REFACS

Nursing care challenges in the face of death: reflections on spirituality

Desafios do cuidado de enfermagem frente à morte: reflexões sobre espiritualidade

Retos del cuidado de enfermería ante la muerte: reflexiones sobre espiritualidad

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This is a qualitative study carried out in 2016, in a city in the state of Minas Gerais. It aimed to describe the dimensions of care in the face of death and the influence of spirituality on the perception of nursing professionals who work in sectors of emergency care and admission of a hospital university. There were 160 participants, of which 141 were female, aged between 30 and 39 years old (44.3%) and 40 to 49 years old (21.8%). As for the category of activity, there were 131 professionals with secondary education (nursing assistants/technicians) and 29 with higher education (nurses), with experience of 5 to 4 years (34.4%) and 10 to 14 years (25%), The majority were Catholics (35.5%), followed by Spiritists (32.5%). The material resulting from the interviews was exposed to the analysis of the Collective Subject Discourse, with the aid of the DSCsoft® software. The grouping of key expressions and similar central ideas resulted in three categories: Professional performance in the face of processes of death; Self reflection; and Spirituality: dimensions and influence in the professional context. The speeches reveal spirituality as a source of support and restoration, although the immanent meaning is reported by the relationships between people and the environment in which they live. An emphasis is put on the importance of self-care and the need for professionals to have welcoming spaces with the opportunity to redefine comprehensive care in face of finitude.
Descriptors: Workforce; Humanizacion of assistance; Nursing care; Attitude to death; Spirituality.

Este é um estudo qualitativo realizado em 2016 em uma cidade do interior mineiro, com o objetivo de descrever as dimensões do cuidar frente à morte e a influência da espiritualidade na percepção de profissionais de enfermagem atuantes em setores de pronto-atendimento e internação de um hospital universitário. Participaram 160 indivíduos, dos quais 141 eram do sexo feminino, com idades entre 30 a 39 anos (44,3%) e 40 a 49 anos (21,8%). Quanto à categoria de atuação, foram 131 profissionais de nível médio (auxiliares/técnicos de enfermagem) e 29 de nível superior (enfermeiros/as), com tempo de atuação 5 a 4 anos (34,4%) e de 10 a 14 anos (25%), religião católica (35,5%), seguida de espirita (32,5%). O material resultante das entrevistas foi exposto à análise do Discurso do Sujeito Coletivo, com o auxílio do software *DSCsoft*®. O agrupamento das expressões-chave e ideias centrais semelhantes resultou em três categorias: *Atuação profissional frente a processos de morte; Olhar para si;* e *Espiritualidade: dimensões e influência no contexto profissional.* Os discursos revelam a espiritualidade como fonte de amparo e restauração, conquanto o sentido imanente seja reportado pelas relações entre as pessoas e o meio em que vivem. Destaca-se a importância do autocuidado e a necessidade de que os profissionais tenham espaços de acolhimento com oportunidade de ressignificação do cuidado integral frente à finitude.
Descritores: Recursos humanos; Humanização da assistência; Cuidados de enfermagem; Atitude frente à morte; Espiritualidade.

Este es un estudio cualitativo realizado en 2016, en una ciudad del interior de Minas Gerais, con el objetivo de describir las dimensiones del cuidado ante la muerte y la influencia de la espiritualidad en la percepción de los profesionales de enfermería que trabajan en los sectores de emergencia y de hospitalización de un hospital universitario. Participaron 160 personas, de las cuales 141 eran mujeres, con edades comprendidas entre 30 y 39 años (44,3%) y entre 40 y 49 años (21,8%). En cuanto a la categoría de trabajo, hubo 131 profesionales de nivel medio (auxiliares/técnicos de enfermería) y 29 de nivel superior (enfermeros/as), con 5 a 4 años de trabajo (34,4%) y 10 a 14 años (25%), de religión católica (35,5%), seguida de espiritista (32,5%). El material resultante de las entrevistas se expuso al análisis del Discurso del Sujeto Colectivo, con la ayuda del software *DSCsoft*®. La agrupación de expresiones clave e ideas centrales similares dio lugar a tres categorías: *Actuación profesional ante los procesos de muerte; Mirar a ti mismo;* y, *Espiritualidad: dimensiones e influencia en el contexto profesional.* Los discursos revelan la espiritualidad como fuente de apoyo y restauración, aunque el significado inmanente lo reportan las relaciones entre las personas y el entorno en el que viven. Se destaca la importancia del autocuidado y la necesidad de que los profesionales tengan espacios de acogida como una oportunidad para resignificar el cuidado integral frente a la finitud.
Descriptores: Recursos humanos; Humanización de la atención; Atención de enfermería; Actitud frente a la muerte; Espiritualidad.

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INTRODUCTION

The historical origin of nursing goes back to religious practices which purpose was to provide relief and physical well-being to patients, in addition to spiritual comfort, even when there was no possibility of cure. It is possible to infer that such precepts permeated the construction of ideals of nursing and are present in common sense about the exercise of this profession[1].

Emerging ideas from socio-cultural environment define death as an enemy to be overcome in favor of life, through the search for new knowledge, technologies, exams and procedures. The health team takes the duty to fight against finitude, as if it were possible to postpone or suppress this component of biological nature. It is possible to identify the diffusion of these ideas among nursing professionals, as well as the belief that they must constantly improve their technical-scientific knowledge to help heal the patients under their care[2].

In a hospital context, nursing is present at each stage of the life cycle, from birth to death. Nursing professionals are directly and constantly involved in the care of patients in the process of death and after the medical confirmation of death; and they are also responsible for the preparation, identification and referral of the body. Such care requires a high sense of responsibility in making complex and quick decisions, in addition to the continuous reorganization of priorities and a wide variety of information[3].

In speeches and attitudes, nursing professionals demonstrate that they understand that care in the face of finitude goes beyond psychobiological needs and covers social, cultural and spiritual dimensions[4]. Due to the daytime proximity, affective bonds are established and it is not rare that, when the death of a patient to whom many hours of work are dedicated, these professionals may experience feelings similar to the loss of family members, showing a sense of failure, both technical and personal.

The death experienced in the daily life of hospitals can produce, among nursing professionals, emotional exhaustion at different levels, which includes spiritual suffering, which in turn can reveal or increase the intensity of physical symptoms[5]. It is possible to observe a direct relationship between health and spiritual well-being, with impacts both on the assistance provided and on the fullness of the work performed.

Witnessing the health-disease processes in hospital environments and acting continuously in these scenarios can impact every vital dimension of the professionals involved, and the increase in the negative impact can lead to the disruption of the logical way of organizing thinking and cognition. Spirituality can help to deal with such processes, being a precursor to comfort, stimulation and balance in contexts of anguish and stress[6].

Existential beliefs, spiritual or religious, can contribute to a positive interpretation of critical events, as well as a more effective coping, constituting a source of energy and support that can strengthen the individual in search of a life full of senses. Religious-spiritual coping encompasses coping tools in the face of such events, with strategies that can be a search for deep meaning, spiritual comfort, intimacy with the transcendent and the immanent, and the re-signification of the life path[7].

Defining spirituality is complex because it involves different human meanings, purposes and values. As an integral dimension of being, it encompasses not only religion, but also hope and the search for a deep meaning to experiences, as well as values, attitudes, practices and feelings that arise from the relationship with oneself, with the environment and with the sacred. The confluence between social, cultural, biological, psychological and religious factors refers to values by which the person lives and believes, the lifestyle they follow, how they use their time, the habits they establish, all of this is reflected in the spirit of the live or spirituality[8].

Although there is ample evidence demonstrating the relevance of spirituality in health, traditionally the training curricula in this area do not include the theme with the necessary

depth and breadth. In this way, professionals demonstrate discomfort not only to address such issues in their practice with patients, but to identify in themselves such strategies of support and security in the face of conflicts[9].

Currently, it has been shown that spirituality is a protective role in issues related to physical and mental health, with impacts on quality of life. There is a prevalence of research aimed at sick people and family members in view of this dimension, as well as the perception of health professionals regarding the care to be observed in such aspects, promoting comprehensive care[10].

However, there is a lack of studies on the protective factors to the mental health of health professionals, with emphasis on the nursing team, considering the characteristics inherent to care in the face of finitude processes and, yet, how spirituality could permeate, modify or reframe such experience.

This study aims to describe the dimensions of care in the face of death and the influence of spirituality on the perception of nursing professionals working in the emergency department and hospitalization sectors of a university hospital.

METHOD

It is a descriptive study with a qualitative design, through which the investigation of relationships, customs and opinions is sought, subjective and non-quantifiable data that represent the product of the interpretations that humans make about how they live, express what they feel, think, build their artifacts and themselves[11].

The Social Representations Theory (SRT) was used as a theoretical-methodological support, which seeks to abstract meaning, introduce order and perceptions that allow to reproduce the world in a meaningful way. The information received is filtered through cognitions and values close to the individual's perception of reality, based on models and beliefs present and shared in the context of the group to which they belong[12].

The study was carried out in a general hospital located in the Southeast region, in the state of Minas Gerais. The emergency care and hospitalization sectors were selected: Adult Emergency Room, Child Emergency Room, Pediatrics, Neurology, Adult Intensive Care, Coronary Intensive Care, Neonatal and Pediatric Intensive Care, Infectious and Parasitic Diseases, Onco-Hematology, Medical Clinic, Surgical Clinic, Orthopedics, Nursery, Gynecology and Joint Accommodation. We chose to exclude from the study sectors characterized by outpatient care, in order to maintain homogeneity of care characteristics.

The sample was random and intentional, composed of nurses, assistants and nursing technicians of both genders, aged 18 years or over. As inclusion criteria, we selected those who provide assistance to people in different stages of health or illness, including the process of death. Professionals who were on leave or vacation during the period foreseen for collection were excluded, in addition to those who do not work in direct care for patients.

There was training and supervision of the team of interviewers, composed of twelve undergraduates in Health. The objectives and script of the study were explained, with the guidance of not modifying the questions or giving an opinion for the answers; however it would be plausible to redo the question or add statements such as: "*Do you have anything more to say?*", "*Could you explain it to me again?*".

The standardization of the collection procedures was verified through pilot tests with professionals from the sectors involved, which allowed to verify the adequacy of the instrument. Such preliminary results were excluded after transcription and were not considered in the analysis.

The collection instrument was developed by the researchers in charge and included data to characterize the sample, referring to gender, age, level of performance, time of professional

practice and sector/service. The interview script sequentially addressed the questions: *What is it like for you to care for patients in the process of dying?*; *What is spirituality for you?*; *Do you believe that spirituality helps to deal with this aspect of your profession?*; *In what way?*. Each collection form was previously identified by an alphanumeric code, used to record results.

Data collection took place over a period of two months - August and September 2016. To ensure greater participation of professionals, individual interviews were arranged with professionals in the sectors at times and periods of convenience for the research participants, in addition, interviews were carried out in places previously selected in the designated sectors, to maintain privacy and free expression of ideas.

The duration of each interview varied between ten and 30 minutes, depending on the volunteer's availability. The interviews were recorded in audio format by electronic devices and transcribed by the same interviewers in full, except for sample characterization data and information that identified the author of the statements. Thus, we sought to preserve the original content of the responses obtained, such as the meaning attributed to expressions and silences.

The characterization data were tabulated and submitted to exploratory analysis using simple frequencies. To systematize the treatment of qualitative data resulting from the transcription of the interviews, it was decided to use the DSCSoft® software, developed based on the Discourse of the Collective Subject (DCS) method. This method consists of a tabulation technique and organization of qualitative data, which results from key expressions identified in more expressive parts of the interviews and which represent the depth of individual responses and the central ideas that synthesize the revealed discourse[12]. The synthesis discourse is written in the first person singular, in which the thought of a collective is expressed as an individual discourse[12].

The project was assessed by the Research Ethics Committee of the Institution under study, approved under opinion number 1,715,828, CAAE 55434616.0.0000.5154. After approval, contact with management of the sectors involved, for clarifications regarding the research, the objectives and methodological procedures.

The professionals who agreed to participate signed the Free and Informed Consent Term, which contains the objectives, the guarantee of confidentiality about any data that can identify them and the right to withdraw from the study at any time. Each instrument previously received a random numeric code to guarantee the anonymity and confidentiality of the information.

RESULTS

160 individuals participated in the study, of which 141 were female, aged between 20 and 60 years. As for the performance category, there were 131 professionals with a secondary educational level (nursing assistants/technicians) and 29 with a higher educational level (nurses).
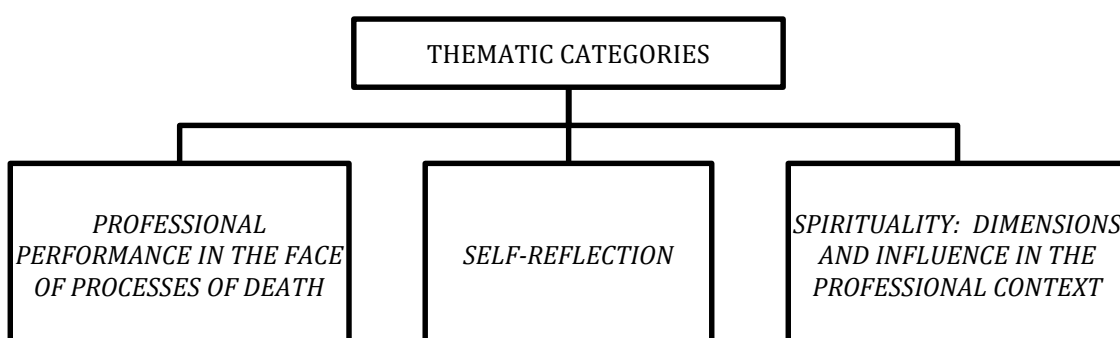
Regarding the time of professional performance, the sample involved varying degrees of hospital experience, from individuals who had just started their careers to those with more than 30 years of experience in inpatient sectors (Table 1).

Table 1. Sociodemographic variables of Nursing professionals at a University Hospital. Uberaba, Minas Gerais, 2016.

Variables	F	%
Gender		
Male	19	11.8
Female	141	88.2
Age group		
20-29 years	22	13.8
30-39 years	71	44.3
40-49 years	35	21.8
50-59 years	25	15.7
60 years or more	7	4.4
Time of professional practice (complete years)		
Less than 5 years	14	8.7
5 to 9 years	55	34.4
10 to 14 years	40	25.0
15 to 19 years	19	12.0
20 to 24 years	12	7.5
25 to 29 years	6	3.3
30 years or more	14	8.7
Religion or preferred belief		
Catholic	57	35.6
Spiritist	52	32.5
Evangelical	27	16.9
Christian/Believes in God	7	4.4
Other denomination	4	2.5
No information	13	8.1
Total	**160**	**100.0**

The grouping of key expressions and similar central ideas resulted in three categories, as follows: *Professional performance in the face of processes of death*; *Self-reflection*; and *Spirituality: dimensions and influence in the professional context.*

After selecting and organizing the key expressions present in each report, the central ideas with similar meanings were identified. Subsequently, the corresponding DCS were edited for the complementarity of the testimonies. These DCS supported the formulation of three thematic categories described in figure 1 below:

Figure 1. Thematic categories. Uberaba, Minas Gerais, 2016.

The thematic category "*Professional performance in the face of processes of death*" covers the perceptions of professionals regarding the care provided to people in the process of death. It is possible to conclude that the professionals are permeable to the feelings and experiences of the patient and his family in this context, according to the following DCS:

Dealing with illness and death every day will not always have positive results; it doesn't really become natural, but it does. It does not mean that we are cold but we get used to it, because someone has to take care of it. We have a very erroneous view that every patient improves, sometimes what is best for us is not the best for them. There are those who accept death in a very natural way, are calm and familiar too; this passage becomes something more serene. In addition to pain, the patient knows that death can happen, they become more depressed, sensitive. You see that the person is afraid. The attention is greater about their feeling, what is going on, the desires, what they still want in this process. Seeing the family there suffering and not being able to say that the time is coming, lying all the time, saying that it will get better even though it will not happen. You look at the person's profile and see if they are open for it, speak a message, comfort. You have to give encouragement, hope, faith that everything will be okay. (E43; E139; E23; E09; E44; E82; E01; E16; E96)

In turn, the thematic category "*Self-reflection*" gathers reports of situations that potentially generate emotional and psychological disorders, related to the care actions provided to seriously ill people. The statements denote some listed strategies to deal with such demands, as highlighted in the following fragments:

I feel very helpless knowing what the end will be, there is this feeling of inability. It gets frustrating, you can't do anything to change that situation, it's not in your hands. I try to do my best while I'm there, I don't let it affect my behavior at work or take it personally, work the other side, otherwise we have no life outside. We have to work hard on our emotional to provide better , humanized care, in the best possible way. Over time I developed a strength, both to help family and patient, and not to keep taking it home. I try not to get too involved in order not to suffer later, but these things get out of reach, end up messing with the mind and you have to balance that, not be totally cold but don't get too attached, be emotionally well stabilized to cope. I suffer, but I think we get a little mechanical and colder, day by day it does that. (E38; E145; E54; E92; E16; E25; E67)

And in the thematic category "*Spirituality: dimensions and influence in the professional context*", the reports denote aspects in the experience of spirituality in everyday life, in its immanent aspect, with emphasis on the way of relating to the environment and the others. They also speak of the spiritual dimension as the transcendence of matter, denoting attribution of a sense of sacredness to assistance in the final phase of life:

It is the care that we have with the soul, because it is not only the body that we have to take care of. It is in the way of feeling and acting with people, showing how it is, knowing how to face and understand the situation with patience. It is a humanized way of taking care of things of your daily life, of your experience here, in your passage as a human being, always looking for harmony between material life and spiritual life. We can only stay in nursing if we believe in something superior, which gives us support, support even for our sanity, otherwise we give up. We end up finding comfort in what we believe. Faith is a very important foundation, whoever believes is able to overcome the moments of conflict and the most difficult stages of life, maintains balance. Having a spiritual base helps in everyday life, we are caught in a greater energy, it is sustained and starts to see with other eyes. It helps us to have more strength to take care of, more serenity. They end up getting ready to be a little better, to appease the soul and heart of each one. This look makes it better every day within the profession, you can see the picture with a greater understanding, have more calm, intuition and wisdom in care. (E22; E116; E38; E42; E107; E04; E32; E23; E21; E80; E122)

DISCUSSION

The nursing team works in all phases of illness until the preparation of the body, after fatal outcome. However, dealing with this aspect of the profession can cause physical and psychological distress, as well as arousing questions and reflections. Due to the characteristics that denote care in the face of death processes, such situations can cause suffering to those who care.

Faced with the death process, the nursing professional may be the last to remain with the departing person. When other members of the health team move away from the patient, considering themselves powerless to recover the fullness of a physical body, nursing persists, following the continuum life/death, while there is a breath of life and even when it is gone, to prepare the body with dignity[13].

Nursing professionals are primarily responsible for caring for patients at the end of life in the hospital. Whether in an emergency context or after hospitalizations, the proximity to the dying person invites them to reflect. Although death is part of the daily work of nursing

professionals, difficulties in talking about the subject persist, as it refers to the inevitability of human finitude[14].

Some professionals react with denial at the time of the fatal outcome, which can interfere with the way they care. Others look for the naturalization of the subject as a way to elaborate their feelings, experiencing this process in a more humanized way. Thus, what may seem like a frantic activity around the bed may represent, on the part of nursing professionals, anxiety and denial of the imminence of death[15]. This can result in behaviors such as reluctance to interact with family and patient, the postponement of difficult conversations and a strict dedication to physical comfort tasks.

Death that occurs in natural time, in a dignified and respectful manner, is known as orthothanasia. However, it is possible for professionals to practice the opposite, as they feel they should invest (or insist) in saving the person who has been cared for[15]. To this end, effective ways of preparing professionals to deal with finitude in their practice are discussed.

Nursing work is permeated by a broad view, aimed at ensuring humanization and comprehensive care. However, when care needs to focus on the process of death and dying, disturbing feelings, intimate conflicts and even existential emptiness emerge. Professionals report sadness, failure, anguish, helplessness, insecurity, guilt, pain and fear as feelings that can emerge from the care of the departing being. Thus, they can maintain a neutral and technical attitude as a way to avoid suffering[16].

It is important to understand that comprehensive care provides quality to the life that remains and enables a dignified death, which allows a new meaning to the actions that aim to care, in addition to treating. Managing such components makes the professional able to better deal with the demands of patients, family members, and their own feelings[16].

Nursing professionals record as remarkable the memories related to the care of people with whom they have established an affective bond and fear failing to alleviate the suffering of others. The individual's youth under care, as well as the clinical history, chronic pain and suffering, are the factors that most refer to suffering for those who care[17].

Witnessing feelings expressed by the patient and the re-elaboration of existence in the face of death are factors perceived as a cause of work-related suffering. The upsurge of negative emotions and the lack of opportunities to freely express their experiences can cause suffering at different levels of depth, including the existential dimension, leading to questioning the practice itself[17].

There is an interdependence between taking care of oneself and others. In Foucault's perspective, taking care of oneself is an exercise in biopower. In this understanding, looking at oneself as a subject worthy of care refers to ethical and freedom issues, becoming a tool for coping with totalitarian discourses of control of practices and knowledge, in order to standardize subjective life for the benefit of the collective good[18].

Self-care encompasses physical, mental and spiritual spectra, being an individual search, but which takes shape in the encounter with the other, showing the need to live harmoniously in a group. It seeks to understand self-care as something to be achieved through inner knowledge, which enhances the understanding of what is essential in oneself and in the other[19].

It is necessary to understand individual and collective aspects inherent in daily life that can interfere with the quality of life of professionals who care, so that they also feel cared for. The creation of places to welcome and listen, or even, the holding of conversation circles are initiatives that can contribute to the genuine experience of dialogue, increasing the motivation of nursing professionals. In this way, one should think about spaces for solidarity sharing, in which care, competence and experiences are found[20].

Health education should include spaces for explanation, listening and acceptance of feelings and attitudes towards death, using different didactic strategies that allow the gradual approach to the care scenario. Although theoretical learning cannot faithfully reproduce the

different levels of impact produced by the daily experiences of professionals in therapeutic spaces, the psychopedagogical approach can mitigate the impact that the experience of dealing with death would have on the personal and academic lives of these future professionals[7].

Humanization policies provide care to those who care. Team discussions about acting in the face of death processes and the impacts caused at different individual levels, so that such situations are not naturalized or trivialized, can contribute to alleviate psychological suffering in the face of impotence in the face of the finitude of life[21]. The volunteers in the present study also mention the desire to speak and listen to their experiences among peers, as a way to validate or refute perceptions and reverberations resulting from professional practice.

Considering that workers contemplated in their needs develop a greater commitment to the work performed, it should be the primary goal of institutions that provide assistance to seriously ill patients, with a daily possibility of death, the valuation of professionals directly involved in these circumstances, which may reflect directly on the quality of care provided and greater satisfaction with care[21].

Each individual has their own unique way of facing situations of suffering in the face of death. Some individuals avoid creating affective bonds, which is a paradox because, at the same time that it mobilizes various emotions in the caregiver, the assistance to the person about to die demands a protective conduct and handling feelings and emotions of the other. The search for spiritual comfort is suggested as a strategy to minimize the psycho-emotional upheavals caused in the daily care/assistance[22].

In order to analyze coping strategies used by nursing professionals, different ways of dealing with suffering are pointed out, with the influence of spirituality as a resource to mitigate work stress being notorious. Spirituality is defined as an individual and intrinsic characteristic to being, it goes beyond religiosity, it involves questions about the purpose of life and its meaning, representing a connection between the "I" and the Universe and with other people[23].

Spirituality is an important construct for nursing professionals who deal with death processes in their daily lives, in terms of spiritual comfort to the patient and family, and the re-signification of potentially stressful events for the professional and the establishment of a higher sense to their job. This dimension provides a therapeutic route both to the other and to oneself, enabling comprehensive and humanized care[24].

CONCLUSION

Assisting seriously ill people, in addition to providing a safe and welcoming environment for family members to experience goodbye moments, can generate conflicting feelings and existential suffering among nursing professionals.

The professionals' speeches demonstrate recognition, appreciation and search for developing aspects related to spirituality. The strategies listed both in relation to both transcendence and in their relationship with themselves, with others and with the environment in which they live, denote the search for comprehensive and meaningful care.

The professionals who care are also worthy of care. And, there is a yearning for spaces for listening and welcoming in the institution where they work. Listening among peers makes it possible to share experiences, feelings and the necessary re-elaborations in the face of critical situations, so that they continue to find meaning and purpose in caring, which can reflect in humanized actions and bring more satisfaction with work.

As a limitation of the study, data collection is pointed out in only one institution. Although there is a significant number of interviews, these portray the ideas circulating and validated in a strata delimited by institutional policies.

In turn, it is expected to have contributed to broaden the understanding about the perceptions of nursing professionals about caring for the death process, in addition to the

influence of spirituality in their attitudes and reflections, in the way of relating to themselves and to the patients too much. The importance of further studies is emphasized, so that a historical profile can be drawn regarding the perceptions and reverberations of nursing care in each vital process and taking care of oneself as a protective factor for the professional's well-being.

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CONTRIBUTIONS
Raquel Lima Dornfeld contributed to the study design, data analysis and interpretation and writing. **Jurema Ribeiro Luiz Gonçalves** participated in the analysis and interpretation of data, writing and review.