Objective: to justify that for the training of health professionals in palliative care and for the care in the process of death and dying there is need to rethink the training of health professionals, with a view to reform of thought, from Morin’s complex thought. Method: reflective-theoretical study. It initially focused on the training of health professionals, especially nurses, and teaching the process of death / dying, ending with the prospect of training for care in end-stage illness, by a reform of thought, from the complex thought. Conclusion: this study shows that the reform of thought for care in end-stage illness requires, in addition to theoretical knowledge, self-reflection, awareness, involvement of emotions and of multiple meanings, enabling contact experiences, thoughts and experiences, often repressed, allowing disruptions to the construction of new knowledge. Descriptors: Nursing Education; Nursing; Palliative care.

RESUMO
Objetivo: defender que para a formação dos profissionais de saúde em cuidados paliativos e para o cuidado no processo de morte e morrer, mostra-se necessário repensar a formação dos profissionais de saúde, em uma perspectiva de reforma do pensamento, a partir do pensamento complexo de Morin. Método: estudo reflexivo-teórico. Inicialmente, enfoca-se a formação dos profissionais de saúde, em especial de enfermeiros, e o ensino do processo de morte/morrer, finalizando-se com a perspectiva da formação para o cuidado na terminalidade, mediante uma reforma do pensamento, a partir do pensamento complexo. Conclusão: o estudo ressalta que a reforma do pensamento para o cuidado na terminalidade requer, para além do conhecimento teórico, autorreflexão, sensibilização, envolvimento das emoções e dos múltiplos sentidos, que possibilitem contato com experiências, pensamentos e vivências, muitas vezes reprimidos, permitindo-se rupturas para a construção de novos conhecimentos. Descritores: Educação em Enfermagem; Enfermagem; Cuidados Paliativos.

Conclusão: el estudio resalta que la reforma del pensamiento para el cuidado en la terminalidad requiere, además del conocimiento teórico, autorreflexión, sensibilización, envolvimiento de las emociones y de los múltiples sentidos, que posibiliten contacto con experiencias, pensamientos y vivencias, muchas veces reprimidos, permitiendo rupturas para la construcción de nuevos conocimientos. Descritores: Educación en Enfermería; Enfermería; Cuidados Paliativos.

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INTRODUCTION

Demographic data have shown that Brazilian population is aging due to the significant reduction in the fertility rate and increasing longevity of Brazilians. This process has happened quickly, and there was not a reorganization of society as a whole, as well as health care, to meet the new emerging demands. According to the Brazilian Institute of Geography and Statistics (IBGE), in 2013, life expectancy at birth was 74.9 years old, an increase of 26 years since the 1960s. Therefore, it is estimated that by 2050 the percentage of people over 60 years old will correspond to 30% of the population.

The increased longevity of the population has been changing the epidemiological profile of the country with increased mortality from chronic diseases such as cardiovascular disease, chronic obstructive pulmonary disease, diabetes, cancer and dementia. Many of these diseases occur simultaneously among the elderly, who often face various health problems and deficiencies. In the last year of their lives, they commonly experience symptoms such as pain, anorexia, depression, constipation, confusion, insomnia and difficulty in bladder and bowel control. In addition to the aging population, there has been significant increase in the incidence of cancer and Acquired Immunodeficiency Syndrome (AIDS). These diseases, in the course of their development, also cause various health problems and deficiencies.

Faced with the increased longevity and the occurrence of limiting diseases, the World Health Organization (WHO) considers palliative care (PC) as the fourth guideline established for the treatment of cancer associated with its prevention, diagnosis and treatment. It also recommends that the PC is a strategy to be adopted in national health systems, extending to the various areas of knowledge, such as pediatrics, geriatrics, HIV / AIDS, chronic diseases, among others, in order to meet the complex needs of these patients.

Such care can and should be offered in the course of any potentially fatal chronic disease in order to ensure an approach that improves the quality of life of patients and their families in the presence of associated problems that threaten life, through prevention and pain relief, early detection and treatment of pain or other physical, psychological, social and spiritual problems, even extending to the mourning phase.

In this perspective, patients who require PC feature a problem of enormous social impact and increasing importance in terms of public health. In Brazil, there is not an adequate PC structure to meet the existing demands, both from a quantitative and from a qualitative point of view.

The International Observatory on End of Life Care (IOELC) presented in 2006 a map of the PC situation in the world with the categorization of hospices and PC developed in countries in order to facilitate international comparison. The study showed that Brazil had a service for 13.315 million inhabitants and, like other developing countries, had few PC services.

In 2010, in a survey conducted by the Economist Intelligence Unit in Britain, Brazil ranked the 38th place of 40 countries in assessing the quality of death. The evaluated items involved quality and availability of PC, policies on how to deal with death, as well as public awareness of services and treatments available to people at the end of life.

Among the difficulties for using PC in Brazil there is how health professionals understand the health-disease process, death and dying. The scientific and technical progress of health has not only increased the hope of living longer and better, but has also generated difficult and complex situations regarding the end of life. Science gives priority to the pursuit of health and healing, understanding death as a failure and defeat. Thus, in diseases with a slow development and poor prognosis, treatment may be even more suffering than the disease itself, with the occurrence of some obstinate conducts that are characterized by continuity of healing treatments, even when cure is not possible anymore, leading to a medically slow and prolonged death, accompanied by suffering.

In this perspective, when studying the therapeutic obstinacy in the nurses' view, trying to understand how these professionals in an ICU faced the implementation of therapeutic measures identified as futile, it was found that nurses recognized the therapeutic obstinacy as very present in their practice, perceiving the suffering of patients, relatives and nursing staff. However, commonly, the nurses interviewed...
did not question the practices they implemented, believing they were necessary to invest in the search for a cure.13

The denial of death and therapeutic obstinacy on the part of health professionals seem to be a reflection of social values, exemplified by the appreciation of health, considering it as the absence of all the ills of the body, of beauty and youth, strengthening the unquestionability of implementation of healing treatments in patients undergoing the process of dying and death. These social values are also present in the training of health professionals and in the organization of undergraduate courses curricula.15-16

In Brazil, studies have investigated the education of health professionals to care for people at the end of life, highlighting difficulties and lack of preparation in this area.17-22 However, the development of skills and abilities before the death and dying process strengthens nurses to work in PC.24 Similarly, training future professionals to work in PC can also qualify them to act in the care of people who experience the process of death and dying.

Among the factors discussed in the Brazilian scientific production associated with the difficulties experienced in caring for people at the end of life, there is the failure of approaching this theme in academic education, which affects the performance of professionals. Santos; Hormnez (2013)25 state that the undergraduate nursing curriculum addresses human finitude in an insufficient manner. This deficiency may be regarded as a major obstacle to the use of PC, too. It is noteworthy that no Brazilian studies presenting experiences in training of PC among graduate health professionals, were found.

In other countries, however, scholars have been working in research to evaluate the effectiveness of educational activities and the identification of facilitators and barriers to care at end of life.26 Still, international studies have presented evidence that the training of health professionals on PC contributes to better care for patients at the end of their lives. Surveys, however, point out that there are still gaps to effective use of PP, being fundamental the use of educational strategies for the inclusion of this practice at the end of life.24-30

Research of nursing, physical therapy and occupational therapy students at the University of Granada, Spain, in 2010, sought to determine the knowledge of the Spanish Law of Rights of the Dignity of the Person in Death Process and found that nursing students had more knowledge about this law; still, those who attended the PC discipline achieved better results than the other students. The authors emphasizes that the discussion of the PC must be inserted transdisciplinary in the training of the students, highlighting that a specific discipline on PC is not enough to ensure adequate strengthening of this care.28

Thus, there is need to reform the way the issue of end-stage illness and PC has predominantly been addressed during academic training, because life and death are perceived as separate and antagonistic events, and that death must always be fought off, despite its proximity and, one might say, its complementarities, for death is part of life.31 Currently, health needs surpass the prospect of recovery and rehabilitation. In this sense, it is not possible to consider the possibility of effective use of PC without thinking and rethinking the education of health professionals, especially in this thematic and in the approach of care to people in the process of death and dying.

Thus, for a proper care in the death and dying process and for the use of the PC philosophy, health professionals need prior and proper training. Such training requires to be rethought, in a perspective of reform of thought, from the complex thought of Morin.

**METHOD**

This study was extracted from the thesis "Ensino educativo em cuidados paliativos e atuação do enfermeiro na terminalidade: um estudo de caso" (Educational teaching of palliative care and nurses' role in end-stage illness: a case study) in force from 2010 to 2015. It is a reflective-theoretical study. Initially it focused on the training of health professionals, especially nurses, and the teaching of the death and dying process, ending with the prospect of training for care in end-stage illness, by a reform of thought, from the complex thought.
The teaching of care in the process of death and dying as a failure

Morin states that the crisis in which humanity is must be overcome from education, through a reform of thought, through a reform of education. The mission of education is not to transmit the mere knowledge, but a culture that allows understanding the human condition and that helps to live, promoting an open and free way of thinking.32

In this perspective, reflecting on the origin of Brazilian curricula of undergraduate nursing courses and how they are organized, as well as the space for training in PC, it is essential to observe the National Curriculum Guidelines for Undergraduate Nursing Courses33, developed by the National Council for Education under the opinion CES / CNE 583/2001.

Those guidelines propose that higher education institutions should aim at competence of intellectual, autonomous and permanent development that allow the continuous process of academic training and the production of knowledge, even after the graduation. They also encourage the abandonment of old and closed conceptions of curricula, which worked predominantly as mere transmitters of knowledge and information, not providing tools for the exercise of thought of professionals.32 Thus, it is understood that the great challenge of nursing education is not the accumulation of knowledge but the development of a general ability to identify, locate and treat problems and organizing principles that allow connecting knowledge and give them meaning.32

Although encouraging the formation of reflective nurses, which is key to change the paradigm from cure to care, that consequently allows another way to take care in the process of death and dying and the performance of PC, the development of curriculum guidelines reflected the social context and history experienced in the period of its development. Thus, these were directed to the social needs arising from the country's health conditions and, accordingly, appreciated the struggle for comprehensive care directed to the Unified Health System (SUS), seeking to change the training focused on hospital environments, emphasizing, disease prevention, health promotion, recovery and rehabilitation.34 It is observed that, when guidelines were adopted, the priority was the training of nurses who aimed to help the patient to live at all costs, by installing a permanent fight against death, and disregarding the need to include training for end of life in the guidelines objectives.35

Thus, the training of health professionals is still focused on the biomedical model, directed to promotion, preservation and recovery of life, disregarding death as part of the life process. Curricula predominantly reflect the culture of denial of death. Professionals' training is focused on the preservation of life and health recovery, and death is still considered a failure. The nurse is trained with the purpose of seeking healing, regardless of its real possibilities.35

Nursing curricula remain fragmented with disciplines predominantly highlighting the technical and scientific knowledge. Thus, the academic training values technique to the detriment of the human being; there is little room for the expression of feelings towards death and for an educational practice that encompasses the emotional, spiritual and social aspects of humans.35

Education is subdivided in small disciplines that look for the body, turning it into organs, tissues and cells, devoid of humanity. The fragmentation of education produces multiple gaps and may hinder the implementation of a humanizing perspective that allows perceiving the sick person in their entirety, requiring the articulation of knowledge for a comprehensive care.35

It is understood also that the gaps in knowledge and academic education for the care of people at the end of life cause suffering to health professionals when taking care of patients who are dying. This suffering, in most cases, seems to be related to the feeling of failure on the part of health professionals since they received training that seeks to cure, regardless of the real possibilities, and sees death as a professional defeat. Thus, death brings suffering not so much by the person who died, but by the sense of failure before the inevitability of their death.23,36

In a perspective of the complex thought, how the care to end of life is articulated in Brazil reflects the way society understands disease, death and dying, extrapolating training issues. The challenge of education is to transcend and change society from
practices that enable the exercise of thought and reform of thought. These educational processes need to take place during graduation with health professionals and with families and patients who experience disease with poor prognosis and possibility of imminent death. Still, the gaps in knowledge and technology about this subject make difficult to provide a comprehensive and quality care to people who are dying.

The care in the process of death and dying and PC and the necessary reform of thought, from the complex thought

Complex thought can begin to be understood from the original sense of the term, which “is woven together”; thus complexity comprises the rewiring of the different aspects of knowledge, as well as the recognition of the incompleteness of any knowledge, of its unfinished condition, opposing to the reductionist thinking. It has principles that help to understand the complexity, being complementary, interdependent and operated jointly in the analysis and explanation of phenomena, called: systemic or organizational, hologramatic, dialogical, retroactive, recursive, autonomy / dependence and the reintroduction of knowledge in all knowledge. The systemic or organizational principle connects the knowledge of the parts to the knowledge of the whole, in opposition to the reductionist idea that “the whole is more than the sum of its parts”. The organization of a whole produces new qualities or properties in relation to the parts considered alone, called by Morin as emergencies. Still, the whole is also less than the sum of the parts whose qualities are inhibited by the whole organization.

The hologramatic principle brings the idea of totality. In the hologram, the lowest point of the image contains almost all the information of the represented object; so when you see a hologram, you cannot dissociate the part and the whole; the part is in the whole, as the whole is in part. The entirety in the complex thought not the sum of the parts, it can be more or less than the sum because entirety is open.

The dialogical principle proposes jointing what is apparently separate, allowing maintaining the duality within the unit. This principle combines two ideas at the same time complementary and antagonistic.

Dialogical thinking is to understand that the reality is built, modified, destroyed and regenerated from opposing principles and forces. The principle of retroactive circuit proposes the idea that the processes are self-regulators, breaking with the principle of linear causality of cause and effect, since “the cause acts on the effect and the effect acts on the cause”, making this regulatory mechanism enables the system autonomy. In its negative form, the feedback circle reduces deviations and thereby stabilizes a system, whereas in its positive form, it acts as an amplifier mechanism. Thus, retroactions can be considered inflationary or stabilizing, being observed in social, political and psychological phenomena.

The principle of organizational recursion uses the thought that the cause acts on the effect and the effect can act on the cause. A recursive process is one in which the products and the effects are at the same time, causes and producers of that producing them. Morin shows an example of society that is produced by interactions between individuals, but society, once produced, acts on its individuals and produces them.

As an additional example of the recursive principle, there are the notions of order and disorder. All natural or human phenomena and systems obey an order that was produced by an initial disorder which, in turn, resulted from a previous order. This concept of order and disorder comes from physics, from the principles of thermodynamics, which indicate that the universe tends to the general entropy, that is, the maximum disorder and, on the other hand, it is revealed that, in the same universe, things are organized, become complex and develop. Thus, order and disorder cooperate to organize the universe.

Morin exemplifies that life and death are paradoxes that complement each other and help to understand the join of order and disorder: “Living is unceasingly dying and rejuvenating. We live from the death of our cells as a society lives from the death of its individuals, which allows them to rejuvenate.”

Thus, complexity always has to do with chance; it comprises uncertainties, indeterminations, random phenomena. Complexity, however, is not limited to
uncertainty; it concerns to semi-random systems whose order is inseparable from the chances that affect them.\textsuperscript{32}

The principle of autonomy / dependence or self-organization refers to the ability of living organisms to organize themselves, needing for such activity, energy to maintain their autonomy: “Since there is need to remove energy, information and organization from its environment, autonomy is inseparable from its dependence; that is why they need to be designed as self-eco-organizers beings”.\textsuperscript{32,95}

The principle of reintroduction of knowledge in all knowledge means that all knowledge is a reconstruction / translation made by a mind in a culture and certain times. In this perspective, Morin points out that the reform of thought is not programmatic, but paradigmatic because it refers to the ability of human beings to organize knowledge by using their intelligence and the organization of ideas.\textsuperscript{32}

In view of the complex thought, each individual is a subject; thus, individuals of the same species are very different from each other. The conception of the subject must be complex. To understand the concept of the subject, one must understand that individuals develop amidst chance and disorder, but also in self-organizer processes, in which each system creates its own determinations and its own purposes. Being subject is putting oneself in the center of one’s own world to deal with it and with oneself, it means taking the place of “I”. Being subject is to be autonomous, while being dependent. Human autonomy is complex because it depends on cultural and social conditions. The dependence is related to the fact that, to be ourselves, we need to learn a language, a culture, a knowledge and it is necessary that this culture is quite varied so that we can choose and think autonomously.\textsuperscript{31}

In his work “The head well made”, Morin presents his thoughts on education reform, questioning how the education is still being built, from a positivist paradigm of science that, by establishing a unique relationship of cause and effect, reduces, separates and simplifies knowledge. He shows that the over-specialization of sciences shatters humans, preventing a vision of totality that encompasses the cultural, social and historical aspects. Science has become blind to seek control, predict, and in an inability to integrate, articulate and reflect on their knowledge. For Morin, the idea of science must be in a multidimensional theoretical / methodological / epistemological coherent whole, open to uncertainty and overcoming, that is not closed in a defined and ready concept.\textsuperscript{31}

This simplistic view of science can also be seen in societies, from their worldview and organization, as well as in schools and in work organization. In this regard, the academic training reproduces and divides knowledge in delimited objects and induces students to select specialties, leading to hyperspecialization. Excessively specialized, knowledge may no longer be able to communicate with each other and the knowledge produced ceases to be integrated.

Thus, school neglects the comprehensive and does not prepare to face the unforeseen and the changes, depriving the individual of a global vision of reality. The severity of this scenario is the fact that people educated in that simplifying system have difficulty to establish ruptures and to take a point of view from which they can modify the state of things.\textsuperscript{31}

The organization of knowledge encompasses three challenges. The first is the cultural challenge of approaching what Morin calls the culture of the humanities and the scientific culture, which are disjoint. Humanistic culture is a generic culture, which stems from philosophy, from novels; it feeds the general intelligence and seeks to address the great human questions, stimulating reflection on the knowledge and promoting the personal integration of thoughts. The scientific culture is related to discoveries, theories, separating the areas of knowledge; its deficiency is not enabling a reflection about human destiny, the future and science itself. The approach and dialogue of these two cultures would allow reflection on the general and global problems, making the science capable of thinking about itself and thinking about social and human problems.\textsuperscript{32}

The second challenge posed by Morin is sociological, when he says that with the growth of cognitive characteristics of economic, technical, social, political and computer activities, increasingly, information is a raw material that knowledge must master and integrate; knowledge should be constantly revisited...
Carvalho KK de, Lunardi VL, Silva PA da Sá et al.

and revised by thought and that is, more than ever, the most valuable asset for the individual and society.32

The third challenge is the civic, i.e., the weakening of a global perception leads to weakening of the sense of responsibility and solidarity. Each person tends to be responsible only for their specialized task, disregarding their organic link with the city and its citizens. In this way, knowledge becomes increasingly accessible only to specialists, quantitative and formalized. Thus, the expert loses the ability to design the global and citizen loses the right to knowledge. Morin proposes that addressing these three challenges must take place by the reform of thought that would allow the full use of intelligence and the connection of the two dissociated cultures.32

A well-made head, then, is one that develops a general ability to place and deal with problems. This ability is related to doubt, to the “ability of rethinking the thought”, of questioning.32,22 Often, education kills curiosity; so, using general ability means appropriating another educational perspective that encourages, instigates to fundamental problems of our own condition and our time.

The well-made head must have also the ability to connect knowledge and give them meaning. Thus, an object, to be studied, cannot be isolated from its environment; it is necessary to contextualize knowledge, which Morin, using the biology concepts, calls ecology thought, in the sense that it places every event, information or knowledge in an inseparable relationship with their environment - natural, cultural, social, economic and political. This perspective allows us to see, also, relations and inter-retro-actions between each phenomenon in its context, relations of reciprocity between the whole and the parts, seeking to understand how a local modification has repercussions on the whole and how a modification in whole reverberates on parts.32

For Morin, learning to live from education requires transforming information into knowledge and knowledge into wisdom. There is need to understand the human condition by the development of compassion, solidarity and understanding of the other’s suffering, seeing them as a subject that suffers and has joy. This learning must be constantly recommenced. Similarly, one should stimulate critical ability and self-criticism.32

Still, it is essential to learn to face life’s uncertainties and, therefore, education must enable the individual to strategize. Strategy seeks to constantly gather the information collected and the hazards encountered during the route. However, as a priority, the current education develops programs. The program determines a priori a sequence of actions in view of a goal and, in the smaller disturbances, actions disrupt the program, forcing it to stop.32

In university, the challenges for a well-made head are in the production of knowledge by the formation of a research posture; in building a culture of autonomy of conscience, of questioning, of truth and ethics, of the development of cross-disciplinary knowledge, which unite humanistic culture and scientific culture. Thus, as presented, the university reform is the reform of thought.32

Education for care in the process of death and dying and in PC proposes to break paradigms of how death is viewed and addressed by society. The PC brings in its principles that the patient in terminal process needs to be understood in their entirety, needing to be seen as a complex being, of whom it is not possible to separate the social, spiritual and emotional aspects of the disease. Similarly, life and death can be interpreted from the dialogic principle, because they are seen as separate and antagonistic events, in which death must always be fought against, but in fact they are close and are complementary, in which death is part of life.

From the principle of organizational recursion, it is possible to understand that nurses are the product of society that values maintenance of youth, beauty and health, ignoring illness and death as integral parts of life. At the same time, in their professional practice, they are producers of a practice that constantly seeks healing, regardless of its real possibilities, understanding death as defeat. Reflecting on the whole, it is necessary to consider that the current health care model in Brazil reflects a positivist science and is still predominantly biomedical, focused on the disease and disregards the multiple causes of health problems, as well as the environment and the social and family context of the patient. Nowadays,
death occurs predominantly in hospitals, where patients are assisted by health professionals, among these the nurse, who has a guided training in the preservation of life and the search for a cure. In this quest for cure, regardless of the real possibilities, there seems to be no room for PC, which does not see death as a defeat, but recognizes the limitations of treatments in health and the need to respect the terminality of life so that the patient can live with dignity until the moment of the death.

In this health care model, death is hidden and seen as defeat and, predominantly, the patient is not informed about the severity of their health status. Ariès (2012) points out two causes of the process of dying and death have become concealed. The first relates to the emergence of the family, because the man, who once decided alone on their life and their death, with the emergence of familial feeling, comes to share decisions with their families, who refuse to admit the death of those they love. The second refers to the progress of science, which replaced in the consciousness of the man the death by the disease difficult to cure; with the progress of clinical and surgical treatments, it is known less and less if a serious illness is mortal; and the chances of surviving, even though mutilated, increase greatly; humanity acts as if the medicine had answer to all ills.

The patient should not ever know that their death is approaching; the new custom requires them to die in ignorance of their death:

[…] from the moment a serious risk threatens one of the family members, this soon conspires to deprive the person from information and freedom. The patient becomes then a minor, as a child or mentally handicapped, of whom spouse or parents take care and separate from the world. Others know better than the sick person what to know and do. The patient is deprived of their rights and particularly of the right once essential to be aware of their death, prepare it and organize it, and the patient gives up because they are convinced that it is for their good and if, despite everything, they have guessed it, they will pretend not knowing. Previously, death was a tragedy, often comic, in which one played the part of one who will die. Today, death is a comedy, often dramatic, where one represents the role of that who does not know they will die.

In the quote above, the patient is treated like a child and stripped of their autonomy. Morin shows in his discussion of the subject that they should be autonomous and be at the center of their existence, having freedom of thought. Autonomy is a fundamental right in order to guarantee dignity. However, in many situations of care to patients who are dying, who often find themselves in fragile conditions, the decision of the professional prevails by the judgement that the patient is not in a position to decide.

In the process of death and dying and in PC the autonomy of the patient is valued, their choice with regard to decisions of their treatment, course of life, place where they want to stay until the end of life and the planning of their death should be maintained as far as it is possible, with the conflicts that may arise involving the approach of death and maintenance of dignity. There must be preservation of the sense of life, existence, history and their place in the world, the quality of life in the dying process.

Thus, from the perspective of complex thought, it is not enough that the PC theme is present in a subject or as a content to be developed in a discipline; it is necessary that the principles that underlie this philosophy of care are transversally present in undergraduate curricula throughout the education of nurses. Among these principles, one can mention skills and areas such as sensitivity to deal with humans, comprising the different aspects of the process of dying; respect for the autonomy of the patient; skills for dialogue and to deal with feelings and emotions triggered; solidarity; social commitment; ethics; the transversal and interdisciplinary collective work; the acceptance of death as life process; and knowledge for the management of symptoms and pain control.

FINAL THOUGHTS

Thinking education in undergraduate nursing courses for actions in care in the death and dying process and the difficulties experienced in the use of PC in Brazilian
health services, one can say that, often, death is also related to loss, defeat, frustration. In a complex perspective, in contrast, death is a life stage, requiring academic training able to discuss and break the reproduction of knowledge, feelings, values and practices that predominantly still represent death negatively, associating it to failure. Nurses, during their training, must learn to deal with uncertainty and apparent failures, developing abilities to strategize considering the care needs of each patient.

The reform of thought for care in terminal illness requires, in addition to theoretical knowledge, self-reflection, awareness, involvement of emotions and multiple meanings, enabling contact with experiences and thoughts often repressed, allowing breaks for building new knowledge.

The establishment of breaks and the room for questions and reflection about death and dying are essential for the education of nurses, and are an important challenge. In this sense, for the continuity of breaks of the hegemonic thought, the training of teachers is also essential reform of thought, as these need to enable spaces for questioning, reflection and contextualization of knowledge, contributing to the development of students’ critical thinking.

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