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Feelings of students in a master's in nursing program facing the death of patients in a critical situation

Sílvia Jorge Delgado[1] **João Francisco de Castro**[2] **Vitor Manuel Costa Pereira Rodrigues**[3,4] **Carlos Manuel Torres Almeida**[3,4]

[1]Centro Hospitalar de Trás-os-Montes e Alto Douro – EPE. Lamego, Portugal.
[2]Universidade de Trás-os-Montes e Alto Douro – UTAD. Vila Real, Portugal.
[3]Centro de Investigação em Desporto, Saúde e Desenvolvimento Humano – CIDESD. Vila Real, Portugal.
[4]Centro Académico Clínico de Trás-os-Montes e Alto Douro-Professor Doutor Nuno Grande – CACTMAD. Vila Real, Portuga
E-mail: calmeida@utad.pt

Abstract

Death is part of nurses' daily lives, especially when they deal with patients in critical situations. The way they perceive death may be relevant for providing humanized care. Objective: to identify the feelings of students of a master's program towards death and its influence on care provided to critical patients. Method: This is a study with a qualitative approach, approved by the ethics committee of the University (Doc11/CE/2018 of 09/04/2018). Interviews were carried out with 11 students, processed by content analysis. Results: the main feelings associated with the death of patients were: impotence, frustration/revolt, sadness/anguish, acceptance, relief, and distancing. Conclusion: students create emotional barriers to manage the suffering of the patients they deal with, and it is important that these do not compromise the quality of care. Students' feelings towards death positively influence critical patient care, as their experiences and life experience allow them to provide care more calmly.

Keywords: Sentiment Analysis. Death. Nurses. Critical Care.

INTRODUCTION

Although little talked about and sometimes even avoided, the theme of death and dying has been increasingly investigated. The technological and scientific evolution verified in the last decades gave us the illusion of absolute control over the disease and, effectively, people live longer and die later and later; however, death is still something that we do not control since we do not decide when we will die or when our loved ones will die. The scientific advances of the last centuries, better health care, and the increase in life expectancy have given us the false idea of immortality, something that we have not yet achieved and that we will hardly ever achieve. Therefore, death is a reality. We have to deal with it, and we have a duty to care for people in a "death

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process", making it vital to face this issue in a balanced way, in order to provide good health care and avoid dysphoric feelings.

Most nurses will inevitably have to deal with death, sometimes daily, in the workplace and "look it in the eye". Therefore, it becomes urgent to be able to face it as part of life, without devaluing or avoiding it. It is important, then, to promote discussions on this topic, not only among health professionals, but also in society in general[1]. There are several studies that indicate that the academic training of professional nurses is essentially aimed at maintaining health and prolonging life, thus death may be seen as a professional failure. This reality can trigger feelings of guilt and sadness, which makes it essential that health professionals are scientifically and psychologically prepared to deal with the issue[1,2]. Thus, the result of several surveys has demonstrated that nurses have difficulties in dealing with this phase of the life cycle.

The themes of death and dying cause discomfort and lead us to our own finitude[1]. Despite being an uncomfortable topic, it is extremely important for nurses to overcome this discomfort and circumvent defense mechanisms that may arise, such as withdrawal or denial, when dealing with patients at the end of life[2,3]. In a study on the experience of nursing professionals towards the death of patients, it is warning to the fact that they suffer in the face of the loss of patients and that they are not always able to deal with end-of-life situations or provide comfort to family members[4]. They also refer to possible consequences of this situation for health professionals, which may result in physical and emotional problems. The authors expose the importance of reflecting on the preparation of nurses for the experiences of death and dying.

There are several studies where it is revealed that these themes are addressed and investigated, essentially in teaching, in basic training, and in the practice of nurses in oncology services, palliative care, and intensive care[5,6]. However, are nurses who decide to continue their studies and embark on a master's degree aware of the complexity of the themes of death and dying? The decision to continue studying and, particularly, to carry out a master's degree demonstrates a great interest in professional improvement and requires the incorporation of the scientific method applied to practice, in order to obtain knowledge based on methodological rigor and scientific foundations. We question, however, whether the scientific increase in practice will be accompanied by a greater understanding and ability to deal with death and dying.

It was based on these concerns that we decided to carry out this study, with the starting question: "What are the feelings of students of a master's program who face death and its influence on care provided to critical patients". In order to respond to this question, the objective was to identify the feelings of these master's students towards death and its influence on the care they provide to critical patients.

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MATERIALS AND METHODS

This is a qualitative study in the sense that it aims to explore a life experience (in this case, the theme of death), from the point of view of those who experience it. The population is made up of master's students of the Person in Critical Situation program, from the School of Higher Education in Health, University of Trás-os-Montes and Alto Douro (UTAD). The sample was collected was non-probabilistic and intentional, accidental, or by convenience. We consider as inclusion criteria students of the Person in Critical Situation Master's Degree program, who are actively practicing nursing, and who in their workplace, deal with patients in critical situations. Eleven participants contributed to this study, with 18 students meeting the inclusion criteria, thus complying with the principle of data saturation. In order to comply with ethical requirements, the study was validated by the Ethics Committee of the University of Trás-os-Montes and Alto Douro (Doc11/CE/2018 of 04/09/2018) and authorization was obtained for the interviews. For data collection, we resorted to a semi-structured interview consisting of two parts. The first consisted of closed questions aimed at collecting sociodemographic data that allowed for the characterization of the participants: gender, age, marital status, educational qualifications, length of service, and service where they perform functions. The second part was composed of several guiding questions that addressed aspects inherent to the perception of death and dying, from which we highlighted the questions "What does death mean to you?", "What feelings does this theme provoke in you?", "What feelings does the death of patients provoke in you?", and "Does the way you deal with and face death influence the care you provide to the patient at the end of life?"

In order to carry out the interviews, the following procedures were followed: we contacted the students of the Person in Critical Situation Master's Program in order to understand who would be available to participate in the study. For those who showed availability and openness, we scheduled the day and time for the interview, seeking, for this purpose, a place with a calm and modest environment in order to facilitate the conversation. Before the interview, we explained the purpose of the study, obtained verbal informed consent, and authorization to record the interviews in an mp4 format. We guarantee the right to refuse data collection at any time, as well as the guarantee of anonymity. In total, we interviewed 11 students from the aforementioned master's program, between May 2018 and February 2019. The interviews lasted an average of 20 minutes, were recorded, and later transcribed to be processed through the content analysis method. We ensured that, when transcribing the interviews, we would respect the language used by the participants, which is mostly presented in the modalities of the current and familiar records.

In the procedure for collecting, processing, and analyzing data, ethical considerations were taken into account, guaranteeing the aforementioned informed consent of the participants, their anonymity, and the confidentiality of the data obtained. For data processing, we resorted to descriptive statistics for the sociodemographic characterization and content analysis for the treatment of information contained in the second part of the interview, resulting from questions about the perception of death and dying.

For the content analysis, we tried to carefully respect the procedures described by Bardin[6-7], which is organized around three phases: i) pre-analysis (floating reading of the interviews and redefinition of objectives); ii) exploration of the material (creation of categories); and iii) treatment of results, inferences, and interpretations. In order to maintain the anonymity of the dialogues, they appear coded with E1, E2, E3 successively.

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RESULTS

11 students participated in the study, with professional experience between 4 and 23 years. The results suggest a great disparity in professional experience, which may influence the reported perceptions of death and dying. The average length of service is 11.6 years (with a strong influence of mode, in the 11–15-year range), which refers to the dominance of a relatively young age group of master's degree nurses, which, once again, may influence their perceptions of the topic addressed. Most participants have a degree and only one has a master's degree. As for the place where they work, 3 of the participants worked in the emergency service and 3 worked in the medicine service, accounting for a total of 54.5%. Each of the five remaining respondents worked in different services (Intensive Care Unit, Operating Room, and Isolation Unit). The ages of the participants are between 28 and 49 years old, with an average of 35.2 years old and a mode of 31-35 years old. With regards to marital status, eight participants are married and three are single. Regarding gender, seven female and four male students participated.

Concerning the results on the perception of death and dying, as a first approach, we questioned the participants about their perception of death in a broader scope, not directly related to the work context, verifying that most participants do not establish a clear distinction between the experience of death outside and in the work context, as many reports refer to situations experienced in the work environment. We therefore chose to address issues directly related to the process of death/dying of patients. The participants were asked about the feelings and attitudes that the theme of death provoked in them, and a large Category – Feelings emerged, in which 6 Themes were revealed: Sadness/Anguish, Distancing, Relief, Acceptance, Frustration/Revolt, and Impotence (Table 1).

We chose to add the themes "Sadness" and "Anguish" as well as "Frustration" and "Revolt" because they fit the same register of emotions. Without this aggregation, the categories would have been less significant and more dispersed in terms of recording units.

The theme with greater weight is sadness/anguish and distance, indicated by five participants.

The revealed feelings of "Sadness/Anguish" are evident in the reports:

... In a young person there is a feeling of anguish, when realizing that we can't do anything else... because it's over... they stayed there. (E2)

... you get to know the patient better, there are several readmissions (...) then, you feel sorry for the person passed away. (E3)

The Distancing category is highlighted in the following dialogues:

... I don't think about it too much (...) I always do my best. (E1)

... there are people, like in the unit, who are very unstable and end up not interacting with you much, so you end up seeing that things are going to go wrong, but also the person is not even interacting with you. (E7)

The issue of emotional distancing from the patient is still visible in the statements:

... Some, indifference because you do not establish that empathy with the patient. (E3)

... When they are people with whom we don't create a connection...we end up accepting it better...it's another person who has reached the end of their life cycle. (E8)

The feeling of "Relief", associated with the death of patients, is described by some of the participants, mainly in situations of

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chronic and incurable illness or extreme suffering:

... most of the time it's relief (...) you know that person was suffering (...) that there wasn't much else to do. (E2)

... and that there is no quality of life anymore (...) you fully accept it and think "the suffering is over!". (...) turns out to be a relief. (E10)

From the speeches of the participants, the category "Acceptance/Sensation of accomplishment" also emerged, evidenced in the statements:

... Sometimes it also causes me a feeling of peace because I still haven't suffered, throughout my life, any death (...) you see those people who are very alone in the world, who die alone? (E7)

... Sometimes the feeling of mission accomplished. (E8)

Other feelings mentioned by the participants before the death of patients is "Frustration/Revolt", mirrored in the following speeches:

... Sometimes they make me angry, in these cases, for example, when they call for palliative care too late, in cases where the doctors... for example, arrive and say that we should do nothing, and then another comes and says, "I know that you are not to do anything, but he won't die with me either! (E7)

The feelings of "Frustration/Revolt" are also related to the "temporality of death."

... you feel a little frustrated, because they're young (...), but why? Did we do everything we could? Did we not? (E10)

One of the participants mentioned a feeling of "Impotence" in the face of the death of patients:

... so this person died and I couldn't do anything else? (...) other times, not directly because of my care, that feeling of "we could have done more." (E8)

When faced with the question "Does the way of dealing with and facing death influence the care you provide to the patient at the end of life?" Six participants believe that they are influenced in the care they provide to the patient at the end of life, while five participants believe that they are not influenced. (Table 2)

The six participants consider themselves to be influenced by the way they face and deal with death with regards to the care they provide to the patient at the end of life, not necessarily being a negative influence. In this case, the encounters and life experience that allow providing care in this complicated situation with more serenity are highlighted:

... Yes. I have already gone through the death of some family members, (...) and these experiences made me a little more sensitive to people and also to the family. (E6)

... Directly to patients, maybe not, I think maybe in the way I deal with the family. (...) I think I deal well with death (...) I think I manage to convey it a little more calmly. (E8)

Conditioned by their own cultural, religious, social, and philosophical experiences and convictions, participants assume these influences in the care they provide:

... Yes, without a doubt...I think I can deal naturally with the death of patients...and that influences me. (E2)

... Yes yes! It's the way of thinking (...) it's what you believe in, in your life, even your religion conditions you. (...) for me, I even think that having dignity in death is not having pain.... (E10)

In a deeper analysis, the five participants who consider that they are not influenced related this fact to the importance and ethical sense applied to the care they provide to the patient at the end of life, apart from any personal opinion:

... No, it doesn't influence me (...) if I have to provide comfort to a patient, it's not because I'm afraid of death that I'm going to provide worse care. (E3)

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Table 1- Recording Units and Meaning of Units by theme, regarding the question "What feelings do you feel when patients die?" (n=11). Vila Real, Portugal, 2018.

Themes	What feelings do you feel when patients die?	
	Recording units	Units of Meaning
Sadness/ Anguish	•••••	E1 - I am always more hurt when they are young patients. E11 - If you have a connection, if the patient has a "life relationship", it gives us that sadness.
Distancing	•••••	E2 - … Now with the patients... death is easier to accept because they are not ours. E4 - It becomes relatively easier for me to deal "inside" with death without thinking too much about what will happen afterwards, be it the suffering of the family, those stages of mourning, maybe it's a self-defense mechanism… go around a little bit, try to get away from these situations a little bit... funerals and the like. E9 - At other times there are no feelings, for us it is such a normal situation, it was the "end of the line".
Relief	••••	E6 - Things were expected and end of life ends the suffering, sometimes it's a feeling of relief... the person had their life, but for some reason it's ending. E9 - In many cases it's even a feeling of relief because a lot of suffering is over.
Acceptance/Feeling of accomplishment	•••	E5 - If they are elderly people, who are suffering, who no longer have a relationship life, I accepted naturally... it is a feeling of acceptance. E8 - Sometimes the feeling of mission accomplished
Frustration/ revolt	••	E5 - When they are younger people there is a little more revolt. E7 - Sometimes they make me angry, in these cases, for example, when they call for palliative care too late, in cases where the doctors... for example, arrive and say that we should do nothing, and then another comes and says, "I know that you are not to do anything, but he won't die with me either!"
Impotence	•	E8 - Other times, not directly because of my care, that feeling of "we could have done something more".

Table 2 - Recording units and meaning by category, regarding the question "Does the way of dealing with and facing death influence the care you provide to the patient at the end of life?" (n=11). Vila Real, Portugal, 2018.

Category	The way of dealing with and facing death influences the care provided to the patient at the end of life	
	Recording Units	Units of Meaning
Yes	••••••	E4 - Yes, it always influences (…) Our personal or professional experiences influence us positively or negatively. E7 - I think so, no matter how much we try to be an element that is impervious to others, this is impossible because you are a person with your characteristics, with your beliefs.
No	•••••	E1 - A person has to abstract and try to overcome things and always try to give the best of us. E3 - No, it does not influence (...) if I have to provide comfort to a patient, it is not because I am afraid of death that I will provide worse care.

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DISCUSSION

Although most participants consider death as a natural phase of the life cycle, the theme provokes negative feelings of sadness, anguish, and impotence, thus corroborating other studies already carried out, namely with nurses from an intensive care unit[1,2]. The emotional bonding factor, as well as the patient's length of stay in the service, increases the feeling of sadness before their death[8]. Proximity in cases of prolonged stay in the services or, in the case of several readmissions, is difficult to overcome, with nurses being the professionals who spend the most time with the users. When caring for the person, bonds and empathy with patients and their families are created. The issue of age is also pressing, being for most participants a condition that could lead to an increase in this feeling of "Sadness/Anguish", as it becomes difficult for participants to accept the death that occurs in young people. This idea also appears in studies that refer to the difficulty in dealing with death in young people, as not being the natural order of things, changing the process of "being born, growing up, aging, and dying", and breaking this desirable and expected cycle by these participants[9]. Some authors refer to the idea of the "temporality of death"[10], translated as a better acceptance of death in elderly people, a fact that respects the logical coherence of man's temporality, in which death occurs after the passing of years of life.

Distancing emerges as a defense mechanism, because when faced with pain, suffering, and finitude, nurses end up questioning their own finitude and that of those close to them. This detachment is also usually described with reference to escape behaviors as a way for professionals to defend themselves from the suffering caused by the patient's death process[10,11]. Emotional detachment from events in the professional environment becomes necessary and is understood as a defense and protection mechanism for most professionals[9].

Sometimes distance can be confused with acceptance; however, in our dialogues this phenomenon is referred to as the absence of emotional connection that will not compromise the nurse emotionally; if there is no connection they will not suffer from the loss. Authors refer to nurses distancing themselves from patients and their families as a way to reduce the affective bond and reduce their suffering when death is foreseen[3]. In fact, there are references to the establishment of ties with the patient as revealing a greater humanization and greater scope of care, which may, on the other hand, condition the care provided to the patient at the end of life[8].

The feeling of relief in the face of death is also a feeling already found in other studies, sometimes pointing out as a cause the fact that the medicalization of death prolongs states of agony, where death does not occur in a peaceful and even natural way as would be desirable[12]. In this sense, the feelings of comfort and relief at the death of patients, despite the end of a life, results from the perception of this death as the end of suffering for the patient[12,13]. There is often a sense of accomplishment in the face of death in situations where professionals feel that everything was done to save a life or provide comfort at the time of death[13].

Faced with the inevitability of death, it is possible for nurses to feel that their work is very valid, which goes against the recognition of the end of life as a professional failure. In this regard, the nurse, when dedicating themselves to the patient, must

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recognize that they gave their all and that they should stop seeing death as a failure in their profession, accepting it as a phase of the life cycle[14].

The feelings of "Frustration/Revolt" arise because death is perceived by some participants as a defeat, since they were trained for healing and for life[1,10]. When it occurs, it becomes difficult to accept. In Western society, there is a tendency to move away from the idea of death, creating a false idea of anticipating and controlling the disease; this fact may cause great difficulty in accepting it when it arises. It is, therefore, important that death is recognized as unavoidable and inevitable, as well as for the recognition of human limits and medical science[1,10].

The feeling of impotence is also portrayed in several studies[1,9,10]. Authors point out that this theme highlights the unpreparedness of nurses to deal with death and dying, as well as the lack of support to deal with situations involving care provided to people at the end of life, leading to the suffering of professionals, described by feelings of sadness, frustration, and impotence[9]. According to them, nurses are aligned with the objective of dealing with life, and see death as a failure, which gives them feelings of anguish, guilt, stress, and impotence. Also addressed in studies is the feeling of impotence in the face of the death of patients, described as the belief that not enough has been done to save the patient's life[13]. In everyday life, nurses are confronted with situations of death or imminent death, constituting a process that is often aggravated by the lack of autonomy in decision-making, by not agreeing with therapeutic options or by believing that the information provided to family members was insufficient[4].

Reflecting now on the influence of attitudes towards death in the care provided, we can say that attitudes towards death vary depending on culture, origin, and individual characteristics. The basic difference between lay people and health professionals, when dealing with death, is that, for the latter, death can be part of everyday life, which allows for greater knowledge about death and dying; however, not exempting them of possible negative feelings associated with this theme[1,2]. The personality, age group, social, and family environment to which they belong, the cultural context, as well as their values, customs, and traditions, influence the way a person deals with death and dying, whether they are a professional health or not. The way a person sees death is influenced by these unique characteristics inherent in every human being and, in the case of health professionals, such characteristics will be reflected not only in their relationship with death, but also in their professional performance in the face of a patient in a critical situation[1].

The experiences of death and end-of-life care, both personal and professional, can, according to the participants, prepare them to deal with these situations in a more humane way. Attitudes towards end-of-life care are positively and significantly correlated with greater preparation, with experience while working professionally, and with having dealt with more patients at the end of life. This is why, according to some authors, the aforementioned conditions help to develop strategies to deal with death and dying, thus, allowing the acquisition of favorable attitudes and beliefs towards end-of-life patient care[1].

Therefore, a phrase repeated several times in irreversible situations: "There is nothing to do!", is totally denied by these participants. Even when there is no possible cure, there is always something that can be done: provide good care and comfort. There may actually be no treatments available for an illness, but there is always something to be done for the patient.

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CONCLUSION

Nurses who care for patients in critical situations deal with situations in which the imminence of death is a constant. Master's students in nursing who care for people in critical situations, when continuing their studies in this area, show interest in professional improvement, and, in the reasons revealed for choosing a master's degree in nursing for people in critical situations, an interest in the area of urgency/emergency nursing. Thus, in the exercise of their functions, they will invariably have to be prepared to deal with death and dying.

When questioned about the feelings associated with the death of patients, the six themes identified were sadness/anguish, distance, relief, acceptance/sense of accomplishment, frustration/revolt, and impotence. The feeling of detachment is highlighted, which is revealed as a defense mechanism, since when faced with pain, suffering, and finitude, nurses end up confronting their own finitude and that of those close to them. Dealing with the death of another makes us think about our own death and this causes discomfort. As a way of escaping this discomfort, nurses create emotional barriers to manage the suffering they deal with on a daily basis. It is important that distancing does not compromise care for others, so that the patient and family do not feel neglected in this vulnerable and critical phase.

The way the participants face and deal with death does not categorically influence the care they provide, according to five of them; meanwhile, six participants indicate that, that aspect influences the care they provide to the patient at the end of life. However, this influence is not, in most reports, portrayed in a negative way. Events and life experiences that allow for providing care in this complicated situation with more serenity are highlighted. In the care process, each nurse brings something from their personal experiences that can often be enriching. The professional and personal experiences of death, of care for patients at the end of life, can, from the perspective of the participants, prepare them to deal with these situations in a more humane way.

Although the present study confirms the assumptions and foundations of the literature on the subject, it has some limitations such as the limited number of participants and the fact that everyone is undergoing the same training; however, we believe that research and investment in the subject of death and dying should continue, despite potentially being uncomfortable and still being seen as taboo.

Author Statement CREdiT

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