; this should not affect me, we put a barrier since it can affect us and don't let it go any further then" (E5).*

Roy states that copying is achieved through an interaction process, in which feelings and practices are involved, which are conditioned by beliefs, values, principles, and experiences. It was found that during the coping process the nurses interviewed showed feelings of denial, which lead to put into practice the detachment that is conditioned by principles learned during the professional practice.

Acceptation

Acceptation is another strategy proposed by Gálvez[7], within the coping process, and from the point of view of Kübler Ross acceptation is the last stage in the mourning process of an individual.

> *"I felt sad at the time, however, I didn't show it, but reflecting on it and on the diagnosis of the patient, well, I believe it was the best thing that could have happened to the baby" (E5).*

Acceptation follows after going through four prior stages (although not necessarily in this sequence), namely, negation-detachment, anger, negation, and depression, that is to say, after a process of meditation or justification of the death of the individual, as E5 stated it.

Secondary Strategies

As secondary strategy, the nursing professional has to look for social support in thanatology and religious groups, as well as psychological help, to alleviate the day-to-day work to deal with death and death process of health users.

> *"When we took this course, I felt a little change since we participated in many activities with the teacher who taught this subject, which helped us so we could be prepared to "let it go", when we go through these processes" (E6).*

Social support through groups and courses that prepare professionals to face the dying process and death itself of a health user has been, no doubt, a cornerstone for the coping process of the nursing professional.

The importance of including support material to prepare future health professionals to face dying processes of health users is crucial, since these professionals leave school with the right tools to face such situation, that although they are not always sufficient, they are of great help, as the nurse Brenda, who took a course on thanatology within her professional training, stated. According to Blumer's Symbolic Interactionism Theory, he explains that human beings direct their acts toward the things on the basis of the importance they have to them[23].

> *[...] "Note that one doesn't have to say, I'm going to try, I have this grief, I'm going to find the support of a professional, or something, to feel free and have peace of mind, no, no, never, you're carried away again, bla, bla, bla, by your rutine, and not really, you don't look for those helps, well, but... How do you overcome it? Yes, there were times where I went to church, whatever, and asked God for the patient, so he could regain his health"(E7)*

Seeking support, either emotional or spiritual, is located within the secondary coping strategies proposed by Gálvez[7]. In this case, E7 states that continuing with the work routine and visiting the death patient at the church and praying for him was an incentive during the coping process.

CONCLUSIONS

Death and the dying process is no doubt one of the experiences that distinguish the daily work of the nursing professional, which is conditioned by past and current experiences in the life of the nurse.

The dying process is conditioned by three types of important contextual stimuli, namely, age of the health user, the nurse-patient relationship, and the duration of the relationship, which is defined by the hospital stay of the patient. Efficient coping processes were found in those nurses who, within their professional preparation, took courses and certified courses where they received tools to face the dying process and death of patients.

Main coping strategies found were: barrier, redefinition of death, understood as a justification mediated by social ideas of the different stages of life, in addition to emotional support provided by some type of religious belief.

While the high quantity of female nurses made it easier to know their experiences, it is also necessary to know how death is experienced by male nurses, since within this research we only had the collaboration of female professionals.

The study provided elements that visualized experiences of nursing personnel who face the death of patients on a regular basis; and with this in mind, it is proposed to include in all curricula, both in undergraduate and post-graduate levels, a course on thanatology or palliative care, and to include within the hospitals a course-workshop on thanatology for personnel who work in the Critical Care Unit. As limitation of the study, it was considered the fact that interviews were made only to women, and male discourse was not included; additionally, forthcoming research shall consider the inclusion of different intensive care scenarios.

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