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Death and die in the hospital: a social, spiritual and ethical look of students

Morte e morrer no hospital: um olhar social, espiritual e ético dos estudantes

Muerte y morir en el hospital: una mirada social, espiritual y ética de los estudiantes

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ABSTRACT

Objective: Identify the social, spiritual and ethical implications that have the death process and die for nursing students. **Methodology:** A qualitative approach, of a descriptive character. Sample comprised of 19 fifth-year nursing students. The data collected were submitted to content analysis precepts, analyzed in the light of the principles of bioethics and related to the Theory of the Peaceful End of Life, by Ruland and Moore. **Results:** Social implications are mainly related to experiences and the family approach, the spiritual meaning is linked to the transcendence of the spirit with an explanation that people are composed of a biological body that ends with death, and the stories about ethical implications show the importance of humanized care and the meaning of a dignified death. **Conclusion and implications for practice:**Self-reflection about the meaning of death and its process, helps the student to respect the values and beliefs of the patient and his family regarding the process of finitude, and thus the dignified care. It is highlighted the nursing education process in relation to ethical aspects and the end of life.

Keywords: Attitude to Death; Nursing Education; Hospital Care; Ethics Nursing.

RESUMO

Objetivo: Identificar as implicâncias sociais, espirituais e éticas que tem o processo de morte e morrer para estudantes de enfermagem. **Método:** Abordagem qualitativa, de caráter descritivo. Amostra composta por 19 estudantes de enfermagem do quinto ano. Os dados coletados foram submetidos aos preceitos da Análise de Conteúdo, analisados à luz dos princípios da bioética e relacionados com a Teoria de Final de Vida Tranquilo, de Ruland e Moore. **Resultados:** As implicâncias sociais são relacionadas com as experiências prévias e a abordagem familiar, o significado espiritual está ligado à transcendência do espírito com a explicação de que as pessoas se compõem de um corpo biológico que termina com a morte, e os relatos sobre as implicações éticas mostram a importância do cuidado humanizado e o significado de uma morte digna. **Conclusão e implicação para a prática:** A autorreflexão acerca do significado da morte e seu processo, ajuda o estudante a respeitar os valores e crenças do paciente e de sua família em relação ao processo de finitude, e assim a entrega de um cuidado mais digno. Destaca-se o processo de educação em enfermagem em relação aos aspectos éticos que envolvem o final de vida.

Palavras-chave: Atitude Frente à Morte; Educação em Enfermagem; Assistência Hospitalar; Ética em Enfermagem.

RESUMEN

Objetivo: Identificar las implicancias sociales, espirituales y éticas que tiene el proceso de muerte y morir para estudiantes de enfermería. **Metodología:** Abordaje cualitativo, de carácter descriptivo. La muestra estuvo compuesta por 19 estudiantes de enfermería de quinto año. Los datos recolectados fueron sometidos a los preceptos de Análisis de Contenido, analizados a la luz de los principios bioéticos y relacionados con la Teoría del Final Tranquilo de la Vida, de Ruland y Moore. **Resultados:** Las implicancias sociales se relacionan con las experiencias previas y el abordaje familiar, el significado espiritual está ligado a la trascendencia del espíritu como una explicación de que la persona se compone de un cuerpo biológico que termina con la muerte, y los relatos sobre las implicancias éticas muestran la importancia del cuidado humanizado y el significado de una muerte digna. **Conclusión e implicación para la práctica:** La autorreflexión acerca del significado de la muerte y su proceso, ayuda al estudiante a respetar los valores y creencias del paciente y su familia con respecto al proceso de finitud, y por lo tanto, a propiciar un cuidado más digno. Destacamos el proceso de educación en enfermería con respecto a los aspectos éticos implicados en el final de la vida.

Palabras clave: Actitud Frente a la Muerte; Educación en Enfermería; Atención Hospitalaria; Ética en Enfermería.

INTRODUCTION

Currently, the criterion used to define death is brain function, because technological advances have made it possible to maintain cardiac and respiratory functions through life support measures, while nothing can be done to maintain brain functions. Death is not only the end of human existence, but it is preceded by different forms of losses that are part of human development. Many authors consider death as one of the few certainties in life that derives from a progressive phenomenon that begins at the time of conception.[1-3]

According to the above, death is not strictly a biological event, but a socially and culturally constructed process. The concepts of death have changed over time, which has already been considered as a natural process. From the twentieth century, death began to be seen as something that simply must be hidden, forbidden and denied, leaving aside the mourning and farewell rituals that were usual mainly in the home environment. Currently, death as a process has been medicalized. Therefore, in Western society, death ceased to be part of social life, dissipating the exchange of experiences among people about the process of dying.[4]

Death has been treated by society as a condition of life, whose analogy between man and death is different from what it has with other transitory phenomena. It represents the temporary being that we all are, and our existence, as beings, is directly connected in this perspective.[5]

The approach with the death of the other during the care process can generate concerns for the nursing professional because this contact can generate fear and anguish due to the awareness of the end and the fragility of life. Therefore, the nurse should try to deal with the feelings raised by this approach and everyone has to live or experience the sensation of seeing their patients die, in many cases, with few psychological tools, little institutional support and ignorance of techniques and therapeutic strategies of coping and self-help that they should have acquired during the nursing education process.[6] When the nursing student enters the field of hospital care in his academic training process, when witnessing the death of the other, he reflects on his own death and that of his loved ones, perceiving as finite and mortal.[5]

Throughout the training process, the professional is trained to commit to the preservation of the patient's life, therefore, his academic education is directed by the care of the patient's cure, and this result is a sign of professional satisfaction, this characteristic reinforces how presence of death in general care routine feelings of lack of preparation and abstinence.[7]

It is known that there are shortcomings in academic training in relation to the issue of death which leads to student insecurity in relation to the experiences of the death and death process. Facing this process is a unique experience for students, which goes far beyond technical and scientific knowledge or academic training, but influences their cultural values and their life history, which will be responsible for addressing the possibility of the finitude.[8]

Most nursing schools have many contents dedicated to promoting, maintaining and recovering health, but few contents related to the end-of-life process. There are several studies that conclude that nursing students do not feel prepared to face this process and therefore, deliver quality care to the dying patient, due to the lack of preparation in academic training.[3,9-12] And this situation is problematic since there is a very high degree of emotional involvement of the nurse in the care of the dying patient and the quality of care may be conditioned to the attitude and the fear of death.[13]

Nursing plays an important role in health services, since it falls to the health care of the individual and society, for the moral qualities and virtues and for the sacred character of human life. However, information and knowledge have no major impact on patient care, because ethics and moral values have been lost and consequently the prestige and recognition of nursing does not progress in society, as it seems that professionalism and the update of new technologies exceed the values of the care delivered.[14]

Thus, as the science of care, an existing theory of the human relationship, guides the nursing profession with the understanding and application of an ethical-moral praxis that promotes, protects and provides human dignity throughout life. For the past 30 years or more, the science of care has transformed nursing by demanding a higher ethical perspective of human dignity in the way nurses practice, educate, research and develop the profession.[15]

Theory of the Peaceful End of Life (TPEL) by Ruland and Moore proposes that the objective is to provide the best possible care through the optimization of care, which can be understood as integral care, aimed at provide well-being, quality of life and, consequently, a peaceful death, prioritizing the family as fundamental to the final process of life and moving away from a technologically advanced treatment.[16]

This theory is appropriate for the theme of the death process, based on the classic Donabedian model of process and outcome structure, where the structure-context is the family system (the terminal patient and his relatives) that is receiving care from professionals in a hospital unit, and the process is defined as nursing actions aimed at promoting the following results: 1) absence of pain; 2) feel well-being; 3) feel dignity and respect; 4) feel peace, and 5) feel the proximity of your relatives and caregivers.[16]

Therefore, the objective of this article is to identify the social, spiritual and ethical implications of the death process and dying in the nursing student.

METHOD

The research was carried out with a qualitative approach, allowing to describe the perception, beliefs, experiences of nursing students in the face of the death process and the acquisition of skills for practice when faced with this process. Descriptive in nature, allowing to investigate and deepen a phenomenon little studied in

the university area, such as the perception that the undergraduate student experiences in relation to death and the process of dying, related to the social, spiritual and ethical implications.

The study was conducted in the city of Punta Arenas, in the XII Region of Magallanes and Antártica Chilena, at the University of Magallanes, School of Health Sciences, Department of Nursing. The research was approved by the Commission of Scientific Ethics in Human Beings of the University of Magallanes through document No 047/CEC/2018.

The choice of the sample was intentional. The universe was composed of 61 students enrolled in ninth and tenth semesters in the Nursing School of the University of Magallanes, during the academic year 2018. The student who participated in the study should be studying the first and/or second period of Professional Internship at the Clinical Hospital of Punta Arenas at the time of data collection, as an inclusion criterion, this is how the number of possible participants in the study was reduced to 36 cases. The sample size was carried out through the inclusion criteria mentioned above and met the theoretical saturation criteria, which was composed of 19 students.

For the data collection, it was carried out in stages that are detailed below: first, the students of the Nursing School who met the criteria for inclusion of the sample were selected, the contact was made personally in their places of Professional Internship and others through telephone communication, where the day and time of the interview was also coordinated, which was carried out in university rooms previously requested for this purpose, the mobilization payment in transportation was offered in order not to cause monetary expenses of transfer for the student. Students who signed the informed consent approving to participate in the study, were informed of the objectives to be achieved, doubts and questions that were expressed were clarified, and they were informed of the confidentiality commitment of the investigation.

The data collection technique was carried out through the semi-structured interview, which was recorded with the participant's authorization, performed between the months of September and October of the year 2018. After the recording of the interviews, these were transcribed in Word Program and saved on external hard disk, to help the treatment and analysis of the data, after transcription, the interviews were organized according to each objective of the study, that is to say grouped by similarity in thematic sets.

The data collected were submitted to the content analysis precepts, and the data collected during the entire investigation was interpreted and recorded to facilitate its study,[17] under the gaze of bioethical principles and briefly related to the Theory of the Peaceful End of Life, by Ruland and Moore, developed in 1998.

RESULTS

According to demographic data collected from the 19 cases: 16 female, 3 male; ages ranged from the range of 22 to 38 years old; all single, 3 of them in living with partners, of these, 14 students declared themselves having a religious belief; 13 of them belonging to the city of Punta Arenas, while the remaining others belong to other regions of the country. All of them had completed or were performing the Professional Internship in different hospitalization services. Three categories were developed from the data analysis: The process of death and die: a social view from the students; The process of death and die and its spiritual meaning and Ethics accompanying the end of life.

The process of death and die: a social view from the students

Nursing students begin hospital care practices in the fifth semester, it is here that they begin their first contacts with people who require various nursing care. All students interviewed reported having had experiences with the process of die and death, either with close people or with patients:

> *When it comes to patients, a patient has never died with me, yes I saw that suddenly we were working with a patient of a coworker and the next day we arrived and the patient was not there, but me, never a patient has died. (E6)*
>
> *I was in a service where the user profile was that did not know that there was a higher mortality rate, I did not have to see when a person died but if I do had to see how the process of agony of the person and in that same period in the I was there to see. (E8)*
>
> *In some practice I had to attend a person who had died. Attend and see the whole process that is done when a person dies in a hospital. (E14)*
>
> *Because I was the one who found her, I found her purple, she wasn't breathing and had a pulse, but it was shocking because I had never seen it as a stoppage itself. (E5)*

In the questions about the meaning of death and the death-die process, the students mentioned various ideas, among which the understanding of death as an integral part of the human life cycle is highlighted, as an event inherent to the vital process according to the following statements:

> *First, for me it is a natural process, it is a difficult process that all people have to go through, but I accept it as a natural process. (E11)*
>
> *Actually, death is a natural thing, I think that at some point we are obviously going to die and we have to take it as normally as possible. (E17)*

The emotions that accompany the shock of witnessing a death in the hospital context sometimes accompany the interviewees to the home.

> *And well, after I left the hospital, feeling bad, I called my mother, I started to cry, I had never seen a person die. (E6)*

> *But it was shocking for my first experience where I saw real people running in the service and all crazy and that his has died and the family was there, we had to do that procedure where we have to take him to pathological anatomy. (E7)*
>
> *He was agonizing all the time long, I had to take him to the morgue, that really struck me, it was a social case, so for me it was very impressive. (E10)*

The bond created with the patient is recognized by the students interviewed as an important factor when accepting death.

> *It depends on the bond that I have created with the person or if I know him for more time, but it is still difficult to know what can happen after the process, it is difficult. (E8)*
>
> *When you really focus on helping those people and something happens to you, I think it hurts, because you not only give your knowledge and practice, but you also give part of yourself to all those people. (E14)*

One of the difficulties pointed out among students is caring for family members. In this instance they report that they experience emotional conflicts when they face family members.

> *The family was in the halls and they were crying, this is also hard, and you are not prepared for that, to see the relatives, contain the relatives. (E3)*
>
> *The most difficult process that I had to see was the process of when we confront the family because the doctor leaves, and the one who bothers to say so is the nurse, who are the ones who give the news, who informs them and seeing that reaction from the family I think that is more shocking than the process of seeing the user who died. (E14)*

The emotional conflicts that the students present do not prevent values such as empathy, putting oneself in the place of the other.

> *What happened to the relatives? because maybe the relatives were going to visit her in the afternoon, as well as "Oh, I'm going to visit my mother" and it turns out that she will realize that the mother is gone. (E6)*
>
> *Until my teacher said: no, your mother is not going to get better and she is going to die, and that moment shocked me more, I think being so direct to the whole process of death, because if it was me, I imagined that if it was my mom or my dad, if someone told me that, it wouldn't be like her, she thanked her, but I would have done everything but thanks. (E12)*

Students show that age is an aggravating factor when accepting death, pointing out that the deaths of younger people are more shocking.

> *I also remember, one of my last long shifts I had, no excuse night and in the previous long shift the baby of... a child under 8 months had passed away, just as it was super strong, one never thinks about it. (E17)*
>
> *Yes, the one that marked me the most was a patient with 39 years of age with cervix cancer, and, a patient who dyed overnight, her stage 4 cancer was detected and there was nothing else to do, the patient with a 21 year old son, a young husband too. (E18)*

The process of death and die and their spiritual significance

Some participants gave this process of death and die a meaning of transcendence to death, dissociating body and soul/spirit:

> *I am a Christian, I think that there is something beyond life and that is a process that is for the good of the patient too, that is, it is not something that ends with death, it is not a process that after this there is nothing more, but there is something after that I feel is good for people who die. A transcendence. (E9)*
>
> *Death for me is a process where all the functions that you have at the body level end, but our spirituality remains a transition. (E13)*
>
> *So, for me, death is not an end, but a continuation. I am not a believer in God or anything. (E2)*

Some of the participants consider death simply as the end of life:

> *I do not see it as one goes into a second life or goes the other way, no more than the cycle ends. (E5)*

Ethics accompanying the end of life

In the stories of the students, it is observed that they identify the process of dying with dignity, mainly through accompaniment, control of symptoms such as pain, tranquility and without the use of unnecessary invasive measures, concepts also found in the TPEL. Thus, according to this, the reports are:

> *I believe that a dignified death for anyone is painless, first, a peaceful death, hopefully peaceful, accompanied by the closest relatives. (E1)*
>
> *That she/he does not have pain, that is accompanied that has to continue with her/his diet as much as possible or*

that she/he receives the same care from a person who is in good condition. (E9)

Fulfilling the wishes he wants, to which I am going with this, I do not mean very extravagant things, if not to the minimum of basic needs, cover them as they should be, say if the patient is one hundred percent terminal, if he wants to be in his house, allow him his last desire to be in his house, if he wants to be with a certain person, allow him, if he wants to taste something at that time, taste something in the period, give it to him because they are small things that I think are going to make him feel like peaceful and more comfortable. (E11)

It can help in the symptomatology, that does not have so much pain or things like that, but just as perhaps not suddenly, of being so invasive with the patient when his life cycle is already complete. (E17)

Another important issue raised by the students is the preservation of the principle of autonomy, which guarantees that information about the evolution of the disease and the outcome should be favored, so that the patient and/or family member can make decisions in relation to treatment and management. The stories of the students show the importance of delivering information to the family, as an essential part when respecting the principle of autonomy, which is sometimes violated:

If, in this good case, I remember, that in the cases of the patients we had, one of them had already arrived with limited therapeutic effort and which had been discussed, the doctor had talked with the family to reach an agreement of limitation. (E9)

How long can we respect the autonomy of the patient or family members in charge of them? (E19)

Students also point out the principles of non-maleficence/beneficence. Students' stories show that they perceive the violation of this principle through therapeutic testing, disproportionate measures, excessive expenses of material resources:

Because we had a patient for a long time, like two months, with an esophageal tumor, who never had an esophageal prosthesis or failing to have a gastrostomy to feed, and they took a long time to do the gastrostomy, as a month and a half, and they did it, for example, in fact they did it in my shift at about 9:00 in the morning and he died in the night shift at about 5:00 AM, it lasted as one day with his gastrostomy and he died. (E2)

If, (laughs) there was other lactate, in the background, it was tachycardic, no, then after tachycardia, then bradycardic, it was going to die, it was already like to fall into a stoppage at any time, then it seemed to me unworthy that get to invade it that way, there was nothing to do at the end, so that's what I thought was a total cruelty. (E13)

Students show that they are able to recognize these disproportionate measures, experiencing frustration for not having greater interference in the management of patients, and in turn, criticize these experiences by delivering a meaning of human suffering:

Do not flatter the life of a patient that you already know that we cannot do anything but you always have to have a limit, the limit of not making the patient suffer or giving false hopes to the family because the patient if or if he is going to die do or do whatever you do, unfortunately it is so. (E12)

Don't even put a via for someone who wants to say: no! Let's keep him hydrated, no, there you have to use your criteria as a professional and say: no! the patient is already committed, there is no need to intervene with him. (E19)

Try to support as much as possible in patients when they are in a process of death, agony, suffering or something, as a student or as future professionals and professionals to accompany the patient and make them feel their best within what can be done. (E2)

Students are able to recognize behaviors that lead to dehumanizing care:

But there is also the other side as more dehumanized, which is how: he has passed away, we must release that bed, we must wait to be fixed (refers to the deceased), make him post-mortem attention and leave. (E1)

No CPR, but the quality of life that we are going to give him until his last minutes is not the same because he is not in No CPR we are not going to do anything, then just we crashed because there were shifts in that if we worried about those patients, go see them at every time if something hurt them or not and there were other shifts that didn't, it was really like: no if the patient of this shift is not going to happen, then that still looks a lot in the service. (E8)

But the patient still struck me a lot because I mean, zero, they were super inhuman, nobody left him anything for the pain, a patient who was suffering, agonizing all day, leaving the window open because he had vasculitis and then the smell and that he arrived in the mornings and had the windows open, so to my feeling that this person suffered so much before he died it was very impressive. (E10)

Students are able to narrate clinical cases where ethical conflicts arise, of experiences analyzed in the classroom or lived during the clinical practice of which they have participated in the

resolution or only observed, although the majority presented difficulties in narrating a case and its solution.

> *But if we saw what conflicts were, death, the issue of how to let a person die, seeing the benefit to them, the least possible damage, we only saw that issue. (E8)*

> *If in ethics we saw some cases, as of the ones I don't know, as clinical cases themselves, the whole process and the dignified death and the ethical things that one has to do with the patient. (10)*

> *And the family was really opposed to leaving LET (limitation of therapeutic effort), so it generated an ethical conflict between professionals and the decision that the family wanted to make. After much conversation with the family, (laughs) I remember that it cost a lot, the family finally agreed to leave the LET and patient died. (E13)*

> *Therefore the family had to respect the decision, however, despite the fact that the family did not want that, I remember to approach in the sense of talking with the family and explaining what it meant to extend the life of their family member. (E15)*

> *But he knew that he was going to die finally and there was equal ethical conflict, that is, we all passed and we gave the opinions that one would do in that case and one always went as well as the patient's well-being. (E16)*

> *It was like leaving because if there was nothing more to do... why harass the patient? But on the part of the family it was very difficult to get there, by what I remember of the case, it was like a family very closed but I do not remember how we treated, on the part of the doctor or nurse do not continue with the procedures, but the part of the family I do not remember. (E5)*

DISCUSSION

Nursing is a profession that deals with the human being throughout the life cycle and is also present at the time of death, or at home, hospital or emergency care.[18]

Despite understanding death as part of the life cycle, students recognized unpleasant emotions and feelings when facing the death of patients. This process triggers brain mechanisms, outlining feelings/references of life, because there is a need to accept the fact that the existence itself, as well as that of the people with whom we interact, has an end, a "period of validity".[19] In this study the emotion that is most recognized is the impact on the news of death, followed by nervousness, discomfort and anguish. These feelings arise because although death is part of life, during training and during professional practice, these issues have not been worked on, mainly they are study programs related to life, therapy, healing, not preparation of students to deal with human finitude.[20]

According to the stories, the difficulty in preparing the losses of the patients with whom it has established more intense ties, the greater the union created, the more difficult to accept the death of the patient.[11]

The lack of preparation to deal with the situation of death, linked to the lack of experience in caring for family members who have experienced the loss causes emotional conflict, for fear of not being prepared to satisfactorily fulfill the role in the care of family members who are experiencing the loss, there is awareness that care should include the family, considered as a fundamental part of nursing care.[8] On the other hand, the TPEL proposes the concept of proximity of close friends and caregivers, where it is emphasized to provide opportunities for the family, to approach them, to make them part of care and attend to pain, concerns and questions from family and/or relatives.[16]

In a study[12] many students interviewed said they identify with family members and their suffering by losing their loved one, imagining their situations.

In the students' perception, life consists of a mortal physical body with an immortal soul. This is strengthened by most religions and spiritual schools that believe in the concept of immortality and the indestructibility of the soul. This vision of death linked to religion is supported by the results of research with nursing students,[8] which indicated that they tend to associate death with the significance of transcendence.

The TPEL, proposes within its concepts, to be at peace, that is to say a state of tranquility, a feeling free of anxiety, agitation, worries and fear, including this concept, the physical, psychological and spiritual dimensions.[16]

Spirituality occupies an important space in the process of confronting diseases by the human being. In a study with a multiprofessional team, spirituality is marked as something that influences this coping process. Professionals who face the death and die process are urged to think about their own terminality, therefore, it is pointed out that spirituality is capable of making sense of the work done.[21]

The spiritual dimension is not always contemplated or attended from the professional field, it is often the least contemplated in the care given to people in the final phase of life and their families although this aspect is emerging in this attention phase at the end of life.[22]

The spiritual dimension allows a dignified death that may be associated with a specific religiosity. It is from this dimension that affective relationships can be strengthened by building emotional moments that facilitate the end of life process and, consequently, the pain experienced by family members.[22] In addition, it is common that with the proximity of death comes the appreciation of life. Faith and support promoted by spirituality provide better internal control over terminality through the sense of God's presence, which is experienced by people in palliative care in different ways that are understood through love, strength, faith, tranquility, protection, the ability to overcome obstacles.[23]

The aging of the population associated with advances in medicine, especially in technological resources, allows us to provide measures to prolong or maintain the life of a person, so the process of attention at the end of life involves several ethical conflicts.[24] From these changes, we observe every international debate on concerns about the rights of patients at the end of life.[25]

In Chile, issues related to the end-of-life process have gained interest in the last decade, with Law 20,584 on the Rights and Duties that people have in relation to actions related to their health care and Decree 162 of The Inter-American Convention on the protection of the human rights of the elderly, promulgated in 2012 and 2017 respectively, both have articles that protect the dignity of people in terminal status, the right to comprehensive palliative care and the right to express Informed consent, protecting their autonomy.[26,27]

The process of dying in a dignified manner can be considered in different ways, which may imply respect for the patient's autonomy to decide how to die, their last wishes, their privacy, the environment and the people with whom they want to share this moment, as well as the need for adequate control of symptoms. The concept of dignified death is closely related to humanized care, there are studies that show that students express great importance and interest about the humanized vision of care during patient care at the end of life[12,13] in order to grant a dignified death.

On a daily basis the nursing professional faces complex issues, from relatively minor problems to serious life and death problems, coupled with the aggravated advance of technology that increases the survival of serious patients, in addition, we observe a greater autonomy of nursing professionals, which requires these decisions in complicated situations associated with routine of end-of-life care and life,[28] all these factors expose the nursing professional to face conflicts ethical. Students who perform their Professional Internship in hospitalized people units are often witnesses of conflictive situations from the ethical point of view, since the care and survival of the patients require the application of procedures and treatments of high complexity, which are not exempt from risk for the patient, as in invasive procedures, for example, where situations can arise in which one can act causing evil, without pretending it, added to the possible iatrogenies of the hospital environment. Thus the principle of beneficence interacts with that of non-maleficence, joint with the need to respect the decision of the patient and/or family, in those cases of incapacity of autonomy, depending on third parties for any decision forcing prudence, especially in the case of assessment of risks and benefits before starting a therapeutic procedure. Finally, the principle of justice by providing the necessary care and treatment to the terminally ill, avoiding discriminating and promoting the impartiality of benefits in an environment where resource scarcity is common.

Applying the principles of bioethics involves respecting the will of the terminal patient and deciding how long to continue using the means that current medicine allows, without exceeding reasonable limits to avoid reaching therapeutic obstinacy.[29]

In order to contribute to a dignified and respectful patient care, it is necessary to include them, together with their families, in making treatment decisions, which must be offered in a respectful and empathetic manner, contemplating the needs and wishes expressed by the patients.[16]

The principles of non-maleficence/beneficence imply adjusting the therapeutic measures provided to the desired objective, that is, the maximum well-being of the terminally ill patient and his family must be achieved. The principle of non-maleficence obliges professionals to use the means indicated by scientific knowledge to control the pain and suffering of patients but without falling into actions that only prolong an irreversible situation that in turn can increase pain.[29]

The therapeutic obstinacy consists of "the application of measures not indicated, disproportionate or extraordinary with the aim of lengthening unnecessary the life. These measures can also be called useless or futile treatments." These types of measures are considered as "a medical malpractice and a deontological fault".[30:178]

The Nursing School of the UMAG within its curriculum includes the subjects of Ethics and Legislation in the 5th semester and Bioethics in the 8th semester, providing the student with an ethics-oriented human formation that bases his personal development and that of his environment around the concept of human dignity, comprehensive nurse care manager for people of different healthy and sick age groups.

The TPEL rescues the humanized sense of our work, the complex and holistic care necessary to help a dignified and calm death, based on the fact that the experiences of the end of life are personal and individual, where nursing has an important and fundamental role through of the different actions to achieve and/or maintain an experience of the end of serene and peaceful life.[16]

Among the limitations, the sample size can be considered. Data self-reported by participants of the research can also be classified as study limitations, because it cannot independently verify.

CONCLUSION

The reflection on the process of die and death, allows the student to give meaning to this experience in different fields, as well as in the social, spiritual and ethical that are experienced around this process, enriching the scenario in nursing professional care.

Understand that death is not only a single act, but rather a complex process to address, which in addition to including the terminal patient, care must also be family oriented, recognized as a fundamental pillar in the process.

As in other studies, the meaning of transcendence in the spiritual dimension, helps the student to a better acceptance of this experience, understanding death as a step to a new life.

Recognizing the meaning, allows the student respect for the values and beliefs of people, promoting sensitive and humanized care to allow a dignified death and alleviate the suffering of the patient in his process of finitude, under the gaze of the principlist bioethics.

The evidence shows that the theme of the end of life can be addressed in different ways both in the classroom and in practice, this is how innovative teaching in the theoretical class is suggested with the use of TPEL, which It is simple and with clear ideas, allowing the student their easy understanding, and therefore the delivery of tools for the best care at the end of life. In addition to this theory, this theory provides a guide for the skills that nurses must perform in front of patients and their families during end-of-life care.

AUTHOR'S CONTRIBUTIONS

Conception of Study design. Data Acquisition, analysis and interpretation of results. Drafting and critical review of the manuscript. Approval of the final version of the article. Responsibility for all aspects of the content and the integrity of the published article. **Sylvia Álvarez Sandoval. Mara Ambrosina de Oliveira Vargas.** Interpretation of results. Drafting and critical review of the manuscript. Approval of the final version of the article. Responsibility for all aspects of the content and the integrity of the published article. **Dulcinéia Guizoni schneider. Aline Lima Pestana Magalhães. Laura Cavalcanti de Farias Brehmer. Francielly Zilli**

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