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### Essay

## About death: To whom it may concern<sup>☆</sup>

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#### ABSTRACT

**Introduction:** One could say that disease and fear of death are the key issues that make most people seek medical help. However, it is striking to find that most of the time devoted to teaching at medical schools focuses on disease while death is simply unspoken. Death as a real and universal fact is a topic rarely discussed in a doctors-to-be classroom.

**Objective:** This essay is intended to make the medical reader aware of the fact that in addition to scientific or empirical criteria, there are other valid and enriching perspectives about agony, death and dying; i.e. the philosophical and theological perspective. To that end, the background is a recently published article in this journal that will be referred to in the next pages.

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#### Sobre la muerte: a quien pueda interesar

#### RESUMEN

**Introducción:** Podría decirse que la enfermedad y el temor a la muerte son los problemas principales que obligan a la mayoría de las personas a buscar ayuda médica. Sin embargo, sorprende que a la enfermedad se le dedique casi todo el tiempo de la enseñanza en las facultades de medicina y que la muerte se tome simplemente como algo implícito; pocas veces el tema de la muerte, como fenómeno real y vivencia universal, es discutido en las clases para los futuros médicos.

**Objetivo:** Por medio de un ensayo de reflexión, se pretende motivar al lector médico de que además de criterios científicos o empíricos, existen otras miradas válidas y enriquecedoras sobre la agonía, la muerte y el morir, como son la mirada filosófica y teológica. Para ello tomamos como base un artículo recientemente publicado en esta revista y del que haremos alusión más adelante.

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## Thinking about death

In their everyday practice doctors are confronted with death and they wrongfully allow theoreticians and philosophers to deal with it when in fact death should be discussed, scrutinized and even expected by every human being. Philosophers have approached the issue giving rise to famous and controverted statements such as the famous Epicurean sophism: "death is nothing to us, since so long as we exist, death is not with us; but when death comes, then we do not exist", or a pessimistic vision and somewhat more difficult to grasp concept: "Individuality for most men is so miserable and insignificant that death brings no loss to them" (Metaphysics of Death, Schopenhauer).

Dying and being born as Edgar Morin puts it, "is not just exceptional good luck, is an ontological mystery". Life is a constant victory over death and for us humans it brings about conflict that you may resolve well or bad. And, although death is a constant and the act of dying is part and parcel of our human condition, we do not get used to it so easily.

In the adult, death causes an array of intense and confusing emotions; however, it is not so much death that brings about such fears, but rather everything that surrounds death: agony, pain, helplessness and many other almost magical ingredients. Not in vain did Tolstoi say that the moment we are born and the moment we die are like two peepholes for us to see the after life.

In our environment there is like a tacit agreement to avoid talking about death; we live in a materialistic culture where death is excluded from the agenda that rules the lives of modern people so we seek everything that helps us to forget our reality. The truth is that a thorough existence does not promote the extreme emotions that actually impregnate the lives of so many; it is only the sense of accomplishment that gives death some meaning.

In primitive cultures, life and death were supra-individual phenomena and not events to be confronted since people did not die but rather traveled to a place to be met by those who left before them. Everything was like a long chain. In brief, the secret of life was death because they believed in life after death and death was just a different way of existing. The dead were more powerful than the living and people counted of them. In the dead-living relationship the dead could harm the living but the opposite could also be truth; in other words, the living could take advantage of the superior knowledge of the dead and that is why the dead were often consulted and some times they were even called Gods (1 Samuel, 28, 13).

According to the Jews, the cult to the dead was exaggerated and it could compete against the cult to Yaveh, trespassing the first commandment: Love thy God. That is why people began to walk away from those cults, except for some cultures such as in some Mexican regions and in many areas in our own country. To solve the problem, Leviticus did away with the exaggeration of some funerary rites (Lev 19, 28; 21,5 ss; Deut 14,1)

For Israelis, death was a complex reality and in their view, weakness, illness, imprisonment and oppression by the enemy were some kind of death. Sick people, who are unable

to do many things, are like dead. A.R. Johnson said: "in the strictest sense of the word, death for the Israeli is the weakest form of life and thus any weakness is in some way like being dead".

But death is not only discussed by the various religions; literature and poetry have also dealt with death in many broad and wonderful ways, mirroring our human concerns and dwelling into the issues that affect us all, and particularly in reference to the most poignant of all which is death. Unamuno in his book "The Tragic Sense of Life" said that the only real concern he had was the issue of death and it tormented him throughout his life. Rilke the poet complained that we were not allowed to die our death because just as everyone has a life, everyone also has his/her own death.

## Where to die?

Evidently, where you die is one thing and another is where you would like to die; this is a multi-faceted issue. Though little research is available and it is usually non-conclusive, experts say that there are factors that play a determining role when there is a difference between the preferred place and the actual death place. These factors are the socio-demographic characteristics, health-related factors and personal and social resources.

*Socio-demographic characteristics:* The place of death is closely related to other factors such as age, sex, education and geographical area; thus, the elderly, women with a high educational background, and the inhabitants of urban areas, usually die at home.

*Health-related characteristics:* The characteristics of the disease and disability including for how long has the patient been sick, treatments required, complexity and intensity of treatment, all have a significant impact on the place of death. As expected, a treatment that requires complex medical technology makes the caretaker's job more difficult at home.

*Personal and social resources:* The characteristics of the formal and informal support system, particularly the close relatives, play a preponderant role on the place of death. It has been shown that social support networks, health care systems and tanatologic support groups, are strongly related to a higher rate of patients who die at home. Moreover, patients with strong family support and a younger caretaker, have a higher tendency to die at home. On the other hand, easy access to hospital services and to extended hospitalization institutions predispose to dying in the hospital.<sup>1</sup>

A survey in China found that 92% the elderly between 80 and 105 years of age, died at home.<sup>2</sup> In the United States, 58% of the elderly die in hospitals, 22% at home and 20% in nursing homes.<sup>3</sup> With regard to Alzheimer's patients, 40% died at home, 30% in hospitals and 30% in geriatric homes.<sup>4</sup>

A study in Belgium found that half of the people over 60 die in hospitals, one-fourth in nursing homes and one-fourth at home. The probability of dying in a hospital was higher for females and lower in the very old. The authors concluded that the place where an old person dies is mainly determined by social factors.<sup>5</sup>

This is in contrast with a survey mainly among elderly people who were hospitalized due to cardiopulmonary disease, asking about where they preferred to die. Almost half of them (43%) said that their preferred place was at home, 48% preferred the hospital and 9% did not have a clear answer. The choice was determined in the former by the desire to be in a family environment, surrounded by their loved ones and in the case of the latter, because they did not want to become a burden to their families or concern about the adequacy of care.<sup>6</sup>

An Israeli study done in over one thousand people over 70 years of age, asked directly about their preference for the place of death. The findings showed that 70% of the interviewed preferred dying at home, 23% preferred dying in a hospital and 5% in a nursing home. When comparing those who preferred dying at home against those who favored institutionalization, it was significantly evident that the former were married, with solid economic status, lived with someone else and their residence was in a rural area. It was also determined that the elderly who preferred to die at home suffered from less severe illnesses, experienced less somatic symptoms and were less disabled as a whole. Furthermore, those who preferred dying at home expressed greater life satisfaction and experienced less mental health issues than their counterparts. In terms of social support, those who preferred dying at home showed significant greater trust in their relatives and friends and were in more frequent contact with their loved ones, in contrast with the elderly who preferred dying somewhere else. The multi-varied analysis showed that social contact, family trust and housing adjustments were statistically significant factors in the preference to choose the place of death. Moreover, personality traits such as self-esteem and a sense of control were not predictive of any preference for the place of death. According to the researchers, their findings suggest that the elderly are realistic in their preference when recognizing that a dignified death at home is mostly dependent on the social support than on their intrinsic wishes.

Finally, the authors consider that caring for a loved one who is about to die is a very demanding task that may result in an overwhelming physical and emotional stress. The recommendation that in order to have a larger number of elderly patients dying at home, there is a need for greater support to family caretakers so that they can improve their skills to cope with the situation. This may be achieved through specific training programs involving volunteers, friends and neighbors, to help with the chores and the emotional factors inherent to the process of death.<sup>1</sup>

The Colombian Journal of Anesthesiology recently published an interesting article about the preferred place to die for elderly living in the Spanish isle of Ibiza. The authors interviewed 105 people over 64 years of age (mean 75 years), who visited different departments of a hospital (emergency room, home visits, ICU, among others). Two thirds of the interviewed said that their preferred place to die was at home, one-fourth said they preferred the palliative care unit and only 7% preferred the ICU. Other findings in the study are consistent with the literature; for instance, the findings showed that people who live with their family mainly prefer to die at home, while very ill or disabled patients who cannot cope with

their daily activities have a tendency to prefer the hospital to die.<sup>7</sup>

Nowadays, the doctor must take care of a larger number of elderly patients and as people age the risk of dying increases exponentially. If we recall the three basic principles of bioethics, we then understand that everyone is entitled to medical and palliative care for a dignified life till the last day of their lives (principle of justice); we must provide adequate medical care for life quality rather than quantity and hence avoid the mistake of therapeutic nihilism (refusing to do the right procedure simply because the patient is old), or the mistake of having very elderly patients undergo extremely invasive procedures leading to increased costs and extending the agony rather than relieving suffering prior to death (principle of doing good rather than evil). Finally, the wishes of the elderly should be respected to choose how, when and where to die (principle of autonomy).

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## Conclusion

Death is a fact inherent to every living creature and particularly to us, human beings. While in the animal kingdom the instinct of life preservation makes animals avoid death, humans exhibit a complex behavior when confronted with death. Such complex approach to dying includes how we would like to die, where and when. If doctors are not prepared to address this situation with their patients, certainly every medical and therapeutic process shall be incomplete. This article is an invitation to reflect on this topic, not just as doctors, but also as individuals with a finite life.

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## Conflicts of interest

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