



**LIVING WITH DEATH AND DYING**  
**CONVIVENDO COM A MORTE E O MORRER**  
**VIVIR CON LA MUERTE Y EL MORIR**

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**ABSTRACT**

**Objective:** describing the factors that interfere with the interaction of health professionals with death and dying. **Method:** a qualitative approach study carried out through semi-structured interviews with 21 health professionals in an Adult Intensive Care Unit. The material produced was analyzed by the thematic content analysis technique. **Results:** the results show for the better acceptance of death of the elderly spirituality, detachment and trivialization as a way of coping, technology prolonging the dying process and the indispensability of expanding the discussion in the academic formation of the subject of death and dying. **Conclusion:** there is a need for discussion and reflection about the factors found, with the implementation of study groups in an attempt to better cope with the death and dying. **Descriptors:** Death; Attitude to Death; Health Staff; Thanatology; Professional Practice.

**RESUMO**

**Objetivo:** descrever os fatores que interferem na convivência dos profissionais da saúde com a morte e o morrer. **Método:** estudo de abordagem qualitativa realizado por meio de entrevista semiestruturada com 21 profissionais da saúde de uma Unidade de Terapia Intensiva Adulta. O material produzido foi analisado mediante a técnica de análise de conteúdo temática. **Resultados:** os resultados mostram para a melhor aceitação da morte do idoso a espiritualidade, o distanciamento e a banalização como forma de enfrentamento, a tecnologia prolongando o processo do morrer e a imprescindibilidade de ampliação da discussão na formação acadêmica do tema da morte e do morrer. **Conclusão:** há a necessidade de discussão e reflexão sobre os fatores encontrados, com implantação de grupos de estudo, na tentativa de melhor conviver com a morte e o morrer. **Descritores:** Morte; Atitude Frente à Morte; Pessoal de Saúde; Tanatologia; Prática Profissional.

**RESUMEN**

**Objetivo:** describir los factores que interfieren con la interacción de profesionales de la salud con la muerte y el morir. **Método:** un estudio de enfoque cualitativo realizado a través de entrevistas semi-estructuradas con 21 profesionales de la salud de una Unidad de Cuidados Intensivos de Adultos. El material producido se analizó mediante la técnica de análisis de contenido temático. **Resultados:** Los resultados muestran para mejor aceptación de la muerte de los ancianos la espiritualidad, el desapego y la banalización como una forma de afrontamiento, tecnología de prolongar el proceso de morir y el carácter indispensable de la ampliación de la discusión en la formación académica del tema de la muerte y el morir. **Conclusión:** hay una necesidad para el debate y la reflexión sobre los factores encontrados, con la implementación de los grupos de estudio en un intento de hacer frente mejor a la muerte y el morir. **Descriptor:** Muerte; Actitud Hacia la Muerte; El Personal de Salud; Tanatología; La Práctica Profesional.

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## INTRODUCTION

In human history, death is one of the phenomena that most instigate the imagination of humans. Several thinkers made and make numerous assumptions about death and the mystery that surrounds it. Until the mid-fifteenth century, death was considered a natural event, was part of everyday life, with participation of the entire community, including children, and occurred mostly in homes. It is currently very varied understanding of patterns, surrounded by emotions and interests determined by.<sup>1</sup>

Technological investments increased the lifespan of patients, but the formation and maturation of health professionals to deal with the patient in the dying process did not follow this growth.<sup>2-3</sup> Death is not an evil to be destroyed, an enemy to be fought or a prison from which we must flee, but part of life, providing meaning to human existence.<sup>4</sup>

The fear of death has the following main components: the anguish of leaving this life; uncertainty as to the absence of afterlife; and the fear of possible suffering at death.<sup>2</sup> Despite all the development of society and of man, with new discoveries in various subjects, the issues surrounding death and dying are still the subject of reflection and changes in driving these phenomena.<sup>2</sup>

From the twentieth century, when death failed to occur in households and transferred to hospitals, it was present in the work of health professionals. Death went from an expected event, natural and shared, to an institutionalized and dying, mostly solitary.<sup>3</sup>

The way people see death certainly influences the way of being of each one, and it depends on multiple factors. For health professionals, this experience will affect not only its relationship with death on the condition of being human, but also in professional activities outside the patient who is in this situation.<sup>4</sup>

Changing the way of facing death, something natural to be associated with the idea of failure, it appears to be one of the elements that affect the difficulty that healthcare professionals have in taking care of the patient during the process of dying.<sup>5</sup>

In the hospital setting, no other event can raise more thoughts driven by emotion and emotional reactions than death, both the individual who is dying, as those around him. Death bothers and interferes deeply in the lives of professionals who, by virtue of labor activity, every day-shift live with it.<sup>6-7</sup>

Learn to live with the process of dying and death is very important for all health

professionals: the doctor, who must usually the decision on how to conduct the process of dying and finding cool death; nursing professionals who experience this process directly, interacting closely with patients and their families; and other professionals within the team. Based on these assumptions one has the following objectives:

- Describe the factors that affect the coexistence of health professionals with death and dying.

## METHOD

The study was extracted from the thesis presented at the Graduate Program in Nursing- Professional Master/UFES and is characterized by a field research of descriptive and exploratory with a qualitative approach, which allows to highlight the meanings, beliefs, values and attitudes that social actors have about death and dying, relating them to issues of culture, life history of every human being and feelings.<sup>8</sup>

The study setting was an Adult Intensive Care Unit (UTIA) of a university hospital in Vitoria. This scenario was chosen because it is a teaching hospital, with its professional trainers of opinion, and the choice of industry happened to be a unit where professionals live daily with death and dying.

Research started after the approval of the University Hospital Research Ethics Committee Cassiano Antonio de Moraes at the Federal University of Espirito Santo in the Opinion 157.413; and in accordance with Resolution 466/12 of the National Health Council.

The study included 21 health professionals, among the categories: doctor, nurse, physiotherapist, nursing technician and nursing assistant. This sample was selected in order to meet the criterion of acting at least two years in adult ICU, being excluded those who were on holidays and licenses.

The number of subjects was defined by data saturation, the information was collected until there were repetitions in content and answers already would meet and report to the objective proposed in the survey.<sup>8</sup>

To identify interviews and anonymity of study participants, letters were used to represent the existing professional categories in the sector: M (medical), F (physiotherapists), and T (nurses), (practical nurse), A (auxiliary nursing), followed by the sequential number of interviews.

Data collection took place from May to July 2013, in the place reserved to professionals of the unity, respecting the privacy and anonymity. Participants were informed about the study objectives, methodology,

guaranteed not to be identified and the confidentiality of information and the freedom to refuse or leave at any time of the study. Those who agreed to participate signed the consent form.

There was elected as a technique for data collection a semi-structured interview, whose script consisted of two parts. The first in order to characterize the subjects of the research, the second with open questions addressing issues of social, educational and emotional, as well as specifics on that refer to feelings and experiences before death. The interviews, previously scheduled, were recorded and later transcribed by the researcher.

Data were analyzed using thematic content analysis technique, which turns out to be "a set of analysis techniques of communications that uses systematic procedures and description of goals of message content."<sup>8</sup>

The resulting material from the interviews was analyzed in three phases: first, a pre-analysis, which was performed a floating reading material to in order to be impregnation of that content by the researcher. In the second phase of exploration of the material, the subjects were being grouped according to their contents, from the originating units of meaning the material, to obtain the formation of the categories. Finally, the processing of the results (inference and interpretation) was carried out by means of theoretical framework, which supported the formation of the so-called categories: temporality of death; Spirituality; Technologies that prolong life and Education.

## RESULTS AND DISCUSSION

The following data will be described the first interview stage - characterization of the subjects of the interviews.

A multidisciplinary team of UTIA is made up of doctors, nurses, physiotherapists, technicians and nursing assistants. The unit used as a research field, there is no presence of psychologists and social workers on staff. Of the 21 respondents, age ranged from 25 to 54 years, with a mean of 37 years. The average length of training was 12.5 years. The average time of experience in UTIA was 8.8 years. As for religious belief, most was named evangelicals, followed by Catholics and other religions, and one respondent reported being agnostic. On the educational level, about 40% of respondents had higher education and the vast majority of these had level of expertise or graduate.

From the corpus of analysis derived from interviews, it was possible to identify some

factors that influence the coexistence of health professionals interviewed with the process of dying and death. From this analysis emerged the following categories presented:

### ◆ Temporality of death

Health professionals have a tendency to better accept the death of an older patient than that of a young, it is independent of the profession, as can be seen in the following statement: *To me, the death of the elderly is easier than the young [...] the elderly will rest, if it turns out here most often is with sequels. The young man did not; he finds it easier to stand up.* (T3)

The explanation for this greater acceptance of death of the elderly can be given based on the culture of death must occur after the passing of years, preferably in old age,<sup>9</sup> and also the logical coherence of the temporality of man, when taught that: *[...] we expect to be buried by our children, then the death of the adult becomes easier for the child's death.* (T4)

### ◆ Ways of coping

When I think of so careful driving with the patient in relation to professional practice time, it is clear that, when faced with successive experiences of death, the professional develops coping strategies, repressing feelings, to assist in the exercise work:<sup>10</sup> *I've stared death in a more humane way, but in these five years of nursing, I think a lot has changed with respect to the feeling and way of seeing the death [...] a long time I have no feeling or suffer the question of the death of a patient.* (E5)

There is a need to deal with death coldly as dealing with death with a certain detachment minimizes pain, loss and indirectly failure: *[...] as soon as I entered the profession, I used to call me to patients and suffered much, today I can distance myself [...] so I try to keep myself emotionally distant at that stage.* (M1)

Professionals are in permanent contact with the dying and this uninterrupted contact can change in care, on the one hand the possibility of banality on the other for the suffering imposed on the worker:<sup>11</sup> *[...] could be a little more human, because sometimes we get so calloused to see so much happen, we lose a little sensitivity we have [...] we see it as a routine thing, like hand washing, "ah died," go there prepared and ready.* (T7)

When assisting the body, after death, there may be an oversimplification as a way of coping: *[...] end up getting used to deaths, in time to prepare the body, people smiling, singing, for they both do as much done.* (T2), but we cannot forget that this procedure should be done with dignity, respect and consideration for patients and their families.

The removal of the health care provider of a patient dying process may stem from something unresolved as a human being, because to get help others face their human conditions within them to death, professionals need to look inside:<sup>12</sup> [...] *in the course of life, we suffer many traumas and this will affect us, maybe we will lose, we lose that sensitivity [...] face death today with less sensitivity than before.* (A3)

Another coping strategy was evidenced spirituality, there is very broadly and beyond any religion, constituting the very essence of man.<sup>13</sup> health professionals take refuge in belief as something divine protection in the process of dying and coping They highlighted the death.<sup>14</sup> who cling to religion at the time worsens the state of a patient and also near death: *When I see that the frequency goes up there and starts to fall, I get close to the patient and pray.* (T4)

Generally, people with religious involvement, regardless of religious belief, are less afraid of death, because religious teachings gives to man answers about the whys of life and death and what happens after death: [...] *before I was afraid, now I no longer have to understand that death is only a passage to another life.* (E2).

Religions and philosophies have been constituted in explanatory strategies of the meanings of existence and finitude. This was realized in the statements of some professionals when reporting on religious belief and mission accomplished feelings [...] *we feel a little shaken, but with my faith I know I can rebuild me again.* (E4). [...] *Ah! Thank God stabilized.* (T1)

#### ◆Technologies those prolong life

The technological and scientific advances are bringing a detachment of care and attention to non-technical aspects of the dying process, giving priority to technical pipelines. Before the pain of the dying process was caused by the disease itself, today is also generated by the treatment:<sup>15</sup> [...] *we are concerned about the procedure, to make a new examination or an invasive procedure and forget that sometimes does not prognosis. And even though we insist a little bit more [...] I think that exacerbates the suffering.* (M4)

The time of suffering of the patient and family is often being too long, which creates trouble at all. Wonders whether the proposed treatments are worth it, because they have not succeeded in improving the quality of life and often worsen existing previous quality procedures:<sup>14</sup> [...] *to do a lot of procedures it knowing that it is only doing suffer more in the final minutes of life [...] do things just to say it was done.* (T7)

The death brings with it a feeling of helplessness and guilt, especially when a death suffered or early process, and the evaluation team nothing can be done.<sup>16</sup> To accompany the dying process, the professional should accept that death is inevitable and inevitable, it implies to recognize human limitations and know that no matter what is done or not do, nothing can prevent death.

In hospitals, though it may be terminal the patient's condition, always talk about the alternatives of life and never about the death because medical science incorporates the main objective of finding a cure for all causes of death, refusing to think about death as something natural: *I think that trying to save at all costs, hinders [...] I think we should help more dying than being born. Birth is more natural, spontaneous, and death should be.* (M4).

Man finds it difficult to endure the anguish generated by death and, in an attempt to minimize it; it creates new technologies with the intention of immortality. But as the death dribbles all the advances and ends the possibility of cure, is the feeling of loss, almost never "well-structured / settled":<sup>17</sup> *a disease to death are trying many things that perhaps the patient does not need to spend so many procedures, but let the person rest.* (E4)

#### ◆Academic training

In the academic training of health professionals, the theme Death is neglected or even non-existent because the curriculum addresses the technical side, but very little of humanistic and philosophical when contemplated is superficially:<sup>18</sup> [...] *precious little was spoken about death, practically nothing [...] we have seen this process in two materials, one cannot remember and the other on the oncology.* (E2)

The larger is the knowledge of death that have, in addition to their clinical and legal aspects, better care health professional can provide to patients in dying process.<sup>19</sup> Lack of guidance and preparation of health professionals to deal with finitude are perceived by respondents, they attach to experience working as a source of knowledge on the subject [...] *does not see that thing in theory and have to learn by doing, if death is one of them.* (T7)

The deficiencies in training, prioritizing in a technical school, does not allow that professionals are prepared to handle situations involving death, leaving the practical experience leads them to discover what is important in this process:<sup>22</sup> *I had only a one-time preparation, one teacher who spoke little in the field of gerontology.* (M4)

The future health professionals are prepared to save lives and forget that death is

also part of the life cycle. Most health professionals are unprepared to face the process of dying and death and dealing with the pain and suffering of others:<sup>11</sup> *I had two or three lessons about the process of dying, but I did not feel prepared for this process when formed [...] was further passed matter. (M1)*

Despite appearing in their curriculum proposals the holistic approach of care in clinical practice, which would include the study of death and dying process, universities and educational institutions do not seem to give much emphasis to this issue, focusing in a technical school:<sup>9</sup> *[...] I had no preparation, spoke of disease, severe life-threatening diseases, but had not prepared a course on death. (M3)*

Knowledge about the position of the professional front of the death and dying process is related to the lack of preparation for the academic life, pointing out flaws in the undergraduate curriculum:<sup>21</sup> *[...] spoke little, talked over when the patient came to die, to prepare the body, but about death does not remember having spoken. Spoke those things, not hold on much the patient, it may be this and that. (T2)*

During training, it is rarely created the opportunity to reflect on the loss of patients and the impact of that fact in the training process, the working lives and personal professional future:<sup>22</sup> *always taught much technique, how to take care and make the preparation of the body but not as you prepare for that process of death itself. (T5)*

The program content provided by graduate professionals not significantly integrates multiple knowledge necessary for patient care in the dying process:<sup>23</sup> *[...] only stage of disease and treatment process [...] no one prepared me to see someone die I never had lessons on the issue of work that feeling, how you can work to improve living the last moments, as have contact with the family, talk, address, address it at that time. Actually you travel on your own. (E5)*

The inclusion of disciplines addressing the topic of death and dying is crucial in addition to technical knowledge, aiming at the professional develop sensitivity for a more humanized care:<sup>24</sup> *I think that academic training has not prepared people, they are little humanized or more insensitive. It seems that they enter that learning eagerness, forget the patient. (E1)*

During the interviews, the professionals proposed interventions to improve the daily contact with death and the dying process, such as: *Place psychologist here to talk to, someone who spends every 15 days or once a month, to have a meeting with all the team. (M1)*

Health professionals feel the need to also be cared for, need to feel welcomed and revitalized, need support, support and

protection:<sup>25</sup> *For me, as a professional, I think we could have lectures, someone going to talk to us right now that there is nothing else to do for a patient. There's nobody talking to you, giving you support, especially when you are very attached to the patient. (T3)*

Health facilities leave much to be desired when it is matter of giving psychological support to its employees, hindering the progress of industry, patient care and the mental health professional: *The professional is charged, but only charged, it handles these things on a daily basis and has nothing that supports it. For us, professionals, there is no support, question goes a psychologist at least once a year and talk with any employee. (E2)*

Training and continuing education within the health institutions are differentiating the quality of life of terminally ill patients and health professionals, for the inclusion of topics that address the death and the dying process can spark a more humanized care:<sup>24</sup> *[...] should have something to prepare professionals for them to understand it better, would help because it humanizes people, get that stigma to do the mechanical stuff [...] would help us to understand what people are going through. (A2)*

To identify the factors that interfere with the interaction of health professionals with death and dying, said to acceptance of difficulty of the death of the young, because it is considered unnatural. Even with the absence of the theme of death and dying approach in the academic training required by these professionals, they have developed ways of coping to deal with these daily events. These confrontations are translated for spirituality, banality and distance Professional patient who is under his care at that time. Excess technology, which allows an extension of the dying process, was also appointed as the anguish and suffering generator.

## CONCLUSION

It was observed that the gap of health professionals in relation to the patient who is in the process of dying increased as the professional experience of time, perhaps as a way of protecting the suffering experienced by death.

Spirituality was found as a resource to alleviate the anguish of the team and as a strategy of trying to provide comfort when faced with death, being perceived to believe in something seems to help the acceptance of the event.

The age factor also interferes in living with death, for the death of a young person is less accepted than that of an elderly. The early death hurts the chronological order headed by

society, in which the natural is to be born, grow, mature and die.

The process of dying is an anxiety generator to the health professional, and so he makes numerous procedures in an attempt to heal the individual. However, the result is just the continuation of the process, increasing the suffering of everyone involved: patients, family and professional.

Referring to the in-depth discussion of the subject in academic education was verified disability and even absence of courses that addressed the subject of death and dying in order to allow the immersion of teachers and students in this universe, and when there were opportunities, it was only the technical aspects. It requires the inclusion of the subject in a specific discipline or fractionated into various disciplines, but in order to meet the multiple contexts in which the process of dying and death are inserted.

There was proposed by respondents deployment in health institutions aid groups to professional, as a space for expression of your feelings from work, and work his personal and professional experiences.

It is important to know the factors that interfere with the interaction of health professionals with death and the dying process to support discussions and reflections on those moments. Better understanding death as part of life cycle, avoiding the overvaluation of the technical care over the emotional aspects, social and psychological, and by acquiring greater knowledge of these issues, it is believed that there will be a facilitation team of living with death and die.

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