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Nobody Should Die Alone. Loneliness and a Dignified Death During the COVID-19 Pandemic

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Abstract

During the direst months of the COVID-19 pandemic, thousands of people died alone. This study analyzes these deaths, which occurred without the presence of loved ones, and seeks to a) examine the significance for relatives, as well as professionals, of dying alone, b) determine if these solitary deaths can be considered dignified, or good deaths, and c) evaluate if the treatment of the cadavers and the funeral rites transpired with the desired dignity and sensitivity. The study was carried out in the autonomous community of Madrid using a qualitative, phenomenological, and interpretative approach through in-depth interviews of 49 informants, professionals and relatives. Interviews were conducted between July and November of 2020, followed by an interpretive, categorical, qualitative analysis. Among the key findings are that during the most critical months, deaths lacked the desired dignity, even though the involved professionals did their best to accompany and dignify the deaths.

Keywords

death, COVID-19, good death, loneliness, dignified death

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Through the end of July 2021, 4.2 million deaths were recorded worldwide as a result of COVID-19, with 80,000 of these deaths recorded in Spain (Statista, 2021). The number of infected and number of deaths between the months of January and May 2020, in what was considered the first wave, were especially high in the country. During this time 152,230 deaths from illnesses occurred in Spain, of which 45,684 were caused by the COVID-19 virus (Instituto Nacional de Estadística, 2020), a 44.8% increase in deaths compared to 2019.

During the first wave in Spain, protocols were activated for hospitals and senior residences that prohibited visitors and prevented family members from accompanying their loved ones. Most people who died during this time spent the last days of their lives without company and passed alone or with just the accompaniment of healthcare workers, who found themselves overwhelmed by the situation.

Dying alone during the pandemic was mostly a result of prevention measures and patient isolation protocols enacted by authorities (Consuegra-Fernández & Fernandez-Trujillo, 2020). Healthcare professionals tried to replace the physical accompaniment of family members with creative solutions, using the telephone or video calls, but neither the professionals nor the family members were able to find a solution that was considered adequate (Wakam et al., 2020).

Dying alone, in another context, might be a choice, but when dying alone is not wanted it can be considered a failure of emotional support (Caswell & O'Connor, 2019). Dying alone is not considered a good death (Seale, 2004) and no one wants to die alone, isolated, in the middle of chaos and with few resources providing care (Khoo & Lantos, 2020), as was the case with many deaths during the direst months of the pandemic.

Even if death might be described as an act of solitude, accompaniment and human contact are necessary (Strang et al., 2020). For patients, healthcare professionals and relatives, saying goodbye to those who are important is one of the factors that defines a good death (Steinhauser et al., 2000) and that, in these circumstances, was not possible.

For anthropology, death is more than an individual experience (Barley, 2012) and is considered a collective phenomenon that belongs to the community.

Death in Spain, Before and After the Pandemic

The experience of death as a collective phenomenon (Lisón, 2008) is a constant in Spanish culture where, guided by catholic tradition, the presence of community in funeral rituals is fundamental, and visiting the sick is considered a labor of mercy for believers, according to their catechism (Iglesia Católica, 2012).

In popular Spanish tradition there are expressions such as "die like a dog" referring to dying alone and abandoned, or sayings like "burials, baptisms and weddings summarize all of life," indicating the community character of death and funeral rites (Rodriguez, n.d.).

There is not a single death culture in Spain as differences are seen depending on the region in which a death occurs, whether it occurs in a rural or urban environment, and whether a specific ethnic group is involved. There is hardly any literature on contemporary death in urban Spanish settings (Vaczi, 2019). In the rural environment, such as Galicia, death is still a central theme in people's lives (Lisón, 2008).

Nevertheless, as in other westernized countries, secularization, medicalization and individualization (Vaczi, 2019) have brought about notable changes in the way Spanish citizens perceive death.

Medicalization has led many people to prefer to die in hospitals, rather than at home as in the past. After death, the corpse is taken to a morgue where family and friends accompany it until the subsequent burial or cremation. This ritual process removes death completely from the home, and therefore from the everyday environment, and in Spain all formalities related to the corpse are typically complete in less than 36 hours, allowing some level of normality to quickly return.

Funeral rituals are still performed in the context of Catholicism, even for lesser believers, and most of the acts performed are religious. However, secularization and the culture of denial of suffering, paradoxically so alien to the Catholic tradition, have recently put the concern for dignified death and euthanasia on the social and political agenda of the country (Bernal-Carcelén, 2020), opening new debates about death.

Death During the Pandemic

During the pandemic the dying only had contact with their caregivers, contact that was limited due to the use of personal protection equipment as well as safety and isolation measures, which prevented the dying from having physical contact with and from even recognizing the faces of the people who were caring for them. Under these conditions the dignity of their last days is called into question (Thompson et al., 2019).

Given the circumstances, it is likely that patients experienced a fear of dying without anyone by their side (Wakam et al., 2020) as well as some symptoms of depression, anxiety, anger and loss of self-esteem (Abad et al., 2010), which can increase distress in the days and hours before death.

In this context, certain questions arise that this study intends to address. How did people die during the COVID-19 pandemic? Is it acceptable for society to have people die alone in hospitals and nursing homes? Could the performance of funeral rituals have dignified the deaths?

This study seeks to a) examine the significance for relatives and mourners, as well as healthcare and social services professionals, of dying alone during the most dire months of the pandemic, b) determine if these solitary deaths can be considered, from the point of view of ethics and community, as dignified, or

good deaths, c) analyze if the treatment of the cadavers and the funeral rites that transpired during the most significant months were carried out with the desired dignity and sensitivity, and were socially acceptable.

Material and Methods

Design

This work is based on a qualitative, phenomenological, and interpretative approach through in-depth interviews. The experience of the participants who had, in one way or another, a relationship with the deaths during the state of alarm is studied in depth, gathering their feelings, perceptions and thoughts, and observing how they gave meaning to what they observed and experienced. The interview offers a contextualized view of the experience, allowing one to historically and socially frame personal experiences and thus understand the social processes that may underlie subjective evaluations or interpretations (Finkel et al., 2008).

Recruitment and Sampling

The study was carried out in Madrid, a city with one of the highest number of deaths from COVID-19 between March and May 2020. To ensure a diverse set of perspectives was acquired, 49 informants of different types (general informants and key informants) (Table 1) were interviewed incorporating: a) nine hospital employees including doctors, nurses, social workers, psychologists and chaplains; (b) eleven senior residence employees including management, psychologists, social workers, chaplains and orderlies; (c) two emergency services professionals, one a doctor and the other a nurse; (d) sixteen funeral service professionals across all functions including management, office administration, sales, customer service, drivers, chaplains, crematorium technicians, and undertakers; (e) two firefighters; (f) two social workers from the Official College of Social Work of Madrid: Emergency Team; (g) six family members of the deceased and (h) one resident of a senior home. All participants were contacted by telephone, the project was explained, and their collaboration was requested. The interviews were carried out progressively, following the theoretical sampling model of Glaser and Strauss (1967), utilizing the constant comparison between each type of informant (general and key), and seeking distinctive aspects in newly selected informants, or to augment central analysis categories that required greater depth; finally, the research questions and objectives guided the inquiry process and the search for new observations and interviewees. When information received was repeated over and over, the information required to fulfill the objectives was considered to have reached a saturation point. Interviews were conducted between July and November 2020. One of them was conducted in writing and seven by videoconference due to pandemic

Table 1. Data Sheet of the Subjects Interviewed.

	Role	Institution
Interview with professionals		
IP01	Medical Director	Private Hospital
IP02	Psychologist	Private Hospital
IP03	Priest	Improvised Morgue
IP04	Director and Owner	Senior Residence
IP05	Orderly	Senior Residence
IP06	Social Worker	Senior Residence
IP07	Psychologist	Senior Residence
IP08	Patient Experience Department Representative	Private Hospital
IP09	Nurse	Public Palliative Care Hospital
IP10	Chaplain	Cemetery
IP11	Communication Director	Chain of Senior Residences
IP12	Social Worker and Sales Manager	Chain of Senior Residences
IP13	Orderly Coordinator	Senior Residence
IP14	Orderly	Senior Residence
IP15	Chaplain	Palliative Care Hospital and Funeral Home
IP16	General Secretary and Secretary of the Board of Directors	Funeral Home
IP17	Quality Assurance Manager	Funeral Home
IP18	Chaplain	Religious Senior Residence
IP19	Sales	Funeral Home
IP20	Sales Director	Funeral Home
IP21	Hearse Driver and Mortician	Funeral Home
IP22	Head of Coordination and Control	Funeral Home
IP23	Customer Service Representative	Funeral Home
IP24	Public Relations Representative	Funeral Home
IP25	Human Resources Manager	Funeral Home
IP26	Communications Manager	Funeral Home
IP27	Assistant to the Business Director	Funeral Home
IP28	Firefighter	Fire Department of Madrid
IP29	Firefighter	Fire Department of Madrid
IP30	Doctor	Public Emergency Service
IP31	Nurse	Public Emergency Service
IP32	Director of Residence	Religious Senior Residence
IP33	Orderly	Religious Senior Residence
IP34	Public Relations Representative and Crematorium Technician	Funeral Home

(continued)

Table 1. Continued.

	Role	Institution
IP35	Nurse	Public Hospital
IP36	Volunteer Social Worker	Official College of Social Work of Madrid: Emergency Team
IP37	Volunteer Social Worker	Official College of Social Work of Madrid: Emergency Team
IP38	Undertaker	Funeral Home
IP39	Public Relations Representative	Funeral Home
IP40	Doctor	Public Hospital
IP41	Doctor	Public Hospital
IP42	Social worker	Public Hospital
Interviews with relatives		
IF01	Granddaughter of deceased	
IF02	Daughter of deceased	
IF03	Daughter of deceased	
IF04	Resident in a Senior Residence	
IF05	Daughter of deceased	
IF06	Wife of deceased	
IF07	Daughter of deceased	

restrictions. The rest were conducted in person, and all were recorded. The interviews were approached as a conversation, following Kvale (2006), around three dimensions: (a) the significance of dying alone, (b) beliefs about a good death and a dignified death, and (c) how the dignity of the deceased is taken into consideration.

Ethical Considerations

Considering the sensitivity of topics involved in this research, compliance with the appropriate ethical requirements was maintained, under the supervision of the university Ethics Committee, who issued a report of approval. All participants were informed of the objectives of the research study, the sources of financing and the planned use of the results. Informed consent was solicited, and informants were notified that their participation was voluntary. Permission for audio recording was also requested. Anonymity was guaranteed through a confidentiality agreement.

Data Analysis

After the verbatim transcription of all the interviews, the analysis began with the support of the Nvivo 12 plus program, which facilitated categorization and

codification. The participants' discourses were examined via a categorical analysis that considered both content and discourse analysis. First, the language used was explored, taking into account the words and phrases spoken and the sentiment associated with them. Secondly, the analysis focused on the meanings associated with the death of patients and the emotions that such deaths provoked for professionals. The development of the analytical categories and the codification of the interviews were central to this stage. The last step of analysis was the interpretation and association of meanings with the circumstances and contexts in which they took place.

The main strategies of rigor and quality criteria associated with qualitative research were applied. Reflexibility was used in the data collection process, as well as content saturation and key categories; to prevent biases in the first author's interpretations, the second author reviewed the results and analysis for dependability and confirmability.

The results are illustrated by extracts from the interviews reflected in Table 2.

Results

(1) He Has Died and He Died Alone, That Is the Worst Part (IF01, Female, 23 Years Old)

One of the factors that had the greatest emotional impact on the family members of those who died during the state of emergency in Spain between March and May 2020, was the fact that their loved ones died alone.

Healthcare professionals reported that when communicating the news of a death, one of the most frequent concerns of the relatives was whether their loved one died alone (VP1).

In their narratives, relatives who were interviewed expressed two key causes of anguish when facing the idea that their loved ones died alone.

On the one hand, the feelings of anger or sadness, that still lingered at the time of this study, were a result of not having been able to be with their loved one in their final moments (VF1), on top of the uncertainty and despair the relatives experienced during the days prior to the death of their family member because they were unable to communicate with them (VF2).

On the other hand, the anguish was caused by imagining how their loved one must have felt when facing dying alone (VF3). These thoughts and emotions were often derived from a family member's feelings of guilt as they processed a feeling that in some way, they had abandoned their loved one. This sensation of culpability has been referred to by both the actual family members, as well as the caregiving professionals who provided social and emotional support to the family members at the time (VF4 and VP2).

Some of the family members interviewed also stated that these thoughts continued to appear months after their family member's death, producing

Table 2. Extract Interview Transcripts—Verbatim Professionals (VP) and Verbatim Family Members (VF).

	Verbatim transcripts
VF1	*If I had to imagine her dying, the truth is, although it sounds selfish, I would have preferred that she would die here with us and not abandoned in a hospital, where they have her alone for 6 or 7 hours in a hospital room, (. . .) There must have been some humane way for one to see their relatives. That should not, I don't believe that it should happen the way it happened.* (IF06, female, 62 years old)
VF2	*I was unable to speak with my father from Sunday until Tuesday. All Monday I was trying to talk to him, calling the phone in the room. They didn't pick it up, they didn't pick it up, and I, desperate, spoke with my brother.* (IF05 female, 47 years old)
VF3	*I know that he suffered because he didn't have us there, (. . .), this just kills me, because he didn't hear anything from us. . . It's just, he couldn't have known anything, besides, we called him and we couldn't speak with him, so the fact that he didn't suffer, I don't know, it doesn't make me feel much better honestly. I mean, he has died and he died alone, that is the worst part.* (IF01, female, 23 years old)
VF4	*And they called him back and I felt super guilty because I imagined him alone somewhere, waiting, not knowing, scared to death, I mean, I just know it.* (IF07 female, 26 years old)
VF5	*I don't cry a lot. But I have lots of panic attacks if I start to think about the fact that my Dad was alone.* (IF07 female, 26 years old)
VF6	*And well, the only thing I can be grateful for is that he passed away at home, that he didn't pass away in the hospital, that he had the chance to be. . .I mean that he was not alone. Fortunately, my brother and I were there to support him when he died.* (IF06 female, 62 years old)
VF6	*The funeral home tried to do everything possible so that we could, in some way, spend some time watching over him or, well, accompanying him.* (IF02 female, 35 years old)
VF7	*The funeral services workers did it with gentleness, honestly, things being as they are.* (IF06 female, 62 years old)
VP1	*And later the feeling of guilt for the relatives, "It's just that he is alone or she is alone" that was brutal, the feeling of guilt was tremendous, when in reality the relatives were not to blame, because evidently none of us were to blame for what happened.* (IP37, female, 36 years old)
VP2	*And one of the questions that you were asked a lot was, "Were you with him? Did he die with you?" They worried a lot about whether they had someone by their side.* (IP09, male 36 years old)
VP3	*To be alone when facing death or dying is the fear and it is the failure. "What have I done in this life that at the end I die alone? I may have achieved things, I may have done things but in the crucial moment, there where. . .I am alone."* (IP02, female, 38 years old)
VP4	*Look, what I have thought a lot about is the anguish of dying alone. The anguish of not being able to say goodbye in the last moments that you are alive.* (IP11. male, 38 years old)
VP5	*The great helplessness of not knowing what is happening. If they have abandoned me or the world has ended, if this has become widespread, if this is something personal, and from there you are led to think of anything and everything, the entire avalanche of feelings.* (IP15, male, 58 years old)

(continued)

Table 2. Continued.

	Verbatim transcripts
VP6	*It's just that it is very sad to die alone. To me this seems very sad.* (IP31, female, 55 years old)
VP7	*(They have died) in a bad way, obviously, dying without your family is a bad death, obviously, dying alone, alone is very bad, I believe they have had a terrible death, very bad.* (IP4150, female, years old)
VP8	*Yes, I believe it is fundamental (to die with others by your side), even if it is only having your hand held, you know, in the last moment, or two words of breath, of goodbye. For me it seems extremely important, I mean, dying alone, to me that seems very sad.* (IP30 female, 63 years old)
VP 9	*If you want to talk about a dignified death, dying alone in a room is not dignified and it is horrible. Horrible. Horrible. I wouldn't have wanted to be in the situation of any of those family members.* (IP01, male, 50 years old)
VP10	*During this entire difficult time, when I was not on duty, I was here alone at home, and I would be overcome by a super distressing feeling about dying alone, you know, it's like how awful, I mean, and I started to cry and I was saying "hey enough, enough, enough" (laughs). (. . .) And this thing about dying alone was one of the things that came into my head.* (IP31 female, 55 years old)
VP11	*The elderly that have died with us, I have felt much pain, but at least they were with us, they died with someone by their side, holding their hand, and at peace. . . "we are here with you" and it seemed like you said these words to them and they stayed, they stayed calm and died.* (IP06, female, 45 years old)
VP12	*Well, if dignified signifies having the people you love by your side, no, no. The have died alone. Have we tried to make it as dignified as possible? Well, yes.* (IP40 female, 50 years old)
VP13	*Those that have passed here, we were with them until the end, always. They were never left alone; they were never left alone.* (IP33 male, 28 years old)
VP14	*The most intense weeks were dreadful because you could go two hours without seeing those patients, two hours would pass -people, alone, eh- these two hours would go by and you would go back, and you would find them all dead, eh, dead without family or anything.* (IP09, male, 36 years old)
VP15	*They talked a lot about death in the senior residences and of the possibility of having died in the hospital, and I have mixed feelings about this, there are people who died in the residences that if they wouldn't have died in the residence, they would have died in the hospital, because the situation was what it was, and they were very sick and the survival rate was nil; And we would say "It is just that. . ." In fact, there was a thread on Twitter about this. Well, it isn't so bad, in the residence you have died with the professional that you know, in the company of people that you know, and with the people by your side who have taken care of you over the last months, years. . .and the alternative. . .in one tweet they said: "yes but at least to have the opportunity to go to the hospital." No. . .well if, but the possibility was very low, then they died within hours, and sometimes they went from the senior home to the hospital and they died, and they died alone.* (IP09 male 36 years old)

(continued)

Table 2. Continued.

	Verbatim transcripts
VP16	*Let's see, that is one of the excuses that the hospitals gave us when they wouldn't take the referrals, they stated it to me directly: "so that you know, in other words, do you want them to die alone in a hallway or to die in the senior residence with someone by their side."* (IP11, male, 38 years old)
VP17	*In view of what I've seen, I think the best thing that could have happened to them is to be here. I don't think the outcome would have changed much; I don't think so. And they were here, in the end we are with them every day and although they have died without their family, they had a familiar face, and not in the hospital; and in the hospital, well, the treatment is different because they are people who come and go, here in the end we have them every day and for many years.* (IP13 female, 42 years old)
VP18	*You can imagine the mess we had here, when we had to put the grandparents in the bags, and we had to do it ourselves because in the beginning it was said that they (the funeral homes) could not pass beyond a certain part of the residence and therefore could not do it.* (IP05 female, 41 years old)
VP19	*Later when they told us at first to put them in a garbage bag. And I: "I don't know, I don't know, until they come from the mortuary and pick them up, I am covering them with a sheet, and I will throw it away, but I am not covering them with a garbage bag," they had already told me what I was supposed to do, but no. What is this? This is inhumane.* (IP04 female, 65 years old)
VP20	*I believe it was Dantesque, it was like. . .well, I imagine like a concentration camp, I don't know, I mean. . .depersonalized, I don't know, I don't know where they took them down to, I imagine to the hospital morgue, I don't know our hospital's morgue capacity, my hospital isn't very big, 400 beds, but. . .apparently it was overflowing. . .and stacked I believe.* (IP41, female, 50 years old)
VP21	*After you have worked a ton of hours and many days, you are already carrying the weight of it, it is yet another burden. You have the respect that there are people in there, and above all you are careful with them because you don't, you don't just throw them around as if they were a sack of potatoes, but, of course, sometimes you do forget a bit that they are corpses.* (IP29 male, 39 years old)
VP22	*Many colleagues said that the families told them, "Hey, take care of yourself."* (IP26, female, 40 years old)
VP23	*Well, my father was going to go to a morgue or wherever, and he was going to be alone for another whole day until someone meets him, at the morgue or wherever.* (IF07, female, 26 years old)
VP24	*Then there had been many deceased who had died alone, and in some way, our presence, although small, was symbolic, we were there (in the morgue).* (IP03, male, 53 years, old)
VP25	*The funeral home thought to put a flower on each coffin and they were doing it. The idea came from the employees.* (IP38 man, 46 años)

disproportionate reactions such as panic attacks or anger when recalling the aloneness of their loved one's last days (VF5).

On the other hand, the relatives who were able to accompany their loved ones, because they died at home, highlighted the positive aspect of having been present at the moment of death and commented on the importance of their relative having been accompanied in their last moments and not having died alone (VF6).

(2) Dying Alone in a Room Is Not Dignified and Is Horrible (IP01, Male, 50 Years Old)

When asked what it might mean for someone to die alone, the answers were associated with feelings of failure and fear (VP3), of anguish (VP4), of abandonment, (VP5), or of sadness (VP6); and even professionals such as medical workers affirmed that the people who died alone during the most difficult months of the pandemic did not have a good death (VP7). They also emphasized the need for every human being to die accompanied in order to die well (VP8).

When faced with the question of whether the deaths that occurred in hospitals or senior residences during the pandemic were dignified deaths, the professionals stated emphatically that no they were not, and the isolation in which patients found themselves meant that many deaths occurred in an undignified manner (VP9).

Being present during the passing of many patients who were alone has awakened a discomfort in the professionals about the end of their own lives and has made them aware of the desire to die accompanied when their end-of-life moments arrive, as they believe it is not good to die without having loved ones close to you (VP10).

(3) We Have Done Everything We Could (IP06, Female, 25 Years Old)

Almost all the professionals agreed that they did their best to ensure that patients died accompanied (VP11), so that a bad death was avoided and to dignify, to the extent possible, the moment of death (VP12).

The professionals in the senior residences spoke often of how they were able to accompany the dying in their last moments of life (VP13), while in the hospitals due to the extreme amount of patient care required, healthcare workers had fewer possibilities for making accompaniment a reality and told how, often, they would enter rooms and find patients had already passed (VP14).

In some cases, hospital professionals believed it was better for the elderly not to be transferred to the hospital centers since this might help ensure that the patients would die accompanied by personnel in the residences, something that would not have occurred if they had ended up in the hospital, where, most likely, they would have still died but would have died alone (VP15).

Professionals in the senior residences, however, expressed that at the very least they should have given these people the opportunity to obtain medical attention and that this failure to provide care was to the detriment of the patients' dignity (VP16). Nonetheless, these same professionals recognized that death in the senior residences almost always transpired in the company of others and was therefore a better death than those that occurred in the hospitals (VP17).

(4) I Had to Put Them in a Bag and Spray Them (IP14, Female, 30 Years Old)

Healthcare professionals also did everything possible to dignify the moments after the deaths when they had to handle and prepare the cadavers, something that not all were accustomed to (VP18). Some professionals in senior residences commented on a lack of resources and extensive security measures around the treatment of the bodies, which placed them in a position where they felt they were treating the bodies in an inhumane or undignified manner (VP19). This feeling of undignified treatment was also generated by the number of bodies that accumulated in some residential and hospital centers as it was impossible for funeral homes to complete their work within normal and adequate timeframes (VP20). Some of the funeral service professionals responsible for collecting the bodies also told us that with such a large volume of deceased, they sometimes ran the risk of forgetting that they were dealing with the corpses of human beings, who deserved respect and dignified treatment (VP21).

(5) "Hey, Take Care of Yourself" (IP26, Female, 40 Years Old)

Caring for the bodies of the dead, as if they were still alive, is something that concerned relatives (VP22), who in the interviews referred to their deceased loved ones with attributes of living people, such as the possibility they could be feeling cold or lonely (VP23). A worry existed that the body of the person who had passed alone was also alone after death, and both funeral homes and family members expressed that the ideal would have been for the body to be accompanied in the time between death and the burial or cremation (VF6). The use of the word accompany appears frequently in reference to the cadaver as if it was a living person who needed to be kept company.

In these cases, it was the funeral service professionals and morgue chaplains who tried to be with the deceased body providing accompaniment in a symbolic way and in doing so, to dignify these solitary deaths (VP24). The workers in one funeral home told us how they placed a rose on every casket at the time of burial to also dignify the funeral rite (VP25).

One interviewee who was able to be with their loved one in the final moments, as their family member had died at home, expressed satisfaction with the

gentleness with which the undertakers collected and treated the body, emphasizing how important it was that the body was treated with tact and dignity (VF7).

Discussion

Given the exceptional circumstances in which millions of deaths have occurred during the COVID-19 crisis, it is necessary to ask whether, in this situation, the people who have died have done so well and in a dignified manner.

Steinhauser et al. (2000) claim that there is no empirical support that allows us to define what a good death is. Meier et al. (2016), in an exhaustive literature review, also indicate that there is a certain lack of agreement regarding this concept. Meier's study makes no reference to dying in the company of others being an indicator of a good death (Meier et al., 2016), but implicit references to this criterion are found in some of the literature reviewed.

This indicator does appear in relation to dying alone or accompanied in studies related to death during COVID-19, such as that of Strang et al. (2020), in which, through an examination of the difference between existential loneliness and social loneliness, it is stated that dying alone is not a good way to die.

Richard Smith (2000) indicates that among others, elements that constitute a good death are having time to say goodbye and having access to adequate emotional and spiritual support, something that did not occur in the deaths studied here.

The testimonies collected in this study confirm that dying alone is not socially considered a good death, and that many of the deaths that occurred during the most critical months of the COVID-19 pandemic occurred without the company of family as would have been desired. To die alone can have the social significance of dying abandoned or to have failed as a human being in the social and family dimension, and this idea has worried family members and professionals during these months.

In the face of the traditional idea that death is understood as a collective act (Lisón, 2008) that transcends the individual (Barley, 2012), this study describes how, in Madrid during the indicated months, the moment of death and the subsequent rituals have been emptied of that important communal element that gives death meaning and that is also necessary for the elaboration of a healthy mourning process (Worden, 2009).

Weisman and Hackett (1961) refer to the concept of an appropriate death, indicating that an appropriate death, to be considered as such, should be supported by four pillars, one of which has to do with the continuity of social relationships. This study could not uncover evidence of whether the dying felt, or not, a rupture in relationships or if they felt emotionally abandoned in

the hospitals and residences, but evidence did appear that relatives felt they had abandoned their loved ones and had let them die in an inappropriate way.

Leaving a family member to die alone can be a threat to both personal ontological security and moral reputation (Seale, 2004), hence, as it appears in the results of this study, the relatives of the deceased have strong feelings of guilt, which could complicate their elaboration of healthy grief (Worden, 2009).

With respect to healthcare professionals, there exists a generalized thought that no one should die alone (Caswell & O'Connor, 2019), a thought that, as this study has proven, often projects an individual's desires for their own death and renews one's desire to die in the company of others.

As a result of this thinking, and to compensate for the sensation of abandoning the dying while also trying to facilitate a good death, healthcare and social services professionals, as this study demonstrates, did their best to accompany their patients and ensure they would not be alone at the moment of death. The professionals tried in this way to carry out the work of accompaniment as described by Torre (2020), focusing not only on the medical aspects, but also seeking to make the patient feel led, and not abandoned to their fate, while facilitating a good death as indicated by Küng (2016).

Strang et al. (2020) concur with the idea that arose in this study, that accompaniment of the dying by professionals could have compensated, to some extent, for the lack of a family presence.

Another aspect shared by the present study and the research of Strang et al. (2020), which was conducted in Sweden, is the fact that in the senior residences it was more feasible to provide professional accompaniment than in the hospitals.

Wang et al. (2020) indicated in May of 2020 how healthcare professionals should help to dignify the deaths that were occurring due to COVID-19 and several of these indications were directly related to this effort to compensate for the lack of family accompaniment.

This study also infers that deaths in solitude are not socially considered to be dignified deaths from an ethics point of view. Family accompaniment is a decisive category for the achievement of a dignified death according to Ibáñez-Masero et al. (2016) but during the pandemic this has not been possible to fulfill. Lack of companionship and support, as well as not feeling valued or respected, undermines the dying's sense of dignity (Chochinov et al., 2020). Chochinov et al. (2020) claim that during the COVID-19 pandemic, dignity has been under assault and Consuegra-Fernández and Fernandez-Trujillo (2020) signal that during the COVID-19 crisis, ethical standards of medical care have been breached and the rights of dying patients have been neglected.

On the other hand, the present study also indicates that for mourners, the dignity of the deceased does not end at the moment of death, but rather extends to the ongoing treatment of the cadaver, from the time of death until the moment of burial or cremation. For relatives, the corpse still has the attributes

of the living person. The ethical and legal question of whether a corpse is a person or a thing, and at what point the transformation transpires, is raised by Stroud (2018) and Posel and Gupta (2009), who state that the living resist the idea that a corpse is simply flesh and indicate that this resistance is the reason for the existence of rituals that try to give human dignity to the bodies of the deceased. These community rituals have been diminished, and almost disappeared during the COVID-19 crisis and as can be seen in the above results, this fact has also provoked a certain sense of guilt or abandonment for the mourners.

The corpses deserve reverence, but the protocols and limitations governing rituals during the pandemic have sometimes broken this respect (Kumari, 2021). The concepts of dignity and respect are intimately linked to each other (Jones, 2015). This research shows how relatives of the deceased want the cadavers to be treated with respect, and it causes them pain to imagine that this has not been the case. Although San Agustín (1995) indicates that funeral services and their solemnity constitute more a consolation for the living than a relief for the deceased; this consolation comes, in part, from considering that the ritual dignifies the deceased.

In a study of forensic pathologists, Schwarz et al. (2021) stated that the external conditions of the work interfered with the dignified handling of the bodies. This result is similar to that of the present study, which found that the volume of deaths and the accumulation of corpses in hospitals and residences created a barrier for the professionals and interfered with the dignified and respectful handling of the corpses. Even so, this study observes that professionals have tried to provide dignity to the handling and accompaniment of the bodies of the deceased, despite the circumstances and the over-saturation of the system (González-Fernández et al., 2020).

The results obtained in this study are well-understood within the theory of the historical evolution of death developed by Ariès (2011). The solitary deaths that occurred during the COVID-19 pandemic are the maximum expression of the individualization and denial of death that Ariès identifies in his studies. From this historical perspective of death, which incorporates the existence of the so-called inverted death, it is easier to appreciate that the solitary deaths mentioned in the current study have indeed come to occur.

Conclusions

Most of the deaths that occurred in Spain during the months of the state of emergency and the accompanying restrictions cannot be considered good or dignified deaths, since they occurred in seclusion without the patient being able to choose whether to be surrounded by his or her loved ones. Healthcare professionals did their best to accompany patients, but in most cases, it was impossible due to the pressures on the healthcare system and providers.

However, the accompaniment of a family member will never be the same as that of a professional.

Likewise, professionals who dealt with corpses have tried to give respect and dignity to the bodies in the absence of the rituals of accompaniment desired by relatives. The volume of deceased and the overload of the system has not always made this possible. Relatives consider that a corpse deserves the same respect as a person who is still alive.

Limitations

The main limitations are derived from the exceptional circumstances in which the data was collected. The interviews were conducted immediately after the most intense months of the pandemic. Some professionals were still under great pressure to provide care, and still had an altered emotional state, therefore making it difficult to make contact with them. Likewise, contact with family members who were initiating the mourning process was complicated. Additionally, the interviews were designed to be conducted in person; however, some had to be conducted virtually, making the expression and observation of nonverbal emotions and meanings more difficult.

On another note, the lack of agreement in the scientific community on the meaning of a good death or death with dignity is another limiting factor for establishing the substance of this study.

Implications

This study highlights the need to review and establish protocols for future crisis and emergency situations to ensure that victims can have a good death and a dignified death whenever and wherever possible.

End-of-life discussions in social intervention and primary care, as well as the use of advance directives, should be encouraged. But this would be insufficient if the public system cannot guarantee that patients' wishes can be carried out. Individuals cannot be forced to die alone or accompanied, but their will must be respected by applying the principle of autonomy.

Likewise, in the face of crises and catastrophes, protocols should be established for the care of the corpse to ensure the corresponding respect it deserves, since it represents the de facto living person.

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Ethical Approval

This research project was approved by the Ethical Committee of the Universidad Pontificia Comillas of Madrid on 15th June 2020.

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