HEALTHCARE DEFINITION OF “END OF LIFE”

Mardiyeva Guzal Karimovna
Assistant, Samarkand State Medical University
Togamurotova Jasmina Jamolovna
Student of Samarkand State Medical University

Abstract: In healthcare "End of life" can be referred to the final stage of a person's life, typically the last months or days, when they are facing death from a terminal illness, or it can refer to the final stage of a product's usefulness before it is discarded or recycled. From a practical point of view, End-of-life issues relate to *someone's death and the time just before it*, when it is known that they are likely to die soon from an illness or condition.

Key words: healthcare, physician, facing death, illness, care, final stage.

Introduction. Until the invention of the stethoscope and acquisition of knowledge about human anatomy in the early nineteenth century, physicians were unable to diagnose death with precision. The ability to do so provided them with great credibility from a public that had, until then, been concerned about premature burial.

Main part. End-of-life issues relate to *someone's death and the time just before it*, when it is known that they are likely to die soon from an illness or condition. Significant uncertainty and debate about the definition and determination of death did not resurface until the second half of the XX century, again owing to the state of medical science. But this time, physicians knew enough compare to too little, about the pathophysiology of the dying process. In the modern intensive care unit (ICU), they have been increasingly able to break down the dying process, teasing apart each of its component parts and supporting some functions while providing technological replacement for others. In the intensive care unit, death approaches as much on the electronic screens of the heart, brain, and blood pressure monitors as it does in the failing bodies of

patients. Identifying the EOL phase is essential for timely initiation of appropriate care. Common clinical indicators include:

Physiological Changes: Progressive weakness, weight loss, decreased oral intake, and altered consciousness.

Organ Dysfunction: End-stage heart, lung, liver, or kidney failure, or advanced neurodegenerative disease.

Frequent Hospitalizations: Increased hospital visits or complications despite maximal therapy.

Symptom Burden: Chronic pain, dyspnea, fatigue, nausea, and psychological distress.

These developments have had two profound and far-reaching consequences, fundamentally reshaping our understanding of life, death, and the role of medical intervention. First, the cascade of events that once inevitably led to death is no longer automatic. In earlier times, the cessation of a single vital function, such as the failure of the heart or lungs, would almost invariably trigger the rapid collapse of other critical systems, making the question of which organ was more “essential” largely irrelevant. Today, however, advancements in medical technology—ranging from mechanical ventilators that breathe for patients, cardiac pacemakers that maintain rhythmic heartbeats, to a variety of drugs capable of stabilizing blood pressure—allow the body to continue functioning even after the failure of organ systems that were once considered indispensable. These interventions have fundamentally disrupted the natural sequence of biological decline, enabling a form of medical life support that prolongs existence in ways previously unimaginable.

The second consequence lies in the unprecedented degree of control over the timing of death afforded by modern monitoring and life-sustaining technologies. Whereas death was historically perceived as a moment dictated by divine will, natural law, or sheer chance, today it is increasingly subject to human decision-making. Physicians, patients, and families now possess tools and knowledge that allow them to influence when and under what circumstances death occurs. While this capability does not—and cannot—defeat death itself, it creates an illusion of mastery over the ultimate

boundary of human existence. At the same time, it imposes a weighty ethical responsibility on those involved, who must grapple with questions of prolonging life versus alleviating suffering, and making choices that have profound moral and emotional implications.

Two interrelated forces have intensified the need to reconsider the very definition of death: the growing ability of medical science to control the timing of death, and the escalating demand for human organs suitable for transplantation. In the absence of such pressing practical concerns, debates over what constitutes death might have remained largely academic, confined to the musings of philosophers, ethicists, and theologians. The surge in organ transplantation and the relentless quest for new sources of organs, however, have made these questions urgent and unavoidable, compelling the medical community and society at large to confront issues that were previously hypothetical or ignored.

In the review that follows, we will explore the novel ethical, medical, and philosophical questions that have emerged over the past three decades, driven by both rapid technological advancements and the pressing need for morally acceptable sources of human organs. This examination demonstrates that death is not a purely biological phenomenon, but a concept deeply embedded in social, cultural, and ethical frameworks. In pluralistic societies, where diverse beliefs, values, and practices coexist, the pursuit of a universally accepted, scientifically precise definition of death proves elusive. Consequently, death must be understood not only as a physiological event but also as a social construct, shaped by the interplay of medicine, ethics, and societal norms.

Conclusion: Not all end-of-life experiences are alike. Death can come suddenly, or a person may linger in a near-death state for days. For some older adults at the end of life, the body weakens while the mind stays clear. Others remain physically strong while cognitive function declines. It's common to wonder what happens when someone is dying. In the end, consider that there may be no “perfect” death so just do the best

you can for your loved one. The deep pain of losing someone close to you may be softened a little by knowing that, when you were needed, you did what you could.

The end of life may look different depending on the person's preferences, needs, or choices. Some people may want to be at home when they die, while others may prefer to seek treatment in a hospital or facility until the very end. Many want to be surrounded by family and friends, but it's common for some to slip away while their loved ones aren't in the room. When possible, there are steps you can take to increase the likelihood of a peaceful death for your loved one, follow their end-of-life wishes, and treat them with respect while they are dying.

Generally speaking, people who are dying need care in four areas: physical comfort, mental and emotional needs, spiritual needs, and practical tasks. Of course, the family of the dying person needs support as well, with practical tasks and emotional distress.

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