

Representation of the Concept of Death in Emergency Medicine Residents following Unsuccessful CPR Procedures

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ABSTRACT

Introduction. In medicine, death is regarded as the total loss of vital functions. However, there is no universally accepted definition as global literature includes various terms for the concept drawn from a range of contexts. **Objective.** To explore how emergency medicine residents perceive death following unsuccessful cardiopulmonary resuscitation (CPR) procedures. **Method.** Qualitative, descriptive, and exploratory study. Participants included five medical residents specializing in emergency medicine who attended patients receiving unsuccessful CPR. Data were obtained through the triangulation method using semi-structured individual interviews. **Results.** For medical residents, death constitutes a painful process associated with loss or departure. The experience elicits feelings of sadness, frustration, and helplessness in them. These feelings are more pronounced in the case of young patients, pregnant women, and children, subsequently manifesting in health problems. **Discussion and conclusion.** The concept of death shared by emergency medicine residents is primarily linked to biological aspects. Despite constant exposure to death, they remain sensitive to it, experiencing feelings such as helplessness, sadness, and frustration, which impact their life stories. Since these residents believe they lack the tools to cope with this situation, it is essential to offer them thanatological training to develop strategies for handling the death of their patients.

Keywords: Death, feelings, emotional skills, representation.

RESUMEN

Introducción. En medicina la muerte es considerada como la pérdida total de las funciones vitales. Pero no podemos quedarnos con una sola definición pues en la literatura mundial existen diferentes análisis sobre la definición de muerte desde perspectivas muy particulares y en diferentes circunstancias. **Objetivo.** Explorar cómo significan la muerte los médicos residentes de urgencias tras la realización de maniobras de reanimación cardiopulmonar no exitosas. **Método.** Estudio cualitativo, descriptivo y exploratorio. Participaron 5 médicos residentes de la especialidad de urgencias médicas que atendieron pacientes que recibieron maniobras de reanimación cardiopulmonar con resultado no exitoso. Datos obtenidos a través del método de triangulación, a través de entrevistas individuales semiestructuradas. **Resultados.** Para los médicos residentes la muerte representa un proceso doloroso que está ligado a una pérdida o partida. Esta experiencia despierta en el médico residente sentimientos de tristeza, frustración e impotencia. Siendo más evidentes cuando se trata de pacientes jóvenes, mujeres embarazadas y niños. Estos sentimientos son manifestados posteriormente con problemas de salud. **Discusión y conclusión.** La representación de la muerte que tiene el médico residente de urgencias está ligada principalmente a aspectos biológicos y a pesar de la convivencia constante con la muerte, aún se sensibilizan con ella generando sentimientos como: impotencia, tristeza y frustración que tiene repercusión en sus historias de vida pues consideran que no cuentan con herramientas necesarias para hacer frente a esta situación. Por lo que es necesario ofertarles capacitación tanatológica que les permitan el desarrollo de estrategias para que puedan lidiar con la muerte de sus pacientes.

Palabras clave: Muerte, sentimientos, competencias emocionales, representación.

INTRODUCTION

The emergency department is a high-pressure work environment where emergency physicians must be prepared to manage situations arising during their shift, including severe illness, trauma, and the possibility of patient death (Howard et al., 2018). Death, whether expected, due to chronic illness or unexpected, resulting from a sudden disease or injury, is a relatively common occurrence in emergency departments.

According to data from the European Registry of Cardiac Arrest (EuReCa), annual incidence of in-hospital cardiac arrest ranges from 1.5 to 2.8 per 1,000 hospital admissions (Gräsner et al., 2021). In Mexico, 212,404 deaths were recorded between January and March 2024 (National Institute of Statistics and Geography Spanish acronym INEGI, 2024). However, no statistical data exist on the number of cardiopulmonary arrest events that received resuscitation efforts or the proportion of unsuccessful outcomes, limiting our ability to grasp the scope of this phenomenon.

Death is an inevitable part of the life process, as natural as being born or growing, although it is difficult to face.

Although medical trainees in emergency services frequently coexist with death and its process, it is not always easy for them to cope with and is regarded as one of the most impactful experiences derived from their work (Halpern et al., 2009; Adriaenssens et al. 2012).

The issue of feelings about death is not addressed in the medical school curriculum. The Hippocratic tradition calls for the acknowledgement of human limitations in the face of death. However, this concept has evolved over time, and in current medical practice, death is considered a therapeutic failure (Gallagher, 2014; Zhang et al. 2022).

In other words, we do not know what happens when, despite the efforts of the resuscitation team, they fail to obtain a satisfactory response and the patient dies. Only those who have been in this situation can understand the silences and looks experienced in the emergency room, which often convey a sense of helplessness.

This raises the following questions. What goes through the minds of the resuscitation team members at that moment? What feelings do they experience? Does this experience have repercussions on their daily lives?

Based on these questions, this study seeks to understand what the concept of death means for medical residents specializing in emergency medicine after performing unsuccessful Cardiopulmonary Resuscitation (CPR) procedures.

METHOD

Study design

A qualitative study was designed with a phenomenological, descriptive, and exploratory approach to understand the meanings of the concept of death arising from the experiences of medical specialists in training within the context of a secondary level hospital in the National Health System. The study adopted the Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item checklist for interviews and focus groups (Tong et al., 2007).

Description of subjects/sample

The resident physicians were personally invited to participate. Of the seven comprising the training staff of the emergency department at the time of the study, five agreed to participate. All were first-year residents specializing in emergency medicine with over six months of clinical activities. During this time, they had attended patients who had received cardiopulmonary resuscitation (CPR) maneuvers with unsuccessful outcomes. This period provided participants with a range of experiences that allowed for an analysis of their understanding of the concept of death. Although attending patients requiring resuscitation is common in emergency services, each physician reacts differently to unsuccessful CPR maneuvers.

Procedure

Information was gathered through the triangulation of in-depth individual interviews and direct observation, which was useful for observing the resident physicians' interactions during the resuscitation process and their nonverbal communication during the interviews. The individual interview technique was employed with the research participants, ensuring privacy so they could comfortably express their experiences, emotions, and feelings.

This semi-structured interview was based on a guide (Annex 1) and was designed to identify participants' points of view, allowing greater freedom of expression and more openness in interacting with them. Interviews were held at the Zone No. 2 IMSS General Hospital, in a comfortable, private area outside the emergency department according to the participants' availability and were scheduled in advance.

Interviews were recorded using a portable recorder, with the prior consent of the participants and subsequently analyzed. Recording ensured more reliable transcriptions of the information. Discourse contents were fully transcribed, and registration units (words or phrases) were determined, reducing texts to significant words and expressions to identify, select, and classify categories.

Interviews were conducted exclusively by the research team comprising a clinical psychologist with a doctorate in human development, a family physician, and an emergency physician, and lasted between forty-five and sixty minutes. Each participant was interviewed once, in line with the research objectives. During the interviews, only the researchers and participants were present. The remaining resuscitation team members were not present during the interview to ensure the resident physician's privacy.

Data analysis was performed to identify the sociodemographic profile of the interviewed participants. The [Bardin method \(2016\)](#) was used to organize and systematize data through content analysis and divided into categories that emerged from the participants' discourse, converging with the research objective.

Results were constructed from four central codes or categories: "representation of the concept of death in the emergency medicine resident," "feelings aroused in the resident physician in response to their patients' death process," "impact on personal history experienced by resident physicians when dealing with their patients' deaths," and "emotional skills developed by resident physicians to cope with their patients' deaths."

Ethical considerations

The study was approved by the local ethics committee in research 7038 and local research committee 703 of the Family Medicine Unit No. 13 in Tuxtla Gutiérrez, Chiapas. The collected data were coded to protect participants' information, and only the researchers had access to the database. In addition, the study adhered to the ethical principles of the General Health Law on Research and the Declaration of Helsinki. Before the interviews, written informed consent was obtained, and participants were informed of the research objective, procedures to follow, and contact information for the researchers responsible for the study.

RESULTS

The study involved five first-year medical residents specializing in emergency medicine. The sample consisted of two men (40%) and three women (60%), aged between twenty-eight and thirty-seven, with an average age of 30.2 ± 3.4 years. Data analysis of the interviews yielded the following four categories.

First category: representation of the concept of death in emergency medicine residents

This category is linked to the questions posed to professionals regarding the meaning of their patients' deaths. According to their accounts, death represents a painful process

associated with loss or departure. This was evident during the interviews, where some of them had a trace of sadness in their voices, together with lowered gazes and silent tears. These considerations are illustrated in the following statements:

It is a painful process, not only for the patient's family [...] (UMQ 1).

Death is the loss of a loved one (UMQ 3).

While most physicians regard death as the absence of vital signs, giving it a biological context, some of them provide a more complex context by including spiritual or holistic aspects:

Clinically, it is the absence of vital signs despite CPR maneuvers (UMQ 2).

From a medical point of view, it is the cessation of the body's vital functions [...] But I also believe that we are made up of body, soul, and spirit [...] (UMQ 5).

Second category: feelings aroused in emergency medicine residents during the process of their patients' deaths

In this category, the feelings aroused in the participants in the face of their patients' deaths were clarified. During the interview, we observed that discussing this was painful for the resident physicians, as borne out by their somber expressions and teary eyes when recalling the events.

The main emotions experienced were sadness, frustration, emotional exhaustion, and helplessness. According to the participants, these feelings intensify and are more evident when dealing with young patients, pregnant women, and children:

We mainly feel sad when it comes to young patients, pregnant women, or children [...] (UMQ 5).

I feel emotionally exhausted [...] when it's a patient you could potentially save, their death fills me with frustration [...] (UMQ 2).

Feelings vary according to each patient, but generally, I feel frustrated (UMQ 4).

Another emotion expressed by some residents was a sense of calm at having provided quality care and having offered their patients the best they could at that moment.

This is evident in the statement of the following resident physician, who, during the interview, after a moment of silence, sighed deeply, smiled faintly, and shared the following with us:

It's a moment that creates a lot of stress that requires a lot of responsibility and commitment [...] In the end, I feel calm because I know I gave my patient my best (UMQ 3).

Third category: impact on the personal history experienced by medical residents dealing with their patients' deaths

This category highlights the difficulties experienced by the participants as a result of their patients' deaths. The negative feelings experienced are subsequently manifested through health problems, such as fatigue, exhaustion, emotional lability, anxiety, and mood swings.

At times, frustration has caused me anxiety [...] personally, it has caused me problems in the workplace (UMQ 3).

I have experienced mood swings such as irritability, emotional lability, and bad temper [...] and I have needed psychological support [...] When I replay the event in my mind and think I could have done something differently, it causes me anxiety (UMQ 2).

Whenever a patient dies, I feel very tired, with intense emotional exhaustion (UMQ 1).

One participant reported that the experience has altered their life story by making them emotionally colder.

I feel that facing the death of patients makes me more guarded with my emotions. I believe it has made me have a stronger character, even making me emotionally colder in various situations (UMQ 4).

Fourth category: emotional skills developed by medical residents to deal with the death of their patients

This category includes the emotional skills developed by the participants in response to their patients' deaths. Medical residents have developed adaptation mechanisms enabling them to regulate their emotions, such as introspection, empathy, confidence, and stress management through recreational activities and breathing exercises.

Listening to music I like relaxes me and allows me to calm my emotions [...] seeing pictures of my family fills me with joy [...] (UMQ 4).

When I feel anxious after resuscitation maneuvers, I take a few minutes to do breathing exercises [...] (UMQ 3).

Feedback from the event allows me to self-reflect [...] comments from colleagues about well-performed actions fill me with positive thoughts [...] Also, listening to music relaxes me (UMQ 1).

In my case, post-event feedback helps me understand the clinical course and feel more at ease [...] Talking to my family and engaging in leisure activities such as listening to music or watching movies helps me feel more relaxed (UMQ 2).

DISCUSSION AND CONCLUSION

Death is not commonly discussed and even within the healthcare sphere, it is not customary to reflect on a patient's death. On the contrary, the topic is often avoided (Sevilla-Godínez, 2009).

This makes it difficult to define death because it involves considering biological, medical, legal, religious, and social viewpoints, which are intricately related.

We know that in the field of health, the concept of death is rooted in the biological sciences. However, each of us imbues the concept of death with our own meaning based on our personal experiences and professional expertise.

According to the interviews, the majority of respondents espoused a concept of death from a biological context, with the absence of vital signs being the first response in all interviews. This aligns with Gaona-Flores et al. (2015), who observe that death in medical practice has been regarded as the total loss of vital functions.

Resident physicians considered that death can occur due to multiple causes. However, the definition of death can vary according to a physician's religious beliefs (Costa et al., 2017). According to the accounts provided in the interviews, the representation of death is also related to a spiritual experience. Some medical residents included spiritual and holistic aspects in their replies, giving it a connotation of the end of physical existence, while considering that the soul or spirit continues to exist.

One element identified as a cultural construct is the difficulty of accepting the death of younger patients. According to Mocellin-Raymundo et al. (2017), "the death of young people, children, or pregnant women is seen as an interruption of a biological cycle, creating dissatisfaction and disillusionment among healthcare professionals."

In this study, we observed that the death of adults or older adults is more easily accepted than that of pediatric patients, as reported by Costa et al. (2017) and Aredes et al. (2018), who note that a resident physician may experience feelings of sadness and loss when a pediatric patient dies.

This situation is obviously more difficult to cope with for resident physicians with young children, as they may identify with the loss, as demonstrated in the work of Poo et al. (2021). The emotional impact of a pediatric patient's death became clearer to the researchers when one of the participants shared the following:

"It was a traumatic event that made me very frustrated because in the end, I felt that maybe I hadn't done everything I could to save the child [...] I feel that this particular case affected me more because I have young children."

Consistent with other research (Fernández et al., 2017; Jiménez-Herrera & Axelsson, 2015) in the emergency field, this study observed feelings of helplessness, frustration, sadness, and anxiety stemming from their work experiences. This is important, as Halpern et al. (2009) and Adriaenssens et al. (2012) note. Even though medical trainees in emergency services frequently encounter death and its process, it is not always easy to cope with and can be considered one of the most impactful experiences derived from their work.

When a healthcare professional is exposed to tense, conflictive, or traumatic situations, such as the death of a patient, it may elicit distress or emotional trauma (World Health Organization [WHO], 2013). Unfortunately, the issue of the feelings caused by a patient's death is not considered in the medical school curriculum (Gallagher, 2014). This lack of training prevents medical trainees from acquiring and developing the necessary emotional skills to deal with their patients' deaths, making them less resilient.

During the course of the study, we realized that despite the negative experience the death of a patient may constitute for resident physicians in the emergency department, there are also moments of reflection that bring them peace, as they feel they did their best to help the patient. These moments can be described as positive experiences and have also been mentioned in other articles (Vázquez et al., 2021).

Studies conducted in the United States on emergency medical personnel indicate that talking with colleagues is used as a coping strategy after a patient's death.

However, it is significant that 75% of the healthcare professionals surveyed in these studies also used the mental health services of their institutions to receive psychological support (Essex & Scott, 2008; Clompus & Albarran, 2016).

These data contrast with our findings, as our interviewees reported not having received support through psychological intervention strategies to mitigate the effects produced by their patients' deaths. Instead, family and coworkers, through debriefing or defusing, were the main sources of emotional support when negative feelings arose from these experiences.

This is interesting because authors such as Roth & Moore (2009) consider that the family environment is not ideal place for sharing the difficult events that occur during

clinical practice. Due to its characteristics, the profession itself is considered a limiting factor in creating an appropriate family climate. Other studies, such as the one undertaken by Valle-Figueroa et al. (2019), consider that social support "makes the everyday task of dealing with death and the process of patients' death more bearable." This social support, provided by family and friends, as we observed in our work, is a key element in the coping process for resident physicians.

The authors recognize several limitations of the study. One limitation stems from the methodology used. Since it is a qualitative study, the results cannot be extrapolated to all healthcare professionals involved in a resuscitation team. However, the study provided valuable insights into the emotional resources of our trainees when coping with a patient's death.

Another limitation was the characteristics of the participating group of medical residents, all in their first year of specialization. Although it would have been ideal to include residents from other years, as it is a new training site, we did not have access to other academic years.

Finally, a point to consider for future research is how the attitude of medical residents toward death varies according to their cultural background, religion, other spiritual aspects, and academic training.

In conclusion, the representation of death among emergency medical residents is primarily linked to biological aspects. Despite their constant exposure to death, they remain sensitive to it, experiencing feelings such as helplessness, sadness, and frustration. These feelings impact their life stories because they believe they lack the necessary tools to cope with this situation. It is therefore essential to offer them thanatology training to develop strategies to deal with the death of their patients.

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Conflicts of interest

The authors declare no conflict of interest.

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INTERVIEW GUIDE (ANNEX 1)

To begin, could you tell me:

- How often do you experience the death of your patients during cardiopulmonary resuscitation maneuvers?

If you feel comfortable, try to visualize the event in your mind. Then tell us:

- What does death mean to you?
- Has your current perspective on death changed from the concept you had at the beginning of your career? How did this change occur?
- Do you think that the concept of death you hold today has been modified by what you've learned throughout your career? In what way?
- Do you think your religious beliefs have influenced the meaning you attribute to the concept of death? How?
- As a physician, how have you been prepared to cope with these situations in your life?
- As a physician, how have you been trained to address these topics with patients' families?
- As a physician, how do you think death is understood in our professional field?

In your own words, when cardiopulmonary resuscitation maneuvers have not been successful, tell us:

- What would you have liked to have been done differently?
- Do you consider that this event posed emotionally challenging results for you?
- How has this experience been for you?
- What thoughts or emotions did this experience elicit in you?
- How intense were these thoughts or emotions?
- Did these thoughts or emotions arise at the moment the resuscitation maneuvers ended, or after they had finished?
- How long did the discomfort caused by the situation persist?
- What did you do to stop feeling distressed?
- Do you think you were able to manage these emotions or feelings?
- What specific training do you think healthcare professionals need to manage their emotions better?
- From your experience, what techniques have you learned for managing emotions after an unsuccessful cardiopulmonary resuscitation?
- In what ways have your experiences with unsuccessful cardiopulmonary resuscitation affected your personal life?