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The importance of the environment in the dying process: humanizing space

Abstract

This reflection describes the experience of people at the end of life: their progressive physical deterioration and increased dependence, which often contrast with the prevailing social view of valuing health, autonomy and vitality. This reflection mobilizes the knowledge and care of nurses in their day-today work in an acute care unit, focusing on the construction of nursing care for end of life patients and their families. At this stage of life, palliative care is essential and aims to offer comfort. Therefore, as long as the nurse can be with the person and their family, it helps to overcome the frailties of the person/family inherent in this stage of life.

Keywords: nurses, person at the end of life, family, fragile body

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Introduction

In a study carried out by Frias,[1] the reality of patients is disconcerting. These people face a physical transformation that is at odds with the standards of beauty and health idealised by society. They may be disfigured, with marked physical changes that alter their appearance, as a consequence of the therapies. Cachexia is common in many diseases, leaving the person with a skeletal appearance, among other transformations. In addition, extreme frailty and increasing dependence for all daily activities are realities that many people face at the end of life. For many, this loss of independence can be the hardest part to cope it.

The fragility of the other: how to deal?

The changes that patients face challenge society to reconsider its values and reflect on the meaning of human dignity. In the context of the end of life, dignity lies not in appearance or independence, but in the respect, care and compassion offered to the patient and family. In the study by Frias,[1] preserving privacy is also an integral part of what nurses call helping to provide 'the best care', i.e. care in which everyone feels comfortable.

Below are the conditions that contribute to the realisation of 'the best care'

Ensuring the privacy of the patient contributed to building a care process in a relationship in which both were dealing with the excretory body and in which the nurses safeguarded the dignity of the person. In 2004, Gallagher[2] stated that dignity is based on respect, which leads to the preservation of a person's identity, and that the loss of this identity occurs in maladjusted circumstances in which they feel incompetent and vulnerable. In the acute hospital, practices are demanding, but it is also in this context that nurses have found routine tactics to ensure privacy in death.

Ensuring privacy also involved nurses being creative and demanding at a supreme moment, which seems to be everyone's last encounter with their life. This was how the death of another person was seen, so we chose to separately set out the ways of ensuring this privacy, such as - Creating a cosy environment - whose intentional interventions by nurses led to ensuring privacy in the dying process at the same time. In the days leading up to the death, the nurses provided these people and their families with as many conditions as possible to ensure their privacy and serenity. The room provided was sometimes the one the patient was in. Patients remained silence, eyes half-closed, and talk about personal matters in private with their families and friends for a few moments.

These strategies resulted in greater serenity for the patient and their family. The environment created helped them to be 'more at ease' and 'forced' families and friends to withdrawn to the patient. In this environment, which was not intended to be as bland or neutral as hospital rooms, we could find flowers, postcards, photographs and other personal objects. The family and nurses could leave the door to the room half-open to avoid noise or glances from other visitors. These were strategies intended to observe the patient and, at the same time, keep the environment as quiet as possible. These strategies legitimise the importance of a physical and emotional environment in the dying process, and aim for a human experience.

Main strategies listed

Welcoming environment: Unlike the neutrality of hospital rooms, the environment is personalised with flowers, postcards, photographs and personal objects. These elements help to create a comforting family space that reflects the patient's life and identity, bringing emotional comfort to everyone involved.

Family closeness: The presence of family and close friends is encouraged, creating a space of intimacy and support. The phrase 'forced families and friends to gather around the patient' suggests that the environment favoured closeness and bonding, allowing loved ones to be close during the final moments.

Control of the environment: The practice of leaving the door of the room half-open has the dual function of protecting the patient's privacy, avoiding prying eyes and external noises, while allowing surveillance by the team, which contributed to maintaining a calm environment.

Serenity for those involved: These strategies are designed to bring greater serenity to the patient and family. Taking care of the environment, being close to loved ones and reducing disturbing stimuli help to create a climate of peace, which can be essential if the dying process is to be more serene and less distressing.

These practices show a person- and family-centred approach, valuing the dignity and comfort of the patient in their final days. They recognises that the end of life is a profoundly human moment and that the environment and emotional support play a crucial role in how this phase is experienced. Thus, it can be seen that in this space, the strategies developed by the nurses in some care encounters involved surrounding the patient's body as in 'mobilisations', preventing her from falling out of bed. Their knowledge of him and his family and the journey they had travelled together led them to create and solidify emotional bonds. We would also emphasise that the progressive transformation of the patients' bodies had led to a growing intimacy with the nurses' bodies which, if they had shared them before, now increasingly entrusted/ surrendered them. This led to a commitment on the part of the nurse's body to get closer and closer to the patient's body, and it was in this private environment that a growing closeness between the nurse and the person at the end of their life and their family developed.

This privacy created around death had an influence on the families' behaviour, leading them to withdraw into the room with great dignity. It was a strategy that had a dual intention: on the one hand, they accompanied the patient and, on the other, they didn't 'bother the service'. After death, the corpse was kept in the room, covered for a while. If the family was not present, it could remain in the ward for some time until they arrived, if they had expressed this wish previously. It was a strategy used by the nurses with the intention of 'looking in private as much as possible'. The practice described reflects a sensitive and respectful approach to handling the body after death, centred on the emotional needs of the family and the dignity of the body. This strategy involves keeping deceased `s body in the room for some time after death, covered, until the family has a chance to arrive, if they are not present.

Main strategies listed

Respect for the family's time: By keeping the body in the room until the family arrives, the nurses show deep respect for the wishes and needs of the deceased. In this way, the family has the opportunity to say goodbye in a proper and personal way, without rushing or interruptions, which can be a moment that has na impact on the grieving process.

Privacy: The strategy of 'looking in private as much as possible' suggests a concern to ensure that the body is treated with the utmost dignity and respect. Keeping the body covered and in a private environment avoids exposing to prying eyes.

Humanising post-mortem care: This practice humanises care even after death, recognising that mourning is a delicate process and that the family needs time and space to begin to process the loss.

Dignity and serenity: By preserving the dignity of the deceased and providing a serene environment for the family, the team helps to create a meaningful experience.

These practices reveal a continuum of care that goes beyond the moment of death. This is demonstrated in the phases of the life cycle, recognising the importance of rituals and private moments that can be essential for the beginning of the grieving process. For example, Nurse Maria recounts a case in which, after informing her son of a patient's death, he came to meet his mother and, in that private setting, was 'allowed' to lie down next to the corpse, after asking the nurse if he could do so. Surprised, the nurse thought that this young man must have had a very affectionate relationship with his mother and possibly wanted to have one last hug.[1]

In these situations, where norms and routines were broken, the nurses emphasised their involvement and the bonds of friendship that united them with the patients and their families. These experiences contained feelings that needed to be shared and expressed in a private space with the nurses and families, but which the context made impossible. The focussed experience was lived in harmony given the uniqueness of the situation. In this sense, the nurses experienced unique encounters, because the end of life and death occupied a large space in a care relationship and this gave them the perspective that they were being taken into an 'ignored' world.

We stress that 'Ensuring privacy in death' guided nurses to reorganise their care in order to build it in harmony with the patients and thus put the harmony of bodies into perspective. The attunement of bodies was a challenging way of sharing them, not without first clarifying some issues. The approach described for interacting with a person at the end of life emphasises the importance of personalised knowledge and communication tailored to the patient's individual needs. This involves not only understanding the person's preferences and wishes, but also integrating the emotional and bodily aspects, which are inseparable in this context.

Key elements of this approach

Personalised knowledge: Having a deep and personalised knowledge of the patient is essential. This means getting to know their history, values, fears, hopes and way of expressing themselves.

Sensitive communication: 'Discovering the best way to communicate' suggests that communication with people at the end of life should be carefully adjusted, respecting the person's rhythm and needs. This can include the use of words, gestures, tones of voice or even silence, depending on what is most comfortable and understandable for the patient.

Clarifying issues: The practice of 'clarifying issues' indicates the need for mutual understanding. Clarifying doubts, ensuring that the patient understands their condition and what is happening around them, or helping them to express their wishes and feelings.

Integrating bodily and emotional potentialities: Discovering bodily potentialities highlights the importance of recognising the patient's remaining physical potentialities while observing their emotional state. In practice, this means that the way a patient communicates or responds to care is a reflection of both their emotional state and their physical capabilities. The two dimensions are closely interlinked and cannot be separated in care practice.

Inseparability between emotions and body: It is not possible to dissociate emotional potential from bodily potential because the body and mind work in harmony. An example of this might be how physical pain can intensify emotional suffering, or how a calm emotional state can, in some cases, help relieve physical symptoms

Conclusion

Interaction with the person at the end of life is mindful, and adapted in a personalised way to meet the unique needs of each person. This requires sensitivity, empathy and a deep understanding of the person in an integrated and inseparable way.

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None.

Conflicts of interest

The authors declared that there are no conflicts of interest.

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