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A contemporary review of understanding the religious and cultural diversity of patients dying or who have died in the intensive care unit. A South African perspective

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Implications for clinical practice

- Lack of familiarity with or knowledge of religions and death rituals may be perceived as disrespectful, and subsequently can be damaging for the dying or dead patient and the family.
- Pedagogical offerings to address death education may enhance the quality of nursing care of dying patients and provide or at least facilitate a good death *(amicus mortis)* in the ICU.
- The expanding area of thanatology requires consideration as part of the ICU nursing curriculum.

1. Introduction

It is important to acknowledge cultural and religious diversity when caring for dying patients in the ICU. Intensive care nurses may experience difficulties in understanding the dying patient's needs when their religious and cultural backgrounds are different to those of the patient. This is an important concept that ICU nurse educators need to consider when addressing death education as part of the ICU nursing curriculum.

The literature is disappointingly limited on the viewpoints of the world's commonly practiced religions and different denominations regarding end-of-life decisions in the ICU. This contemporary review will concentrate on the major religions' and religious groups' in South Africa on dying and death in the ICU (Table 1).

A search was conducted of the electronic databases (i) Educational Research Information Center **(ERIC)**; (ii) Dissertation Abstracts International **(DAI)**; (iii) **MEDLINE**; (iv) Academic Search Premier via **EBSCO** Host and (v) Cumulative Index to Nursing and Allied Health **(CINHAL)**.

The term Christian encompasses a variety of religious groups ranging from Roman Catholics and Jehovah's Witnesses to Lutherans and Mormons (Barett, 2001).

1.1. Roman Catholic perspective

The Catholics' attitude towards the futility of life-support was officially expressed in 1995 by Pope John Paul II in his *'Evangelium Vitae'* (1995). This was later summarised in a shorter version in *'Catechismus Catholicae Ecclesiae'* (1997) in which the Catholic Church supported the withholding and withdrawing of futile therapy if the expected outcome was one that would endanger or worsen the outcome for the dying patient. 'The Declaration on Euthanasia' issued in 1980 allowed for the alleviation of pain in dying patients, even though there was the real possibility that this strategy would shorten the life of the dying.

However, too many Catholics there is some special meaning in not alleviating pain when dying, as it holds an ideation of Christ's suffering on the cross. Active euthanasia is forbidden, and instead, palliative care is considered. The word euthanasia comes from the Greek for 'good death.' The Greek Orthodox Church defines good death as a 'peaceful death with dignity and without pain.' The current international meaning of 'active euthanasia' is perceived as 'mercy killing' (Bülow et al., 2008: 425). Euthanasia may be active, passive, voluntary, involuntary, physician-assisted or assisted suicide.

Withdrawal of therapy was instituted in Pope John Paul's case but, shortly before he died, he was against withdrawing artificial nutritional support of patients who were believed to be brain damaged or were not expected to survive. His thinking on this issue has provoked much debate around bio-ethical dilemmas and the rights to basic human needs (Shannon, 2006) (Clark, 2006).

1.1.1. Post mortem care

Routine post mortem care (last offices) is performed (de Swardt & Fouché, 2017). Burial is the preferred option for bestowing of the body but there are no objections to cremation. A traditional Catholic ritual in Irish communities is to show the body before the funeral procession. There is no objection to organ donation.

The Anglican tradition holds, as with many Catholic doctrines, that should an infant die unbaptised, the rite of baptism can be performed by a priest soon after death.

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Table 1
Commonly practiced religions and different denominations regarding end-of-life decisions in the ICU.

Religion	Life-sustaining Modalities	Euthanasia	Post Mortem Care	Forensic Post Mortem	Organ Donation	Other
Roman Catholic Anglican	• Withdraw/withhold if futile. • Continue nutritional support	• Continue pain management even if futile but not at a dose to prolong/assist in death	• Routine • Burial preferred • Cremation acceptable	• Yes	• Yes	• Administer last rites • Baptise if not done • Advance Directives acceptable
Protestant	• Withdraw/withhold if futile including nutritional support	• No • Physician-assisted suicide (Netherlands)	• Routine • Cremation acceptable	• Yes	• Yes	• Administer last rites • Baptise if not done • Advance Directives acceptable
Jehovah's Witness	• No blood products	• No	• Routine • Cremation acceptable • No funeral services	• Yes/No depends on the individual	• Organs and tissues to be drained of blood	• No last rites • Men decision-makers
Greek Orthodox	• Withdraw/withhold if futile • Continue nutritional support • DNR	• Continue pain management but not dose to prolong/assist in death	• Routine • Cremation acceptable	• Yes	• Allowed if family and donor agree voluntarily • 'Non-refusal' according to Greek Law = consent	• Administer last rites • Baptise if not done
Jewish (Judaism) Reformed Conservative Orthodox	• Withdraw including nutritional support if related to the dying process • Continue if related to treatment including dialysis, ventilator support, nutrition if requested by patient	• No even if requested by the patient	• Minimal handling of body. Covered with a sheet only • Washed by same gender as deceased • Ritual regarding closing of eyes and mouth • Jewish undertaker • Burial. Cremation not an option	• No under Jewish Law but yes according to Civil Law	• Yes • Orthodox believe both cessation of heart activity as well as respiration	• Burial should ideally take place within 24 h, unless it is the Sabbath (Saturday).
Muslim (Islamic)	• Continue life-support modalities to prevent premature death unless collective consensus with the family and healthcare professionals • Withdraw/withhold in terminally ill • Continue nutritional support	• No • Continue pain management including sedation even if hastens death (double effect)	• If no family available, post mortem care may be performed by healthcare personnel with minimal handling • Must use disposable gloves • Healthcare personnel may not wash the body , cut hair or nails • Only a sheet spread over body. Ensure whole body covered • Burial should ideally take place within 24 h	• Permitted but must be done before the strict washing and ceremonial rituals	• Acceptable in cases of brain dead	• Muslims follow specific rituals in handling the body after removal from place of death
Buddhism	• There is no mandate or moral obligation to preserve life at all costs - seen as a denial of human mortality • Must 'meet death with mental clarity' therefore some may abstain analgesia or sedation	• Not acceptable	• Leave undisturbed for minimum 4 h • No negative emotions to be expressed • Minimal handling • Burial and cremation acceptable	• Burial or cremation • If required should be performed after 4 days • An autopsy is required, may only take place after four days post death	• Generally, no but may be acceptable - decision to be made during their life time	• Not specified
Hindu	• Diverse thinking around death • Untimely death profound grief • The way death happens is important • DNR and DNAR acceptable	• No	• Consult with relatives before dead body is handled by healthcare personnel • Healthcare personnel may close the eyes, straighten limbs and wrap body in plain sheet • Must use disposable gloves • Cremation preferable	• Not opposed. But unpopular • Permitted but must be done before the strict washing and ceremonial rituals	• Acceptable but limited – donor must have had a 'good death'	• Hindu's follow specific rituals in handling the body after removal from place of death • Adherence to cremation practices and disposal of body ashes
Xhosa and Zulu	• Not popular to commence life-support – ancestral beliefs • Life sustaining support interferes with dying process –	• No	• The body is washed by women. • Because death seldom happens in the home, the undertakers do most of the preparation of the	• Viewed as suspicious	• It is the head (chief) of the tribe that decides if organ donation is permitted. • Often, organ donation is declined because the journey to the	• Healthcare personnel should attempt to create the necessary conditions for the transition to the ancestors

(*continued on next page*)

Table 1 (*continued*)

Religion	Life-sustaining Modalities	Euthanasia	Post Mortem Care	Forensic Post Mortem	Organ Donation	Other
	may be seen as a traumatic death		body and arrangements for the funeral. ● Death Insurance Schemes/Clubs/ Societies		ancestral world is thought to be broken for the dead person missing an organ	● The dying prefer to go 'home' and not die in hospital

1.2. Protestant perspective

The Protestant traditions are more amenable to the vast array of life-sustaining medical and technological therapies and accepts that if there is no positive outcome or hope of recovery, withdrawal of therapy is an appropriate action to take (Pauls & Hutchinson, 2002).

The diversity within Protestantism, for example the Evangelical Lutheran Church in Germany has developed advance directives for end-of-life options but disallows active euthanasia, also referred to as 'physician-assisted suicide' (May, 2003). This is in contrast to the reformed traditions, as seen in the Netherlands, in which active euthanasia is regulated by the 'Termination of Life on Request and Assisted Suicide (Review Procedures) Act' from 2002 (Netherlands Ministry of Health, Welfare and Sport, Ministry of Security and Justice, 2011).

1.3. Jehovah's Witnesses

The main aim for Jehovah's witnesses is to live their lives according to the *Old and New Testament.* Jehovah is the Supreme Being and Jesus is the Son of God who was formerly in a pre-human state as the Archangel Michael (Rutty, 2005). Just prior to World War I, the Heavenly Kingdom resulted in the invisible enthronement of Christ as King.

The future, for Jehovah's Witnesses, is the Battle of Armageddon where Jesus, under Jehovah's wrath, will perform retribution on all other religions of the world (Rutty, 2005). This cleansing would create God's Kingdom on Earth for one thousand years. Jehovah's Witnesses believe that Satan controls the world. Followers will not run for public office, vote or join the military or police force (Rutty, 2005).

1.3.1. Post mortem care

Post mortem care is carried out but no last rites are offered. Cremation and burial are acceptable with no formal funeral service. Organ donation and post-mortems for forensic purposes are discouraged but may be considered according to the individual's conscience. All organs and tissue must be thoroughly drained of blood prior to transplantation, as blood represents life and must be treated with respect. There are followers who do not permit blood to be stored or reused. Orthodox Jehovah's Witnesses do not allow equal opportunity for men and women and hence the authority in the family tends to be held in men (Holden, 2002).

1.4. Greek Orthodox perspective

The Greek Orthodox Church views that death is not only a biological event but a mystery with a sacred, spiritual component and a great blessing. With regards to end-of-life decisions, the church rejects any death resulting from human decisions as being an insult to God and any medical intervention that does not contribute to the prolonging of life is condemned (Hatzinikolaou, 2003). The Holy Synod of the Church of Greece Bioethics Committee (2007) stipulates that: (i) medication to alleviate pain is permitted but must be administered in doses that do not hasten or assist death; (ii) withholding or withdrawing of any form of nutritional support is not allowed, even if there is no prospect of recovery and (iii) organ transplantation is allowed if the donor or the family have knowingly and voluntarily agreed. However, the Greek law states that 'non-refusal' by the relatives is interpreted as consent of the donor (Bülow et al., 2008).

1.5. Jewish perspective (Judaism)

The Jewish faith consists of three branches: Reformed, Conservative and Orthodox, of which the Orthodox Jews are the most religious (Cohn-Sherbok, 2003).

Halacha or the Jewish legal system, which was developed from the Bible (*Tanach*) and the Talmud, does not allow the hastening of death,

even if the patient is terminally ill (Ravitsky, 2005; Steinberg & Sprung, 2006).

However, there is no compulsion to prolong pain and suffering in the dying or to keep the dying alive. Halacha allows for the withholding of life-sustaining therapies, provided that it is relevant to the dying process, but the withdrawal of life-sustaining therapies when it is an ongoing form of treatment, is forbidden (Ravitsky, 2005; Steinberg & Sprung, 2006). Physician-assisted suicide or active euthanasia is prohibited, even at the request of the dying patient. Steinberg and Sprung (2006) point out that a new Israeli law attempts to seek a balance between the sanctity of life and the principles of autonomy.

The law prohibits the withdrawal of any life-sustaining therapies but allows withholding further treatment should it be an intermittent life-sustaining measure and only if this action is in keeping with the patient's request. This may include mechanical ventilation surgery, dialysis or chemotherapy (Steinberg & Sprung, 2006).

Withdrawal of mechanical ventilation, food and fluids is forbidden, as these life-sustaining therapies are viewed as a continuous form of treatment (Ravitsky, 2005; Steinberg & Sprung, 2006). However, such a decision may result in prolonging suffering and hence Israeli Law and Halacha have allowed for the changing of mechanical ventilatory support from a continuous form to an intermittent form of treatment (Ravitsky, 2005). This is done by connecting the ventilator to a timing device. The patient's death according to their wishes is seen as morally acceptable because the aim is achieved by omission rather than by commission (Ravitsky, 2005; Steinberg & Sprung, 2006).

The Jewish definition of death is when spontaneous breathing ceases (Ravitsky, 2005; Steinberg & Sprung, 2006). The Halacha permits organ transplantation only if strict medical criteria are met to verify total and irreversible cessation of breathing (Ravitsky, 2005; Steinberg & Sprung, 2006). There are some Halachic authorities, especially the ultra-orthodox Jews, which insist on the cessation of heart action as well as breathing before organ donation may be considered (Ravitsky, 2005; Steinberg & Sprung, 2006).

1.5.1. Post mortem care

Minimal handling of the body is essential as there is a significant relation to the ritual cleansing and clothing of the body which must be carried out by the same gender to that of the deceased (Rutty, 2005). This is important for all health-care providers to acknowledge. Ideally, the eyes and mouth of the deceased should be closed by a child, relative or devoted friend, preferably in this order (Cohn-Sherbok, 2003).

The body is then covered with a sheet, labelled and the Jewish undertaker and the synagogue notified.

Forensic post-mortem examination is disapproved of and therefore is not permitted by Jewish law unless required by civil law. The belief concerning forensic post-mortem originates from the Jewish belief that all humans are created in God's image and no form of mutilation is allowed so that the body can be buried as a whole person (Rutty, 2005).

Between the time of death and burial of the body, the body is seen as vulnerable and unable to watch over itself and therefore is closely guarded. Only when the body has 'come home' to its final resting place within the grave, is it seen as safe (Rutty, 2005: 525). As it is a humiliation for the deceased not to be buried, the burial should ideally take place within 24 h, unless it is the Sabbath (Saturday). Cremation is not an option as it is seen as an unnatural way of treating a human body.

1.6. Islamic perspective

The *Qur'an* (the holy book of the Muslim faith), the *Shariah* (Islamic Law) and the *Sunna* (Islamic Law based on the Prophet Muhammad's words and acts) form the basis of Islamic bioethics (Daar & Khitamy, 2001). Muslims believe that everything possible must be done to prevent premature death, although life-sustaining therapies can be withheld or withdrawn in the terminally ill provided that the physician(s) are certain about the inevitability of death (Daar & Khitamy, 2001). The hastening of death is not permitted and is based on the Islamic principle of *la dararwa la dirar* - no harm and no harassment (Ebrahim, 2000). It is unlawful to discontinue any form of nutrition because such withdrawal would in effect starve the patient to death. In cases where treatment is deemed futile, the decision to withdraw therapy is seen as allowing death to take its natural course provided that there has been a collective consensus with the family and health-care professionals (Ebrahim, 2000).

The retrieval of organs for transplantation following brain death is accepted by most Islamic countries (Ebrahim, 2000). The *Qur'an* takes a firm stance regarding the alleviation of pain – 'Allah does not tax any soul beyond that which he can bear' and pain and suffering is not a punishment but rather a *kaffarah* (expiation) for one's sins (Ebrahim, 2000). Providing pain relief or sedation is permitted even if death is hastened (double effect), as long as death was not the intention of the physician (Sachedina, 2005). Euthanasia is never allowed as it is Allah's prerogative to bestow life and cause death.

1.6.1. Post mortem care

Should the family not be available, then post mortem care may be performed by health-care personnel with minimal handling whilst always using disposable gloves. Neither washing of the body nor cutting of hair or nails is permitted by health-care personnel. A white sheet is spread over the body making sure that the whole body is covered (Rutty, 2005).

Practising Muslims wash the body with soap and water a minimum of three times and then the body is wrapped in a specific way. Three pieces of white cotton cloth *(kafan)* and a scent or perfume is used. The eyes are then closed, and the lower jaw strapped to the head to prevent gaping of the mouth (Rutty, 2005). The body is laid out straight and the head is turned towards the right shoulder so that the body can be buried with the face looking towards Mecca. It may be in the interest of the relatives for the nurse to assist with turning the dead body's head as specified by religious preference (Rutty, 2005). Cremation is not an option as Muslims believe in resurrection. Burial takes place within 24 h and delays cause much anguish for the relatives. Should a forensic post-mortem examination be required, ceremonial preparations in caring for the body will only begin after this procedure (Rutty, 2005).

1.7. Buddhist perspective

Buddhism is seen as a flexible and moderate religion. Organ donation within this religion is seen as acceptable. There is no mandate or moral obligation to preserve life at all costs in Buddhism; this is seen as a denial of human mortality (Bülow et al., 2008). Within this belief system it is important to 'meet death with mental clarity' therefore some may abstain analgesia or sedation (Bülow et al., 2008: 427). Euthanasia is not acceptable in this religion. Organ donation is deemed acceptable for Buddhists who have decided during their lifetime to donate an organ or organs (Bülow et al., 2008: 427).

1.7.1. Post mortem care

Once the patient has died, the body must be left undisturbed for a minimum of four hours if possible. Negative emotions may not be expressed at the bedside but positive and encouraging words can be spoken. Post mortem care activities and handling of the body and must be kept to a minimum (Bardo Group, 2013). Burial or cremation, and if an autopsy is required, may only take place after four days post death (Bardo Group, 2013).

1.8. Hindu perspective

Diverse interpretations, opinions and actions around death are possible with regard to the Hindu religion as there is no single central authority to oversee legal and ethical issues that arise in the ICU arena (Mani, 2006).

The Hindus believe in a duty-based (deontic) rather than rights-based approach (human-rights based) to ethical decision making. Death is perceived as the passage to a new life (Mani, 2006). However, untimely death is profoundly grieved as it is the way that the person dies that is important for the Hindus. Good deaths are considered by old age, proper good-byes and the settlement of all family and financial obligations. A bad death may be violent, premature or considered to have occurred in the wrong place such as in the home or the Ganges River and is usually accompanied by excrement, vomit and horrible facial expressions (Firth, 2005). Dying in the ICU appears to fall into the category of a bad death.

Do-Not-Resuscitate (DNR) order states that cardio-pulmonary resuscitation (CPR) is not initiated when breathing and pulse ceases (Do not resuscitate, 2007). The order may be written by the person's doctor after discussing the issue beforehand with the person (if possible) or his/her proxy or family. The acronym of DNR has evolved to include (do not attempt resuscitation (DNAR); allow natural death (AND) and in nursing homes and long-care facilities;–do not hospitalise (DNH).

The DNR order is by and large acceptable to the Hindus because death should be peaceful and mechanical life-sustaining support is viewed as being of no value.

Organ transplantation is permitted (Firth, 2005). However, in India this is extremely limited. In some Hindu traditions, suicide is viewed as a form of spiritual purification, especially among the terminally ill. By ensuring that the dying person is not exposed to their own faeces, vomit or urine, a good death is realised (Firth, 2005).

1.8.1. Post mortem care

Consultation of the relatives is required before the dead body is washed by non-Hindus. Washing of the dead body is part of the funeral rites (Firth, 2005).

Non-Hindus may not wash the dead body but are permitted to close the eyes, straighten the limbs and wrap the body in a plain sheet with no patterns or religious insignia. This can only be done when wearing disposable gloves (Firth, 2005).

Hindu family members wash the dead body and wrap it in a piece of new cloth. Removal of sacred beads or other forms of body adornment is not allowed (Firth, 2005). Cremation is advocated, as the soul is re-incarnated. In India, the eldest son lights the funeral pyre. In westernised countries he watches the coffin pass into the crematorium furnace to ensure that the deceased has a favourable rebirth. On the third day following the cremation, the ashes are thrown into a river and if possible, the Ganges (Firth, 2005).

Organ donation and forensic post-mortem examination are not opposed however are not deemed popular. As in the Muslim religion, preparation of the dead body begins after post-mortem examination (Firth, 2005).

1.9. Traditional Xhosa/Zulu perspective

There is a dearth of information in the literature concerning this aspect of dying and death amongst the Xhosa and Zulu populations. Most information was obtained from colleagues within the Department of African Religious Studies at the University of Cape Town (Fouché, 2013: 222).

The traditional Xhosa and Zulu tribes are traditionally venerate ancestor believers but today many of the Xhosa and Zulu speaking people in South Africa are Christians as a result of their early contact with missionaries from Europe in the mid-19th century.

Death for the traditional Xhosa and Zulu is not perceived as the end of life but rather as a physical detachment from other human beings. Their strong belief in the ancestors is associated with the life hereafter (Mndende, 1997). Mcetywa (1991) illustrates this traditional view of death by using words or phrases from the Mpondo people who originate in the Transkei:

- *Utshonile* (has disappeared) and also in less-used *Utshabile*
- *Akasekho* (not present)
- *Usishiyile* (has left us)
- *Uhambile* (has gone)
- *Ukusweleka* (that which is scarce)

The death of a traditional Xhosa or Zulu person means to join the ancestral world to become a guardian of the living and an intermediary between the spiritual and physical worlds (Mndende, 1997). This concept is extremely important for health-care professionals who may be involved in the dying process so that the necessary conditions are provided or adapted to facilitate the transition. The conditions and facilities make it almost impossible to respect such traditions should a Xhosa or Zulu person be dying in an ICU.

Mndende (1997) conducted informal interviews in Khayelitsha (an area in Cape Town inhabited predominately by Black people) with the *amagoduka* (those who come to urban areas to work but return home intermittently to rural areas) about where they most preferred to die. The respondents indicated that hospitals would be avoided if at all possible and cited three reasons: (i) a hospital is not a home; (ii) the wishes of the dying person are not easily taken into account and (iii) the traditional approach to treating the dead is difficult to respect (Mndende, 1997: 796).

The Xhosa and Zulu view hospitals as foreign structures and therefore are not conducive to preparing for death. A person is born in an *endlinienkulu* (main hut) and the soul should ideally depart from the world from the same place. Another difficulty that is encountered is that the body should be buried near the *inkaba* (kraal or cattle pen) which is complicated to arrange from a hospital (Bryant, 1949) (Mbiti, 1981).

Critical care medical interventions, especially mechanical ventilatory support, are seen as undesirable and pointless interference in the process of dying naturally. A concerning consequence is that such a death results in traumatic memories for the family and community. Equally important for the family is their presence at the bedside or home as it is believed that blessings are bestowed upon them from the dying person (Mcetywa, 1991).

1.9.1. Post mortem care

The body is washed by women who have passed child-bearing age in the belief that younger women may become infertile, which is not viewed favourably by their clans. Because death seldom happens in the home, the undertakers do most of the preparation of the body and arrangements for the funeral (Mndende, 1997).

Traditional Zulu and Xhosa people view autopsies as suspicious, as it is important that the dead are buried whole.

Mndende (1997) writes that the Zulu and Xhosa also believe that body parts are removed at autopsies and used for research or even for *muti* and witchcraft by traditional healers or witch-doctors. This reaffirms this group's desire often to avoid hospitals when dying.

Muti is a term used for traditional medicine in southern Africa. The word is derived from isi-Zulu meaning tree. *Muti* may also be applied in different formulations used in traditional dispensaries by traditional healers or witch-doctors (Richter, 2003).

It is the head (chief) of the tribe that decides if organ donation is permitted. Often, organ donation is declined because the journey to the ancestral world is thought to be broken for the dead person missing an organ(s) (Richter, 2003).

Although no literature is available, communication with the Department of African Religious Studies at the University of Cape Town reports on a unique South African phenomenon known as 'the politics of dying.' The social standing of the dying person determines how they will be buried. In contemporary society, affluent families tend to have large, lavish funerals (Fouché, 2013: 222).

The poor also try to give their dead relatives the same type of funeral. To a large extent, this has become possible as a result of the

Table 2
Phases of Dying. Modified and Adapted from Anderson (2000).

PHASE ONE Preparation	PHASE TWO Symptom Management	PHASE THREE At the Time of Death
• Focus on the patient and family • Educate the family and/or significant other on the last hours process to alleviate fear • Increase involvement in patient care as much as possible • Get contact details of family and/or significant other – home, work, cell, neighbour • Discuss death certificate process • Family education – there may be different agenda of family, children, religious customs and beliefs, DNR orders • If patient dying of a brain injury or non-malignant illness, consider bringing up the topic of organ donation • If possible and appropriate, children and pets to have a short farewell visit	• *Pressure care and positioning*. Elevate head slightly. Use of flat boards/draw sheet to aid turning. This prevents tearing of the skin • *Skin care*. Keep patient clean and pleasant smelling as there may be physical contact from the family and significant other. Gentle massaging of extremities • *Mouth care*. Keep mouth clean – use of mouthwash helpful but dilute as can be abrasive. The family/significant other may want to kiss the patient. Clean and moisten dentures or remove if drowsy • *Relieve pain*. Literature suggests that pain rarely increases in the last hours. May need to reduce or change Morphine • *Continue nutrition and hydration* – human right not to 'starve to death.' Reassure the family/significant other that this is not so. Moisten conjunctivae (artificial tears), nostrils and lips (lip lotion, petroleum jelly • *Remove accumulating secretions* by positioning patient on his/her side • Gentle oro-pharyngeal suction or use 'finger swab' to dab out secretions • Consider medication to dry out secretions • Oxygen rarely needed • *Incontinence* of urine/faeces cleaned up immediately. • May require use of urinary catheter as diapers/nappies cause creases and require securing and therefore effects skin integrity • Terminal sedation. May be required if signs of pain and suffering. Requires discussion with family/significant other	• Counsel family/significant other not to be alarmed • Advise and encourage family/significant other to be with the deceased • At an appropriate time, discuss the death certificate and 'what happens now?' • This is an opportunity for the ICU nurse and other members of the interdisciplinary team to say goodbye

Table 3
End of Life Care for the Dying Patient in ICU (Fouché, 2013: 226).

Comfort care	✓ Promote the provision of quality comfort care to the dying as an active, desirable and important skill
	✓ Assess (i) current medication and discontinue 'non-essentials'; (ii) continue with medication for pain, agitation, nausea and vomiting; (iii) withdraw antibiotics, stop blood test and x-rays and (iv) maintain good basic nursing care – pressure and mouth care, fresh/clean linen
	✓ Apply knowledge gained from palliative care research to end of life education and care
Psychological care	✓ Have the ability communicate in the language of the patient and/or family. May need an interpreter
Social care	✓ Recognise one's own attitudes, feelings, values and expectations about death and the dying person's cultural and spiritual diversity existing in beliefs and customs
	✓ Identify barriers and facilitators to patient's and care-givers' effective use of resources
	✓ General practitioner or 'Family Doctor' notified of patient's condition
	✓ If appropriate, the patient's place of employment notified
Spiritual care	✓ Religious, cultural and spiritual concerns discussed with family
	✓ The probability of performing traditional and cultural rituals in the ICU
	✓ Early contact with religious personnel – prayers for the dying/last rites/anointing of the dead. The patient may even be required to be baptised
Family care	✓ Communicate effectively and compassionately with the patient (if conscious), family and other members of the ICU team about EoLC
	✓ Assist the family, colleagues and one's self to cope with suffering, grief, loss and bereavement at end of life
	✓ Demonstrate respect for the patient's (and family's) views and wishes during end of life
Ethical & legal care	✓ Understand the implementation and consequences of issues related to resuscitation, with-holding and with-drawing treatment, foreshortening life and futility
	✓ Be aware of medico-legal issues
Preparation to die	✓ Respect Advanced Directives, Living Wills, DNR, Organ Donation.
	✓ Involvement of family with post mortem care
	✓ ICU nurses' knowledge of post mortem care of various religious groups.
	✓ Observance of rituals and traditions

proliferation of insurance companies offering funeral cover targeted at the Black population (Mndende, 1997). It is quite common in the townships and rural areas to have burial societies or clubs – *Omasingcwabisane* or *imibutho*. Membership of these societies and clubs contribute a fee every month to ensure that when a death occurs, there will be no financial ruin after the requisite burial ceremony (Mndende, 1997).

In the final hours of living, there are absolute necessities that need to be adhered to. Firstly, the family requires education about the dying process and that the time of death is unpredictable. Secondly, the interdisciplinary team should endeavour to assist the family as much as possible to avoid physical psychological exhaustion.

Considering the ICU nurses' experiences of the deaths of patients under their care in the ICU, necessary knowledge, skills and competencies are incorporated below in order for nurses to deliver quality care in the last days/hours of their patients' lives (Fouché, 2013).

1.10. Signs and symptoms of impending death

Identifying the key signs and symptoms of dying is an important clinical skill. These are:

- Rapidly increasing weakness and fatigue
- Difficulty in swallowing with a loss of the gag reflex. This results in pooling of oro-pharyngeal secretions causing a gurgling sound known as the 'death rattle'
- Decreasing level of consciousness which may cause delirium and agitation
- The patient may have apnoeic (cessation of breathing) spells
- Evident cardiovascular changes – slowing of the pulse rate and

electrocardiogram (ECG) abnormalities – extra heart beats (ectopics); lethal arrhythmias (ventricular fibrillation or flutter) and even asystole (no heart beat) (School, 2018).

For ICU nurse educators, learning how death education is taught in other countries (or other ICUs) can lead to a cross-pollination of ideas in the teaching and learning of multi-cultural issues surrounding dying and death.

1.11. The phases of dying

There are three phases of dying as shown in Table 2 below

The End of Life Care Plan for the dying patient in ICU (Table 3) has been adapted and modified (Fouché, 2013: 226) and includes components from the Liverpool Care Pathway (Ellershaw & Ward, 2003: 32) and the American Association of Colleges of Nursing Competencies necessary for nurses to provide high-quality care to patients and families during the transition at the end of life (Brenner, 2002: 12).

2. Conclusion

Lack of familiarity with or knowledge of religions and death rituals may be perceived as disrespectful, and subsequently can be damaging for the dying or deceased patient and the family.

Health professionals may be seen as strangers or outsiders, rather than as a valued person in whom the dying patient and family can have trust and confidence. It is through knowledge and experience of the dying and deaths of people that empathy and compassion will succeed in earning the gratitude of families (Rutty, 2005).

The need to understand the influence of culture and race on the dying process has received more extensive attention among death educators (Schim, Doorenbos, Miller, & Benkert, 2003). This issue, especially from a South African multi-cultural perspective, involves examining how culture, religion, spirituality and diversity influence the social aspect of dying processes together with moral and ethical issues at the end of life.

Providing dignified comfort care of the dying in the last days of living may be achieved and it is possible to have scenarios as depicted in the images below. Such scenarios have been in place for centuries and despite great advances in health care and life sustaining technology, we should strive for the well-being of the patient, their families and ourselves.

When a patient is dying in the ICU, the ICU nurse has only one chance to allow for a good death and if done well, there may be significant personal and family growth. However, if done poorly, the ‘closure’ or ‘finale’ of death for the patient and family may be incomplete and bereavement can possibly be prolonged and traumatic.

It is a time that allows an opportunity for the patient and family to build upon final memories, attend to any unfinished business and of course to say goodbye. Should the patient be conscious, semi-conscious or even comatosed, the role of the ICU nurse is to provide care to the patient and family and to maintain the identity and dignity of the dying. This requires of her to explore ways of involving families in patient care and this contribution can provide a sense of a final gift.

Conflict of interest

None.

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References

Anderson, I. (2000). Last Hours of Living. Retrieved March 18, 2014, from < http://www.cme.utoronto.ca/endoflife/Modules/LAST20%HOURS.pdf > .

Bardo Group (2013). *When a Buddhist Dies: Instructions and Prayers.* Cape Town: Bardo Group.

Barett, D. B. (2001). *World Christian Encyclopedia: A Comparative Survey of Churches and Religions in the Modern World.* New York: Oxford University Press.

Brenner, Z. R. (2002). Lessons for critical care nurses on caring for the dying. *Critical Care Nurse, 22*, 11–12.

Bryant, A. T. (1949). *The Zulu people: As they were before the white man came.* Pietermaritzburg: Shuter and Shooter.

Bülow, H., Sprung, C. L., Reinhart, K., Prayag, S., Du, B., Armaganidis, A., & Mitchell, M. L. (2008). The world’s major religions’ points of view on end-of-life decisions in the intensive care unit. *Intensive Care Medicine, 34*(3), 423–430.

Clark, P. (2006). Tube feedings and persistent vegetative state patients: ordinary or extraordinary.

Cohn-Sherbok, D. (2003). *Judaism: History, Belief, and Practice.* London: Routledge.

Daar, S., & Khitamy, B. (2001). Bioethics for clinicians. 21. Islamic bioethics. *Journal of the Canadian Medical Association, 164*, 60–63.

de Swardt, C., & Fouché, N. (2017). “What happens behind the curtains?” An exploration of ICU nurses’ experiences of post mortem care on patients who have died in intensive care. Advance online publication *Intensive and Critical Care Nursing.* https://doi.org/10.1016/j.iccn.2017.05.005.

Ebrahim, A. (2000). The living will *(wasiyat al-hayy)*: A study of its legality in the light of Islamic jurisprudence. *Medical Law, 19*, 147–160.

Ellershaw, J., & Ward, C. (2003). Care of the dying patient: The last hours or days of life. *British Medical Journal, 326*, 30–34.

Firth, S. (2005). End-of-life: A hindu view. *Lancet, 366*, 682–686.

Fouché, N.A. (2013). Intensive care nurses’ experiences of death in the ICU and the implications for postgraduate nursing pedagogy: a Heideggerian phenomenological study (Doctoral thesis). < http://open.uct.ac.za/handle/11427/13185 > .

Hatzinikolaou, N. (2003). Prolonging life or hindering death? An orthodox perspective on death, dying and euthanasia. *Christian Bioethics, 9*, 187–201.

Holden, A. (2002). *Jehovah's Witnesses: Portrait of a Contemporary Religious Movement.* London: Routledge.

Mani, R. (2006). End-of-life care in India. *Intensive Care Medicine, 32*, 1066–1068.

May, A. (2003). Physician assisted suicide, euthanasia and Christian bioethics: Moral controversy in Germany. *Christian Bioethics, 9*, 273–283.

Mbiti, J. S. (1981). *Introduction to African Religion.* London: Heinnemann Ltd.

Mcetywa, S. (1991). *Hermeneutics in the Context of African Traditional Religion with Particular Reference to the Mpondo People in Transkei.* Unpublished MADurban, South Africa: University of Durban-Westville.

Mndende, N. (1997). African traditional attitudes to death and dying. *Continuing Medical Education Journal, 15*(7), 793–798.

Netherlands Ministry of Health, Welfare and Sport & Ministry of Security and Justice. (2011). Euthanasia, assisted suicide and non-resuscitation on request. < https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request > (accessed 17.07.26).

Pauls, M., & Hutchinson, R. (2002). Bioethics for clinicians: Protestant bioethics. *Journal Canadian Medical Association, 166*, 339–344.

Ravitsky, V. (2005). Timers on ventilators. *British Medical Journal, 330*, 415–417.

Richter, M. (2003). Traditional medicines and traditional healers in South Africa. Paper presented at the Discussion Paper Prepared for the Treatment Action Campaign and AIDS Law Project, Johannesburg. Retrieved from < http://www.tac.org.za/Documents/ResearcgPapers/Traditional_Medicine_briefing.pdf > .

Rutty, J. E. (2005). Religious attitudes to death. In J. Payne-James (Ed.). *Encylopedia of Forensic and Legal Medicine* (pp. 525–536). Boston: Elsevier Academic Press.

Sachedina, A. (2005). End-of-life: The Islamic view. *Lancet, 366*, 774–779.

Schim, S., Doorenbos, A., Miller, J., & Benkert, R. (2003). Development of a cultural competence assessment instrument. *Journal of Nursing Measurement, 11*(1), 29–40.

Shannon, T. A. (2006). Nutrition and hydration: An analysis of the recent Papal statement in the light of the Roman Catholic bioethical tradition. *Christ Bioeth, 12*, 29–41.

Stanford School of Medicine Pallative Care. 2018. https: [ONLINE] Available at: < https://pallative.stanford.edu/transition.edu/transition-to-death/signs-of-impending-death/ > . [accessed 11.12.18].

Steinberg, A., & Sprung, C. (2006). The dying patient: New Israeli legislation. *Intensive Care Medicine, 32*, 1234–1237.Further reading

Schim, S. M., Briller, S. H., Thurston, C. C., & Meert, K. L. (2007). Life as death education scholars: Passion, personality and professional perspectives. *Death Studies, 31*, 165–172.