Reflection on death and dying in the ICU from a professional perspective in intensive care

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Abstract

This article is a reflexive analysis with bioethical concerns on death and the process of dying in intensive care from a professional perspective, employing the bibliographic review method. It should be emphasized that despite death being part of the working context of these health professionals, it brings about feelings of impotence, indifference and even of flight and denial. The professionals demonstrate uneasiness or even attempt to hide their real feelings about death. Death is thus conceived as loss, suffering, uneasiness, unhappiness, fear, absence and the end of everything. The present study evidences the difficulties experienced by health professionals in accepting the idea of death in an ICU where an intensive struggle for life occurs. Such difficulty is the result of contemporary education and of non-humanized training, removed from an awareness of death and the concept of the death process as part of life.

Keywords: Death. Terminal care, hospice care. Patient care team. Intensive care units.

Resumo

Reflexão sobre a morte e o morrer na UTI: a perspectiva do profissional

Este artigo trata de análise reflexiva, com preocupações bioéticas, sobre a morte e o processo de morrer na perspectiva do profissional em terapia intensiva, por meio do método de revisão bibliográfica. Busca ressaltar que esse processo, embora faça parte do contexto laboral desses profissionais, desperta sentimentos de impotência, de indiferença e até mesmo de fuga e negação, demonstrando desconforto ou, ainda, certa tentativa de camuflar o verdadeiro sentimento em relação à morte. Procura-se também discorrer sobre a morte concebida como perda, sofrimento, mal-estar, tristeza, medo, ausência e fim de tudo. O estudo evidencia as dificuldades sentidas pelos profissionais, ao admitirem a morte em uma UTI, local onde se luta intensamente pela vida. Constatou-se que essa dificuldade é fruto não apenas da educação contemporânea, mas também da formação desses profissionais, pouco humanizada e distante da conscientização da morte e do processo de morrer como parte da vida.

Palavras-chave: Morte. Cuidados paliativos na terminalidade da vida. Equipe de assistência ao paciente. Unidades de terapia intensiva.

Resumen

Reflexión sobre la muerte y el morir en la UCI a partir de la perspectiva profesional en cuidados intensivos

Este artículo se ocupa del análisis reflexivo de las preocupaciones bioéticas sobre la muerte y el proceso de morir desde el punto de vista profesional en cuidados intensivos, a través del método de revisión bibliográfica. Se busca resaltar que a pesar de que la muerte es parte del contexto laboral de estos profesionales, despierta sentimientos de impotencia, de indiferencia e incluso de evasión y negación, visibilizando incomodidad o algún intento de camuflar el verdadero sentimiento en relación a la muerte. Se busca también discutir sobre la muerte concebida como pérdida, dolor, malestar, tristeza, miedo, ausencia y el final de todo. El estudio evidencia las dificultades sentidas por los profesionales a la hora de verificar la muerte en una UCI, lugar en el cual se lucha intensamente por la vida. Se constató que esta dificultad es el resultado tanto de la educación contemporánea, como de la formación poco humanizada y distante de la concientización de la muerte y del proceso de morir como parte de la vida.

Palabras-clave: Muerte. Cuidados paliativos al final de la vida. Grupo de atención al paciente. Unidades de cuidados intensivos.

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Declara não haver conflito de interesse.

Death and dying are subjects that affect and incite powerful feelings in almost everyone, including health care professionals. No one remains umoved by the thought of an inevitable end, irrespective of who it is that is at risk of dying. When this possibility emerges as a result of illness or accident which forces a person to undergo hours, weeks or even months at the mercy of medication and continuous medical attention, the proximity or even the possibility of death reverberates strongly within those at its epicenter in a manner that is highly complex even to health care and other professionals that have experience in the field or those that are theoretically more prepared to face such situations. It is within the intensive care unit (ICU) that one can have a greater appreciation of the process of dying and its implications with respect to the relationship between the health care professional, the patient and the family.

Although the classic conception of the ICU still follows the cartesian-mechanistic model, which created a culture of detachment and coldness within health care professionals in their interaction with patients and their relatives, today, the health care community recognizes that a humanization of the process is the only viable path for working in such an environment. These new perspectives and practices within the ICU are directly related to the issue of death and dying, and the inevitable feelings that this involves.

This article is a reflexive analysis, based on bioethical concerns, of the subject of death and the process of dying from the perspective of the intensive care unit health care professional. As such, the article conducts a review of the relevant literature to base its analysis of the subject matter under review.

Death *versus* naturalness/normality

Death is a paradoxical subject: on one hand, it is seductive and serves as an inspiration for artists, transcending all artistic modes; on the other hand, it incites fear, fugue and terror. According to each individual's perception, it can signify absence or permanence; finiteness or eternity.

Within the set of more common conceptions regarding the subject is what is referred to as the natural understanding of death. Birth and death are both equally normal life processes. Generically speaking, living beings are governed by biological determinism, due to the fact that they are born, grow, mature and die. Similarly, from a religious perspective, death is dealt with in natural terms; more specifically, that death represents a moment of passing, not of finitude. However, from the religious perspective, death and the process of dying are also the object of beliefs, philosophies and specific rituals that may present themselves in a paradoxical way due to the differences that exist between the various religious conceptions and credos.

Although it incites fear within people, mainly due to the difficulty of dealing with one's own finiteness, death, much like the process of dying, constitutes a phenomenon of life itself. It can be characterized as an event that is inherent within life because, in a way, everyone is dying, albeit gradually, with each passing moment.

The manner in which one faces death, or the process of dying, has changed radically. If, for thousands of years, the process occurred over a period of approximately five days, currently it lasts, on average, five years; it was an event that was beheld by relatives, parents, friends, and even by the strangers that participated in the final rites. Death was thought of as something familiar, an inevitable element of life, and it was believed that that was how it should be treated, even though, at that time, there were already rites that aimed to keep the dead from disturbing the living [1]. The fear, therefore, was of the dead, not of death itself.

According to Ariés [2], the philosophy and the customs of contemporary living cultivate attitudes that attempt to repress, ignore or even defeat death entirely in an attempt to overcome our ultimate demise in search of immortality. Urbanization and the development of science and technology have promoted a significant increase in life expectancy and in quality of life. On the other hand, these changes brought with them a distancing from one's consciousness of the finiteness of life - or, more appropriately, the concept of death and the process of dying - due to it being directly affected by the extension of the period known as the final days, i.e., the time period during which is it possible to maintain someone alive [3].

Currently, the event of dying, especially in hospitals and specifically with respect to health care professionals, has become a symbol of failure and inefficiency. The health care sciences have become obsessed with the task of avoiding and impeding death from occurring, and the hospital has become the place where the most natural and frequent occurrences of life, such as pain, suffering and death, have come to be treated as something that must be avoided at all costs. However, as the avoidance of death has proven to be impossible, society has come to ignore it, isolating it from the social lives of its members, and emotionally, spiritually and

psychologically distancing not only the person that is terminally ill, but also his or her family members from the concept of death [4].

In light of this social intervention of death as a concept, the process of dying has been transformed into a source of anxiety for health care professionals when they are confronted with the feeling of failure that stems from the non-acceptance of death as a natural phenomenon. As such, various techniques and procedures are employed in the attempt to save the life of a sick individual; however, what actually happens, frequently, is that only the patient's suffering, and that of his loved ones, is prolonged [5].

There are reports from the past century in which severely ill patients, for whom no medical solutions to their maladies existed, were treated very poorly, to the point where they were placed in isolated areas, with no attention given to their well-being, as though the specter of their death itself were contagious. This approach to dealing with such patients created a barrier in the relationship between health care staff, the patient and his or her family members. Contact became very minimalistic, very superficial and devoid of any exchange of empathy [4].

The naturalness/normality of death was forgotten, replaced by a distancing, or detachment, of life within hospitals. In this sense, the various possibilities of hiding death, which manifest themselves as defense mechanisms, should be noted: negation, repression, intelectualization and detachment [4]. Such mechanisms, however, give rise to a perception that the health sciences are failing at their mission and are inefficient. As a result, death begins to be treated as a sickness that should be overcome and cured [5].

Within the health care sector, science and technology promote the extension of life through the use of techniques that offer a vast range of treatment possibilities, or even of maintaining the lives of patients that, in the past, would not have been afforded any chance of life, nor of living longer. However, health care professionals face a dilemma between their responsibilities and their technical capabilities, between their beliefs and feelings regarding death and what happens with the patient as he deals with the process of dying. Furthermore, health care professionals have to live with the dilemmas of the patient himself and of his or her family members, who are also enveloped in a complex multiplicity of feelings, beliefs, scientisms, and, above all, their perceptions regarding the real possibility of death befalling their loved one.

Death and dying from the point of view of the multidisciplinary staff of the ICU

As much as one avoids thinking of death, the event resides within the daily routine of everyone that works in the ICU, and, in many cases, the repression of the thought of death is impossible despite the many resources that are on hand to overcome it. The ICU is a specialized environment that has, at its disposal, the human and material resources necessary to deal with death; however, the it is, at the same time, one of the most aggressive and tense sectors within the hospital, for it contains patients that are terminally ill or severely debilitated [6].

Even though it is an area of the hospital that is designed for patient recovery, the ICU also houses patients in such severe circumstances that the unit is the only one entrusted [5] with the task of maintaining life in the face of death. The end, therefore, emerges as a real possibility and, notwithstanding the cultural imposition to attempt to evade the subject, one cannot flee from thinking of death, nor even from sensing its presence. Not only do these feelings and perceptions imbue the patient, they also equally affect his or her family members and the staff that oversees their well-being.

The manner with which this reality is dealt invokes, once again, the primary issue: ultimately, what is the relationship that these professionals have with dying and the process of dying? Their doubts, fears, insecurities and feelings are diverse and profound. The central point of the difficult process of dealing with death also harks back to the specialization and preparation of health care professionals, a process that is still largely incapable of producing professionals that embody scientific discipline, sound medical technique and humanity in their treatment of patients.

The ICU gives rise to an important paradox regarding its role and how it relates to the professionals that work there: some staff members view it as a place where patients die; others, who do not accept death, delude themselves by placing undue faith in the death defeating resources that have been developed by science and technology. In doing so, the latter category of health care professional loses their capacity for critical thinking upon believing that they can ameliorate the situations of so many terminally ill patients. Such a belief results in increased suffering for the patient, their families and the entire health care staff [5].

This dichotomy of roles played by the ICU – a unit that cares not only for patients that can be

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helped to recover, but also for terminal patients, as we have already seen [5] – fosters among ICU staff a desire to defeat death; however, it also puts them in a position where they have to deal with death on a daily basis. Furthermore, these professionals are, in fact, affected by this process, since, upon expressing the rational need to not let their daily work-related experiences interfere in their personal lives (because such experiences are laden with all of the vicissitudes that are characteristic of this type of contact), it is not possible for them to achieve such extreme levels of emotional detachment [7].

A qualitative study was conducted of members of a multidisciplinary ICU staff from a public hospital located in the western region of the state of Santa Catarina. From the data that was collected, study administrators were able to identify and classify four different groups of professionals. The first group conceives death as natural/normal and believes that it is a process that is as natural as birth. The second group views death dichotomously, characterizing it as something that produces order and disorder, something that creates sadness, pain, discomfort and suffering. The third group connects death with religious ideals, believing that, in death, individuals merely gain a passage to a plane of existence that is beyond what we can conceptualize in life. Lastly, the fourth group disguises death, viewing it with detachment, omnipotence, negation and professional defeat [8].

Another study, conducted with ten ICU nurses from a public university hospital, revealed that, beyond there being no uniformity in patient care, a kind of indifference also exists regarding emotional, spiritual and social aspects, and a overestimation of the capabilities of technical forms of treatment. Although the study highlighted the care that nurses took regarding the suffering of family members, the study found, overall, that these professionals find it difficult to view death as being part of the vital cycle of life; which also brings to light the fact that, in both the academic and practical realms of medicine, a disconnect exists in the preparation of health care professionals in facing all aspects of patient care [9].

The results of a study of 18 ICU adult care doctors from a general hospital indicated that these professionals presented the same difficulties as other health care professionals, whether it be in accepting death, or the manner in which they deal with patients and their loved ones. In addition, during such extreme circumstances, these professionals tend to suffer from stress, anxiety and a wide variety of emotional disturbances [10].

In analyzing these studies, one can deduce that the same doubts, fears or beliefs of the population in general are present in the lives of these health care professionals, and that these states of being cannot be eliminated completely during the exercise of their professions. On the contrary, when one thinks of a more humanized process, these perceptions should be contemplated and felt, mainly during extreme situations, such as in dealing with patients who face severe or terminal prognoses. The recognition that these professionals are, first and foremost, human beings who are involved in a tumult of emotions and responsibilities is the first step in fostering the proper development of these individuals to deal not only with their own feelings, but also with those of other professionals, the patient's relatives, and, above all, those of the patient.

As has been observed, with technical and scientific development comes the belief in the myth of immortality, which has been established in society at large and among health care professionals, in particular, those that tend to relate death to failure in their daily activities, as if they had not developed sufficiently as professionals if they cannot defeat it. As such, their preparation for dealing with the process of dying and of death itself is an aspect that has become (almost) ignored within the activities of the health care sciences. A study that was conducted with nurses and nursing technicians that work in neonatal ICUs at two public hospitals in the city of Natal, Rio Grande do Norte, confirmed this hypothesis in its identification of the feelings that these professionals have regarding the death of patients, showing that feelings of guilt, failure and negation are common among them [11].

However, in addition to the medical aspects, the practice of various treatments, diagnoses and the administering of medicines also involves "medicinal" concerns, which encompass each kind of act that is capable of promoting the well-being, or the consolation of, the unfortunate, such as medicines, various types of care, affection and respect for the person and his or her own beliefs and culture. The difference between the medical and medicinal aspects is the fact that the former depends solely on the involvement of the health care professional, while the latter is present not only in the lives of the caretakers, but also in the lives of those that receive care. Therefore, when the health care professional finds himself in the position of caregiver, among the usual attributes of a caregiver one must include not only the search for a cure, but also the understanding of how to deal with the death of that intensive care patient, and with his or her relatives, without

setting aside the responsibility of caring for oneself, as a human being that faces death on a daily basis [9]. Even though it is not always possible to attain this balance between the technical and medicinal facets of the practice of medicine, health care professionals should strive to achieve this equilibrium [12].

Among those responsibilities of the multidisciplinary ICU staff, palliative care procedures can be included, such as structural-mechanical tasks. A study that was conducted with ICU professionals from a Brazilian university hospital found that, although emphasis was given to aspects involving hygiene, aesthetics and physical comfort, such as the minimization of pain, frequently the reduction of psychological, spiritual and social suffering was left untreated, and the establishment of a friendly relationship between health care professional, family and patient went unaddressed [13]. Palliative measures remain ill-explored and are even considered inappropriate within the realm of the ICU, whose functioning is still based on mechanistic concepts [14], which is probably indicative of the presuppositions adopted by the undergraduate disciplines that are related to health care - among them intensive care practices, which do not take more profound theoretical approaches seriously.

The terminally ill patient has the same rights as other patients: personal support, the right to be kept informed and to refuse procedures or methods of treatment, and especially the right to respectful and ethical care. In addition, if the patient refuses to receive traditional forms of medical treatment, the palliative care measures that are given should be as effective as possible, and the hospital staff should provide nothing more than comprehensive care [1].

As is taught by Kübler-Ross [4], one of the aspects that may substantially favor the preparation of health care professionals is for them to think of their own finiteness, to acquire a greater consciousness of the inevitability of death and of the process of dying. The exercise of this thought process helps to develop one's capacity to gain a tangible perception of oneself, of who we are and of what we need, and, as a result, to develop a greater capacity in viewing our peer as a unique being, an individual whose needs must be respected. This is one of the pathways not only for understanding death as an inconceivable part of life, but also for fomenting the courage necessary to accept it when it is inevitable, shattering, as such, social taboos and contributing to changing the "antideath" mentality, which has become a mainstay in our culture and, by extension, in the comportment of health care professionals [5].

As health care professionals, the acquisition of such an understanding will allow them to treat their patients in a manner that is more holistic. According to Alves and Selli [15], the totality of the care, considering an efficient and humanized form of medicine, requires that a multidisciplinary team be capable of helping patients and their relatives cope with terminal diseases, providing them with support during this turbulent time, while also respecting their spirituality and beliefs as much as they respect their biological characteristics and rational decision making capabilities. Ethics, specifically bioethics within the health care field, collaborates directly not only in the preparation of health care professionals, but also in the manner in which they work, since it forms the basis for their manner in which they make decisions, and of their understanding of their role as a professional caregiver of terminally ill patients.

Within this theoretical and conceptual context, bioethics proposes an ethical examination of concrete daily activities and the acceptance of interpersonal differences [15]. Furthermore, bioethics demonstrates that the overall care of a patient that is facing the process of death is as important and gratifying as the process of helping a patient that can be cured. The ability to provide an honorable death with the least possible suffering is to provide care with dignity and respect [9].

The act of providing care, therefore, does not mean saving lives at any cost. On the contrary, it involves the preservation of life with dignity, a respect for each patient's time of dying, or their individual needs and desires, in addition to helping the sick person, even though that means that he or she may not be cured and, therefore, die [5]. The incorporation of this medical vision within the practice of medicine and health care is of utmost importance in regaining the humanistic character in the relationship between the patient, his family members and the professionals that help care for them. If this were to occur, health care professionals would be capable of acting in accordance with the directives of science and technical aspects, while, at the same time, not ignoring or repressing personal beliefs or sentiments and emotions that arise from the beliefs of each individual. In addition, health care professionals must also respect themselves and understand that they have needs, just as the terminally ill do, in at least one respect: their own quality of being finite.

Comprehensive care and medical training

Among the difficulties that are faced by the health care professional, inadequate training is most

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notable. In light of recent medical advancements, medical academic institutions have lagged behind with respect to the conveyance of knowledge and the adequate preparation of health care professionals to work in supervising death and the process of dying, which is a reflection of already-recognized taboo that exists among a large portion of the population regarding the subject of death. Medical training in Brazil often reproduces the overall perception within society that death is symptomatic of therapeutic failure, or, furthermore, that it represents a disrespect for life and a disconnect among health care professionals in the search for adequate forms of treatment. By extension, society distrusts that there is a disinterest in finding the cure, which is the only outcome that is perceived as acceptable, even in the face of the finiteness of life [16]. In many universities, finding a cure to a patient's suffering is still considered as the only acceptable outcome of a successful health care professional. Health care staff, by their own academic background, fight constantly for the maintenance of life and will not allow themselves to question, discuss or even consider the event of dying [16].

In Brazil, university curricula contain little specific content that aims to prepare medical students for dealing with terminal patients; on the contrary, what is most notable is an increase in the dehumanization of the student body within these institutions. Intensive care doctors report that, during university, they did not receive any preparation or training with respect to how to deal the feelings and emotions they must face during the practice of medicine within the ICU environment. This subject matter is actually received with surprise, such is the detachment that develops during the daily activities of these professionals [10].

This lack of preparation is exactly the opposite of what happens in many developed countries, where society has long discussed issues related to the finality of life, including the right of indivudals to a dignified death. Many universities and medical courses within these countries include in their curricula the discipline of thanatology, a mandatory course in the academic preparation of a diverse cross-section of professionals within the field of medicine. Many of the hospitals and institutions in developed countries maintain excellent thanatologists on their staffs, in addition to promoting specific programs for working not only with health care professionals, but also with patients and their relatives [1].

In Brazil, the technical and mechanistic model that guides the academic formation of health care professionals promotes what many hospital users and their families characterize as callousness, since the perception that is applied is that the health care professional should not involve himself emotionally, that there is no room for comprehensive care and procedures that are more humanized, especially when death, or the imminence of death, are being dealt with. This traditional academic development within universities and learning institutions in the field of medicine ignores the fact that these students and future doctors and nurses are, and will continue to be, human beings, with all the emotions, expectations and beliefs that that entails, and that patients, whether they are terminal or not, also share these feelings. In following this approach, such institutions do not recognize that taking the human aspect of medicine into account directly influences the well-being and quality of life of the patient. As a result of this trend within medical academia, a variety of defense mechanisms arises among health care professionals, such as emotional detachment, callousness and an overall difficulty in dealing with death [16].

In an attempt to explain this process of mechanizing the ICU, and of the intensive care professional himself, Oliveira [12] has described the daily routine of the ICU, which depersonalizes and deconstructs the patient. The process begins with replacing the patient's clothing and personal effects, if these have not already been removed in some previous setting, with hospital clothing. Afterwards, various technical procedures are undertaken regarding the type of bed that will be used and the life-support equipment that will be brought online, the filling out of forms, the proffer-ment of instructions and the explanation of hospital regulations to family members, without omitting such hygienic procedures as bathing and disinfection. In addition, the physical space itself is completely distinct from anywhere that could be familiar to the patient: the plaque on the door that prohibits the entry of strangers; the isolation of the unit, which is far from other sectors, even within the hospital itself; the absence of windows; the artificial lighting; the air conditioning that operates at a constant temperature; and the odor of medications and disinfectants. Everything that is present is planned out with ritualistic precision to achieve technical perfection in its operation, even if this is at the cost of transforming the patient and his relatives into mere statistics, totally devoid of their own personalities and vulnerabilities, who are submissive and dependent and lack lives of their own. This is how it is taught in the classroom, so, therefore, this is what occurs in the ICU.

The exaggerated degree of technicism, which is assimilated during university study, and the attitudes of more experienced professionals, acquired

during the exercise of their professions, comes into conflict with each health care professional's belief set, whether it be their credos and religious background, or the perceptions they hold that are shared by everyone. As such, many of these professionals were not prepared to deal with situations that involve death, in addition to not knowing how to act within their daily practice of medicine in such a way so as to discover what is important in this process.

This callousness and detachment is a daily occurrence in their interaction with ICU patients; notwithstanding, adverse feelings accumulate within each professional - feelings of dissatisfaction, guilt and self-negation. The academic backgrounds of these individuals emphasizes the characterization of health care professionals as heroes that save lives, which means, by extension, that they are capable of defeating death. As a consequence, when a patient dies, deeply negative feelings emerge, and, as a result, generally speaking, health care professionals become burnt out and patients suffer [11].

The Kübler-Ross studies demonstrate that health care professionals also suffer during the process of treating a person that is dying. These professionals tend to experience much difficulty when discussing the subject and in their search for help in resolving their own conflicting feelings [4]. According to the author: *At the beginning of my work with dying patients, I noticed that there were people in the hospital team who had the unexpected habit of denying that there were terminal patients under their care* [17].

The role of nursing departments in this debate should be considered with respect to intensive care units, since it is this department that monitors most closely and assiduously the daily lives of terminally ill patients and their relatives, even if the form of treatment that is provided is multidisciplinary. Treatment should indeed be multidisciplinary, for it presupposes that the comprehensive care of patients should, in fact, be balanced. In addition to promoting the integration of each agent that is involved in providing care, nursing professionals are directly responsible for procuring the resources that are necessary to improve the quality of life of the patient, and for adequately preparing him or her for the process of dying when it is inevitable [9-14].

The curricula of the majority of medical school courses pay relatively little attention to the manner in which a health care professional should deal with death and the process of dying among patients during the daily practice of their professions. There is an increase in the number of disciplines that focus on the development of technicians that are qualified to care for and prolong life, but are little prepared to assist and care for the terminally ill. However, medical schools with curricula that aim to humanize patient treatment are on the upswing, and, furthermore, there are professors that promote debate regarding the issue and encourage students to reflect on the feelings and emotions that are involved in health care, specifically with respect to death and the process of dying [18]. Considering that the purpose of nursing is to promote not only the integration of the multidisciplinary staff, but also the relationship between hospital personnel, the patient and his or her relatives, the insertion of palliative care techniques in the planning and guidelines of intensive care wards is of fundamental importance [14].

How should death and the process of dying be taught in universities? The issue had been debated for decades by the time Kübler-Ross proposed that seminars should be held to deal with it more systematically [4]. First, the recognition of the fragility of man vis-à-vis death [4], which is the first step in creating an environment that is more natural and normal, is indispensable; second, it is of fundamental importance to give voice to our own fears and anxieties [19], and these aspects should be dealt with during the academic development of health care professionals. Dealing with death and the process of dying, providing incentives to students, and extending these efforts to those that have already graduated and are practicing medicine and who are debating their beliefs, feelings and perceptions regarding the issue - such efforts make it possible to acknowledge what we are: finite. It also helps us to understand that, in being responsible for the health and well-being of our peer, even if he is terminally ill, we should care for him comprehensively, providing that patient with what he needs.

Among the most important aspects within this movement towards the humanization of care and the study of palliative care techniques, both of which are espoused by various disciplines and theoretical currents, lies the fact that, regarding health care, specifically with respect to the ICU, the professional attributes of health care professionals cannot be restricted to the simple maintenance of life; these attributes must also include the objective and subjective elements of comprehensive care, such as more precise prognoses of death, the use of stronger analgesics in controlling pain, as well as the adoption of more effective psychological treatment for the alleviation of anxiety and suffering [20]. This point of view is corroborated by the principles and underlying concepts of bioethics, which aim to

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maximize the application of ethics in the safeguarding and promotion of human dignity.

In this context, palliative care, as a discipline, is an indispensable component of comprehensive care, which is why medical schools should incorporate it as a fundamental concept in their curricula. However, the lack of knowledge or motivation among ICU professionals to work with palliative techniques has become evident insofar as such professionals allege that they were trained to merely treat, rehabilitate and cure patients [13]. In reformulating their curricula, medical schools should, therefore, incorporate the tenets of palliative care in their courses so that comprehensive, multidisciplinary care may effectively assimilate those principles, resulting in their application by future health care professionals in the exercise of their daily activities. This means that these doctors and nurses must abandon the mechanistic perspective - adopted by even the rare professors that so much as mention palliative care techniques - within their understanding of intensive care.

It should be noted that the principles of palliative care, or care that includes palliative efforts in the health care practices of the ICU, in addition to being of fundamental importance, also complement the academic development of nurses and doctors. These principles could be established by a national policy for palliative care, focused on caring for patients that are in critical or terminal condition, which involves comprehensiveness, communication and finality [13]. The humanization of health care is already recognized as a model for attaining more efficient comprehensive care, and is considered to be as important as the administration of medication and instrumental procedures [20]. In addition, although conditions are not yet ideal, the humanization movement has gradually been established and further developed, not only within undergraduate medical courses, but also in the practice of medicine itself. Comprehensive care, which has been elevated by the humanization movement, involves the following principles: that an appreciation for life and the perception that death is a natural process should be promoted; that life should not be unnecessarily prolonged nor the process of death accelerated; that suffering and other distressing symptoms should be alleviated; and that family and loved ones should be offered support during the patient's care and during the process of bereavement [6].

Another important aspect that should be an integral part of medical schooling is the role of the multidisciplinary medical staff in the creation of conditions within which the patient and his relatives can come to understand his illness, since this process not only aids directly in the development of a positive framework for facing the illness, with the purpose of recovering one's health, but also, when necessary, it facilitates and promotes an acceptance of the inevitability of death [21].

Discussion, debate and the teaching of this issue must be fostered in the academic development of health care professionals, and the study of palliative care techniques must be included in this process. Bringing death closer to daily life does not mean relinquishing the use of the available means of defeating, or delaying, it; it means recognizing human beings more holistically and understanding how ephemeral life is [19]. As such, it is understood that the responsibility for maintaining health is much more linked to caring for patients, promoting their well-being and respecting their individual qualities and the dignity of their beings, rather than simply of the application of mechanistic procedures that are incapable of changing the course of the lives of terminally ill patients.

Conclusions

Understanding the cycle of birth, life and death is complex and paradoxical. If, on one hand, we want to live, and live well, on the other we must consider and prepare ourselves for death; after all, one of the great truths of life is that it ends, we are finite beings. Even for those who believe that death, as a phenomenon, simply represents biological death, there are still aspects of it for which we must prepare ourselves. The finiteness of life is a fact, and the process of dying, especially when it occurs by way of illness, accident or any other situation that causes physical suffering, demands that everyone that has to deal with these situations have the understanding and knowledge to face them.

Therefore, one cannot underestimate how the imminence of death is capable of destabilizing a person. Death surpasses all human efforts to defeat it; we can even delay it, but eliminating it is impossible. The death of someone that is close is as capable of psychologically and emotionally staggering us as is the imminence of our own death.

Each of these aspects are present in the psychological and emotional lives of everyone; health care professionals are not an exception to this rule. When these professionals discover their vocation and decide to become doctors, nurses, nutritionists, physical therapists or practice in any other of the many health care professions, they do not remove themselves from the feelings, perceptions or beliefs

that are involved in death and the process of dying. These individuals also do not become immortal; to the contrary, they begin to live these moments of passing more frequently and with greater proximity.

As prepared and experienced as health care professionals may become in dealing on a daily basis with situations that involve death, these professionals are incapable of becoming more familiar with it; confronting death always incites conflicting feelings, such as those of failure, guilt and impotence. Each health care professional faces situations that are painful to a greater or lesser extent, which depend on factors such as the age of the patient, some feature of the patient that may remind the doctor or nurse of someone they close to, and the frustration at their powerlessness in not being able to rehabilitate the patient, among other variables.

These professionals are left to recognize that reflecting upon and understanding death and the process of dying is the best choice, not only to work with greater efficacy and dignity within the field of health care, but also to recover the understanding that death is a natural/normal phenomenon, an integral part of the life cycle.

The subject of death, because it generates such conflicting feelings among health care professionals, should permeate their academic development and training so they may come to view it as a fundamental component of human existence. Lastly, the humanization of caring for patients and their loved ones should be promoted in the reduction of the suffering and the difficulties they face in dealing with death, and should form the foundation upon which any activities that are undertaken within the context of bioethics are based.

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