



Experiencing the possibility of near death on a daily basis: A phenomenological study of patients with chronic heart failure



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ABSTRACT

Background: Chronic heart failure (CHF) is a syndrome that greatly impacts people's lives. Due to the poor prognosis of CHF, together with the frequent exacerbations of symptoms, death is a topic that is very present in the lives of patients with CHF.

Objective: To explore thoughts about death experienced by patients with chronic heart failure in their daily lives.

Methods: A hermeneutic phenomenological study was carried out. Conversational interviews were conducted with 20 outpatients with chronic heart failure. Analysis of the responses was based on the method proposed by van Manen.

Results: From the analysis, four main themes emerged: (1) Feeling afraid of the possibility of dying; (2) Acceptance of the possibility of death; (3) Desiring death for relief from suffering; and (4) Striving to continue living to enjoy family.

Conclusions: This study presents, as a novel finding, that people with CHF experience the possibility of near death on a daily basis. This experience, which they must encounter on their own, makes them afraid. In addition, some of them, in view of the discomfort they are living, wish to die, with some even considering committing suicide.

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Introduction

Patients with chronic heart failure (CHF) have become a priority care group for health systems in both developed and developing countries,¹ with more than 26 million people affected worldwide.² This increased concern is primarily due to the increasing prevalence of CHF, as it affects 1 and 2% of the adult population in developed countries and more than 10% in people over 70 years of age,³ as well as the low quality of life of people

who suffer from CHF.⁴ Among diseases, CHF is associated with one of the worst life expectancies, i.e., a 53% survival rate at 5 years after diagnosis.⁵ One of the challenges for health providers regarding treating individuals with CHF is the complexity of their care.

In their day-to-day lives, these patients experience great concern and discomfort related to intense fatigue, dyspnea, and a progressive deterioration of health that interrupts the normal course of life, producing feelings of frustration, loss, depression, and loneliness, among others, and health professionals should know how to treat these feelings.⁶ These patients must develop strict self-care behaviors, modify their lifestyles, and undergo complex treatments.⁷ Furthermore, they experience situations that produce profound changes in all personal dimensions, such as the perception of change in personal identity, the notable impact on family and social roles, and numerous spiritual needs, among which the need for hope and thoughts regarding death

Abbreviations: CHF, chronic heart failure

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Modelo de Enfermería Universidad de Navarra

Model of Interpersonal Relationship between the Nurse and the Person/Family Cared for

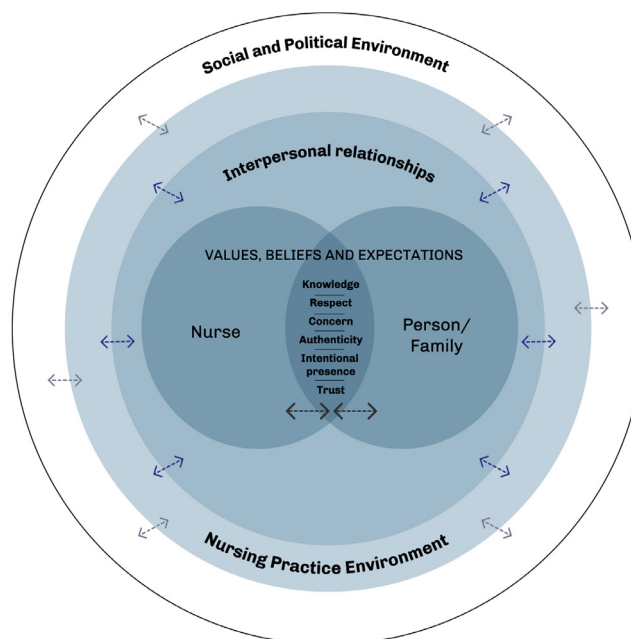


Fig. 1. Model of interpersonal relationship between the nurse and the person/family cared for (Saracibar, 2009).

are notable.⁸ The poor prognosis, together with the threat patients perceive to their life when they suffer from a decompensation or exacerbation of their symptoms, are, among others, aspects that generate thoughts about death.^{9,10} However, even though people with CHF show a desire to talk about this issue with their families and/or with healthcare professionals, most have been found to avoid facing these conversations.^{11–13} This fact, far from helping patients, further increases their concern and discomfort.⁸

Current clinical practice guidelines indicate the importance of discussing future care strategies with patients with CHF.¹⁴ Studies that have explored the advantages of health professionals addressing thoughts about near death with patients have reported benefits for patients. Specifically, several studies found that treating these thoughts improved the decision-making process^{15,16} and provided some clarity, sense of control, and hope to patients.¹⁷ Although it has been shown that addressing these issues through strategies such as advanced care planning can improve communication with the patient around end-of-life issues and improve documentation of individual preferences, this is an uncommon practice in people with heart failure.¹⁸ In fact, studies have identified discrepancies in patients' and physicians' perceptions of the risk of CHF severity, demonstrating that some people with CHF are not fully aware of the severity of their condition and are not prepared to make treatment decisions.¹⁹

Another aspect that should be highlighted is that most of the studies that collected the experiences of patients with CHF related to death did so from the perspective of very advanced disease or in the framework of palliative care.^{10,20–23} In fact, very few studies have explored this topic in depth, from a broader perspective of the daily life of patients with CHF, and those that do exist were conducted more than a decade ago.⁹ In addition, few interventions have been designed to address these issues for people with CHF, and these have had very limited impact.¹³

Faced with this situation, health professionals need to understand these patients' experiences to design updated and innovative interventions that improve their wellbeing. Therefore, the objective of this study was to explore the thoughts about death experienced by patients with CHF in their daily lives.

Materials and methods

Design

The results presented were obtained through a phenomenological hermeneutic study²⁴ which was carried out on the basis of the method proposed by van Manen.²⁵ The research methods used in this approach are both descriptive and interpretative in that it provides a description of the event or lived experience and interprets its meaning.²⁶

Theoretical framework

This research was illuminated by the conceptual "Model of interpersonal relationship between the nurse and the person/family cared for" developed by Saracibar²⁷ (see Fig. 1). This model promotes person-centered care and encourages the development of disciplinary knowledge.^{8,28–34} According to this framework,⁸ the human person is conceived as being made up of body and soul in a relationship. The person is understood as a unitary set of parts—singular, indistinct in itself, and distinct from others—and in a continuous state of growth and newness. Health is conceived as a human experience that is integrated into people's lives. The experience of illness is part of the experience of health and goes beyond it because it constitutes a strong cause of change in the person. Health is both a value and a lived experience according to the perspective of each person and refers to the person's wellbeing and the realization of his/her potential. From this understanding, the framework focuses on enabling people/families to realize their own possibilities and find meaning in their health experiences and their lives.

Participants

This study was conducted in an outpatient heart failure unit of a tertiary hospital in the north of Spain. The sample consisted of 20 patients with CHF who were selected based on purposive sampling that ensured meaningful experiences with the phenomenon under study.³⁵ Patients were selected based on the following inclusion

Table 1
Sociodemographic characteristics of the sample
(n = 20).

	years
Age	
Mean	74.6
Range	65–89
Time since diagnosis	
Mean	5
Range	1–9
	n (%)
Sex	
Male	8 (40)
Female	12 (60)
Marital status	
Married	12 (60)
Single	4 (20)
Widowed	3 (15)
Divorced	1 (5)
Education level	
High school or less	14 (70)
University degree	6 (30)
Job status	
Retired	12 (60)
Unemployed	8 (40)
NYHA class	
II	15 (75)
III	4 (20)
IV	1 (5)

criteria: (a) age over 18 years; (b) NYHA class II-IV (*New York Heart Association Functional Class*); (c) CHF diagnosed more than 6 months prior; (d) outpatient status; (e) the physical and mental ability to have a conversation; (f) the ability to speak the Spanish language; and (g) a signed consent form. Subjects were advised that participation in the study was voluntary.

The nurses in the CHF outpatient unit were the gatekeepers who recruited these patients and were responsible for the follow-up. First, based on the established selection criteria, the nurses contacted patients by phone to inform them about the possibility of participating in the study, and in the case that they showed interest during the phone call, they delivered a participant information leaflet to the patients upon their arrival at the CHF outpatient unit. If the patients agreed to participate, the nurses called the interviewing researcher (first author) at that time. Once at the CHF unit, the interviewer clarified possible doubts, provided the patients with an informed consent form, and began the interviews after the form was signed. None of the people invited to participate refused to take part in the study.

Data collection

The data were collected through conversational phenomenological interviews that were conducted face to face between the first author and each patient. The interviews took place from July 2015 to March 2016. At the beginning of the interviews, the sociodemographic data of the patients were collected (Table 1) (data regarding functional class and time since CHF diagnosis were collected by the nurses of the CHF outpatient unit from the medical records). Then, the interviews began with an open question similar to “I would like you to tell me what it is like for you to live with CHF...”. While participants reported their experience, notes were taken on key words or ideas that were used by the researcher to thread the themes together in relation to the interest of the study and the personal experiences of the patients. Patients were not directly asked about topics related to death, but it was a main topic that emerged from the results. The purpose of the interviews was to be open to the experience as it was

Table 2
Thematic guide.

Tell me, how do you live with chronic heart failure?
Has your life changed since your illness began?
Is there anything especially worrisome about your situation?
How is your “day-to-day” life?
What would you like to be able to do now but cannot do because of your condition?
How is this affecting you?
In general, what do you think could help you in all this?
If you had to summarize everything you said or highlight the most important aspects, what would you say?
Would you like to add anything not covered yet or important to you?

lived and to determine how certain phenomena and events were constituted and occurred in the lived experience without presupposing anything.²⁵ A thematic guide was developed that was used only in those cases in which patients showed difficulties focusing on the phenomenon and/or continuing the interview (Table 2).

The interviews took place in one of the rooms of the CHF unit on one of the days that participants went to the hospital for a medical/nursing appointment or to undergo a medical or laboratory test. The interviews lasted between 30 and 60 min, and they were recorded by voice recorder for later transcription. In addition, field notes, such as tone of voice, gestures, and body position, were taken to enrich the interpretations of the recordings. The sample size was determined adequate after verifying that new interpretations were redundant and did not reveal novel aspects about this experience,³⁶ and the experiential material obtained supported deep descriptions and interpretations of the phenomenon under study.²⁵

Ethical considerations

Participants received oral and written information, and free participation, confidentiality, and anonymity of the data were emphasized. The first author coded the identities of the participants without any other member of the team having access to them. Additionally, the patients were informed about the possibility of withdrawing from the study if they wished and that their participation would not affect the care that they were receiving in the unit. Each patient signed an informed consent form before beginning the interview. Notably, the researcher who interviewed the patients did not have any contact with them prior to the interview.

This research was approved by the Research Ethics Committee of the University of Navarra (Code 042/2013) and by the hospital management team and meets the criteria of the Declaration of Helsinki.³⁷

Data analysis

The philosophical, philological, and reflective methods developed by van Manen were applied, thus achieving a systematic analysis of the transcriptions.^{25,26} First, macro-thematic reflection or a *wholistic reading approach* was performed, and then, micro-thematic reflection, which consisted of two levels, the *selective or highlighting approach* and the *detailed or line-by-line approach*, was conducted. During this process, the researchers applied *epoché reduction*, through which they reflected and put aside their preconceptions. Likewise, through *vocatio*, the interpretations of what the patients had indicated in their interviews were written. Another key aspect that the researchers had very much in mind was the *hermeneutic circle*, which, together with *reduction*, helped confront the preconceptions of the researchers with new knowledge and provided a continuous reflection between “the whole and the parts” within each interview and in light of all the interviews. From the analysis process that emerged as a main theme, meaning about near death is a key aspect in the experience of living with CHF. QSR International’s NVivo 10 qualitative data analysis software was used to organize the data. Table 3 shows an example of the analysis process.

Table 3
Examples of the analysis process.

Wholistic reading approach	Selective approach	Detailed approach	Theme
My life has changed radically: it is very traumatizing, and I'm scared.	"There are several aspects of my life that I am afraid of. . . One of the things that scares me is the implanted automatic defibrillator that I carry because I am afraid that I can have a shock at any time and that something can happen to me. . . In addition, as this disease can lead to so many complications, I brood on everything I feel. . . I would say that I have even become a little hypochondriac. . . At night, all these fears that I feel are even more accentuated because I easily wake up." (P-11)	I am afraid of death.	Feeling afraid of the possibility of dying
I am satisfied with my life, and I am not afraid of death.	"I have been part of this process for many years, since I was a child, and I have reached 77 years; so, at this point in life, having this disease is not something that worries or distresses me (. . .). I am not afraid that something will happen to me or that my situation will worsen and my end will come. That is, I am not afraid to die (. . .). In fact, I think I have to thank God because he has allowed me to live all this time. That is why, really, I do not see my end as something dramatic" (P-13).	I am not afraid of death.	Acceptance of the possibility of death
The physical affectation caused by my illness has led me to want to take my life.	"For me, living with CHF is horrible because all day long, I have the feeling of drowning, and that is very hard to bear. . . The truth is that being the way I am. . . I would not mind leaving, right? Although I have never said it, sometimes I have thought about (gets emotional) even taking several boxes of medicines or throwing myself over a bridge that I used to go for a walk with my daughters, to see if at once I would end with this suffering and pain. . ." (P-09).	The disease has changed me: I have thought about taking my life	Desiring death for relief from suffering
I have my limitations, but I must continue.	"I am aware that I will not live for many more years. Therefore, I have no economic or material ambitions because of what I have left of my life. . . All I ask is to have slightly more health. . . Nothing more. As I see it difficult for that to be achieved, even though I feel as bad as I am now, the only thing I want is to be able to live a few more years to be able to enjoy my family for a longer time (gets emotional). That is my only desire. . ." (P-07).	I want to live to enjoy more time with my family.	Striving to continue living to enjoy family

Rigor

To ensure the rigor of the interpretations, the aforementioned analysis process was performed first by two of the researchers (MOL & MSR) independently, then jointly, and finally with the rest of the researchers. Other aspects that preserved the rigor of the data were continuous reflection on and discussions of the interpretations by the team, the application of *epoché reduction*, and the application of criteria for credibility and bias control proposed by van Manen.²⁵ Reporting of this research adheres to the COREQ guidelines.

Results

Regarding the sample characteristics, the mean age of the participants was 74.6 years, 60% were female ($n = 12$), 60% were married ($n = 12$), and 70% ($n = 14$) had primary or secondary education. None of the interviewees were working at the time of the interview. Regarding the evolution of CHF, the mean time since diagnosis was 5 years, and 75% ($n = 15$) had an NYHA functional class II.

This study showed that the possibility of a near death is an experience that is very present in the thinking of people with CHF; however, this is experienced differently among these patients. Thus, four themes related to this experience were identified: 1. feeling afraid of the possibility of dying; 2. acceptance of the possibility of death; 3. desiring death for relief from suffering; and 4. striving to continue living to enjoy family.

Theme 1. Feeling afraid of the possibility of dying

The patients with CHF indicated that they worried frequently and with great intensity about their situation and about everything that could disrupt the stability of their health status ($n = 11$). Most patients experienced a fear of dying, and fear was related to different aspects. According to several of the patients, on many occasions, this feeling was motivated by the appearance of acute symptoms of

the disease, a fact that they confessed was something continuous in their life. This patient provided the following statement: "As this disease can lead to so many complications, I give a lot of thought to everything I feel. For example, if my side hurts, I begin to think that it may be because my kidney is beginning to fail (. . .). The darkness is very bad for these things because you see everything very black, with a very negative outlook. At night, as I have to go to the bathroom frequently because of diuretics, I wake up and begin to feel stitches in my chest, shortness of breath, extrasystoles, and I worry and think about my future (. . .). And a lot of things I do not tell my wife, that I conceal so that she does not worry all day. If I die, she will find me, right?" (P-11, male, 65 years).

As other patients commented, this fear was also caused by the uncertainty they felt in the face of changes in treatment or medical interventions proposed by health professionals. "I start to think: What will they have to do to me, and how will they do it? And I get more and more nervous, and I feel more afraid of that situation. All this destroys me and makes me have a very bad time because I start to think that something bad can happen to me and that I can die. . . And I do not want to die yet!" (P-02, female, 74 years), one patient exclaimed. For some patients, the possibility of having to receive a heart transplant frightened them: "Another aspect that causes me real fear is the fact that they have to transplant me. The doctors told me that all possibilities of treatment had been exhausted and that the only possible alternative was a heart transplant. . . That was a very, very hard blow. After that news, I was very discouraged because I began to think of a friend who died after a transplant, of the complications I could have. . . and the truth is that I do not see this option with too much optimism" (P-11, male, 65 years).

Along with these concerns, other patients noted that this fear of dying caused them to feel pressure to take good care of themselves, adopt new lifestyles, and strictly comply with the therapeutic plan. "The doctor who treated me initially already told me, "If you listen to me, you will not die from this. However, if you ignore me, you know what is coming. . .". These words had a great impact on me, and although all the changes I had to make in my life shocked me at first, I understood

that I had no choice but to listen to him” (P-12, male, 74 years), one patient reported.

In addition, there were people who claimed that fear was constantly present in their lives because they continually experienced signs of their vital instability and the possibility of sudden death. One patient explained it this way: “The issue is that I always have something that reminds me that I am not well and makes me aware that anything can happen to me at any time...” (P-11, male, 65 years).

Theme 2. Acceptance of the possibility of death

Although some patients also felt the presence of a possible near death, this fact did not generate uneasiness or anguish because, as they explained, they observed it as a natural part of their lives ($n = 6$). This is how one patient explained it: “I am aware that there will come a day in which my heart says “enough”, that it will begin to fail irremediably and that this will be my end. I think that we have to be realistic with the situation that each one has and take into account that we are human and that here, nobody stays!” (P-04, male, 78 years).

The people who experienced this sense of calm said that they felt lucky with the life they had until then and that it helped them not think with such fear in its end. One patient’s comment exemplified this attitude: “I have been with this illness for many years, since I was a child, and I have reached 77 years; so, at this point in life, having this disease is not something that worries or distresses me (...). I am not afraid that something will happen to me or that my situation will worsen and my end will come. That is, I am not afraid to die (...). In fact, I think I have to thank God because he has allowed me to live all this time” (P-13, female, 77 years).

Theme 3. Desiring death for relief from suffering

Some of the patients recognized that the impact of the disease on their lives and the discomfort that it caused frequently elicited a desire for death ($n = 4$). One patient explained, “I want to die, and I do not feel sorry to recognize it. I have already told this many times to my husband, to my family, to the priest... even the doctor who attends to me! But they don’t even listen to me. (...). When my grandchildren hear me say that I want to die, they cry, and then I tell them, “My children, it is not worth living to be like this!” Because seeing myself in this situation and thinking that I can do almost nothing by myself makes me feel very overwhelmed” (P-19, female, 72 years).

In some cases, this desire to die went even further; thus, some patients confessed that the suffering they experienced was such that they had thought of committing suicide. The story of one patient is an example of this: “For me, living with CHF is horrible because all day long, I have the feeling of drowning, and that is very hard to bear... The truth is that being the way I am... I would not mind leaving, right? Although I have never said it, sometimes I have thought about (gets emotional) even taking several boxes of medicines or throwing myself over a bridge where I used to go for a walk with my daughters, to see if at once I would end with this suffering and pain...” (P-09, female, 78 years). However, this same patient, after having shared her thoughts with the researcher, recognized that she had overcome these ideas, even though the causes that motivated her suffering were still present: “I know that thinking about these things is horrible, but I felt terrible! Now I have tried to erase these ideas from my mind with the help of God and my family, and I am accepting what God has for me...” (P-09, female, 78 years).

Theme 4. Striving to continue living to enjoy family

For some people with CHF, despite the considerable impact of the illness on their lives, they longed to continue living for a few more years ($n = 6$). One patient explained this excitedly: “I am aware that I will not live for many more years. Therefore, I have no economic or

material ambitions because of what I have left of my life... All I ask is to have slightly more health... Nothing more. As I see that it is difficult for that to be achieved, even though I feel as bad as I am now, the only thing I want is to be able to live a few more years to be able to enjoy my family for a longer time (gets emotional). That is my only desire...” (P-07, female, 69). As this patient said, one aspect that helped maintain this desire to continue living, despite her suffering, was to focus her energy and attention on the aspects that she considered central in her life: “The most important thing I have in my life is my family and, especially, my grandchildren. In addition, my husband was able to retire a few years ago to be with me and... we are so happy together, and we get along so well!” (P-07, female, 69).

Discussion

To our knowledge, this is one of the few published studies showing that suffering from CHF causes the patient face to the reality of death on a daily basis. This finding differs from what other studies identified, in which the majority of patients said that they thought little about death, but when they did, it was because they were admitted to the hospital.^{10,20} However, our study showed that death is very present in the daily lives of patients, although each patient’s experience differs.

Specifically, in this study, the feeling most frequently expressed by patients when they alluded to death was fear. This fact contrasts with the study by Strömberg and Jaarsma,⁹ who identified that very few patients felt severe fear of their situation. These authors explained this finding by saying that most of the patients were probably unaware of the poor prognosis of their disease or that they had already accepted and adapted to their situation. The lack of awareness of the poor prognosis associated with CHF by patients, family members, and some health professionals is also highlighted by other studies.^{38,39} However, it has been shown that sometimes, even though people are aware of their circumstances, they may not be prepared to accept the possibility of their life coming to an end, and they may live with fear.⁴⁰ According to our results, this fear was sometimes continuous and, in other cases, was related to the appearance of acute symptoms or uncertainty regarding certain medical treatments, such as surgical treatments. Studies such as that by Klindworth et al.²⁰ attributed the fear of these patients to thoughts related to the possibility of a prolonged and painful death.

This research has shown that some people with CHF live with acceptance of the possibility of dying. Several of the participants considered death as a natural part of life, and others confessed that this tranquility came from the satisfaction and fortune they felt for the life they had lived until then. Some patients also believed that their faith in God gave them peace and hope and mitigated the fear of death. This result coincides with the findings reported by Abshire et al.,⁴¹ in which most patients reported not being afraid of death. The concept of death, as a natural part of life, was also identified in another study conducted with elderly people with CHF, in which they commented that death is something that we should all accept and that we should all learn to face.⁹ This attitude has also been reported in studies on the general population, such as that of Strupp et al.,⁴² in which it was found that most participants appreciated dealing with the finitude of life as part of the life. In fact, it seems that having an awareness of finiteness as a person helps oneself prepare for death because it decreases anxiety about this fact and facilitates acceptance of one’s condition as a process of being mortal.⁴³ Another aspect that seems to contribute to these patients seeing death as one more event in life is their advanced age; they contemplate death in the context of their age and not so much as a result of an advanced disease.⁴⁴

Another important result of this research was that in some people with CHF, daily suffering was such that they wished for death as a relief. This fact coincides with the findings of Gott et al.⁴⁵ that death

can be welcomed for patients with CHF because of the release that it can provide in the face of a condition that they consider intolerable. Even further, an issue observed in our study and noted by Celano and Huffman⁴⁶ but rarely reported in the literature is the fact that there were patients who confessed their intentions to commit suicide due to CHF. Previous research linking CHF with suicide risk indicates that the greatest risk is found in the first 6 months after diagnosis.^{47,48} This statement contrasts with our results because, in our case, suicidal ideation was identified in people who were in more severe stages of the disease and who had been diagnosed for several years. However, this finding coincides with the conclusions of Wu et al.,⁴⁹ who observed that while suicides seem to peak immediately after the diagnosis of an acute heart disease, such as myocardial infarction and stroke, for chronic heart diseases such as CHF, suicide rates progressively increase over time.

Regarding the origin of these suicidal ideations, there are studies that show that they are closely related to the high prevalence of depression in these patients.⁵⁰ However, there are also those who claim that having CHF is an independent risk factor for suicidal ideation.⁵¹ Depression affects approximately 20% of patients with CHF and is associated with worse psychiatric and cardiovascular outcomes, including a low quality of life related to health, reduced functional capacity, and repeated and elevated hospitalization mortality rates.⁵² Therefore, both depression⁵² and suicidal ideation⁴⁷ require greater attention from health systems to achieve greater prevention and better screening and treatment.

In contrast to the desire of people with CHF to die, it should be noted that some patients in our study mentioned the desire for a prolonged life, despite the strong negative impact that the disease had on their lives. This attitude coincides with that of some patients in another study in which thoughts about death were explored.⁹ However, these thoughts are not considered in most literature reviews investigating the experience of living with CHF.^{6,53–56} This paucity of evidence may lead to the conclusions that most patients with CHF do not have these thoughts, possibly because of the advanced age of most of these people or because the impact of this illness causes such suffering that these people do not wish to prolong life beyond nature's intention.

Notably, in both this and other studies,^{11–13,16,57,58} despite the considerable impact of the possibility of near death on people with CHF, most family members and health professionals have been shown to avoid addressing this aspect. This lack of attention substantially affects these patients because they are denied the possibility of talking about a topic that has an important impact on and relevance to their lives. In these circumstances, people who are afraid of dying and those who welcome death will continue to replay harmful thoughts, leading to a more negative experience with CHF. The improvement in communication in this sense is a priority issue that should be addressed, especially considering that there are studies that have demonstrated the benefits of fluid communication about the end of life.^{15–17}

Given this situation, another very interesting consideration would be to advocate the inclusion of palliative care for all people suffering from a life-limiting chronic illness,⁵⁹ which can be provided at any time during the illness trajectory, from diagnosis to death, and simultaneously with curative or disease-focused treatments. Such advocacy may be very beneficial since palliative care providers focus on communication, establishing care goals, addressing psychosocial symptoms, spiritual issues, prognostic understanding, and assisting with treatment decision-making, coping, and coordinating individualized care, among other roles.⁶⁰ This issue is particularly emphasized by the European Society of Cardiology-Heart Failure Association in one of its most recent position papers about the integration of a palliative approach into heart failure care.¹⁴ On this basis and in line with the results of the present study, it is considered particularly beneficial for health professionals to systematically assess the psychosocial and

spiritual needs of patients. Furthermore, patients' expectations and treatment preferences should be discussed as well as helping them plan their near future by discussing the trajectory of their process and the personal and family challenges they are facing; all this would favor a shared decision-making process between the patient/family and the professionals. A key aspect could be the incorporation of early advanced care planning, as it would help improve crisis management, to understand the trajectory of the disease, and to initiate end-of-life discussions and decisions about the type of social and health care support desired in the most advanced stage.¹⁴

Limitations

This study has some limitations in relation to the sample. On the one hand, as in other qualitative studies, the results are not generalizable to the CHF population. However, although the sample may be considered small, it is sufficiently large for a qualitative study, as saturation of patient data was ensured. Furthermore, this study has contributed to a general phenomenological understanding that has allowed us to recognize the essential, universal, and recurrent aspects of the thoughts about death experienced by CHF patients in their daily lives.²⁵ On the other hand, all patients interviewed were older than 65 years of age; therefore, it would be interesting to explore whether continuous thoughts about death are also present in younger populations with CHF. In addition, none of the interviewees were working at the time of the study, and it is possible that in some cases, their experience would have been more positive, taking into account the positive repercussions that other studies have shown in relation to maintaining an active working life.³² Another aspect to consider is that most patients had an NYHA II functional class and that all were interviewed on an outpatient basis in periods of relative disease stability; therefore, the experience could have been even more negative in people with greater functional impairment and at times of greater symptomatic predominance or in the context of hospitalization.

Conclusion

In conclusion, this study reports for the first time that people with CHF experience the possibility of near death on a daily basis. Specifically, it should be noted that many of these patients are afraid of the possibility of near death. Additionally, on some occasions, the suffering they experience is such that some have thought of committing suicide.

This study has shown the need to delve deeper into this phenomenon, translating into practice the importance of healthcare providers, including topics related to death in the interviews they have with their patients. This consideration should be included not only in situations in which CHF is very advanced but also as one of the key aspects warranting support for these people in their day-to-day lives. With this knowledge, professionals will be better positioned to help CHF patients by offering situational support that helps them find meaning and sense in their experience and thus improve their quality of life. Therefore, interventions to refocus patients' fear and the desire to die into clear thoughts and actions must be developed.

Declaration of Competing Interest

No conflict of interest has been declared by the authors.

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