REFACS

Original Article
Rev. Fam., Ciclos Vida Saúde Contexto Soc.
http://seer.uftm.edu.br/revistaeletronica/index.php/refacs/index
ISSN: 2318-8413 DOI: 10.18554/refacs.v14i00.9085

Nurses' perception regarding the finitude of those under their care

Percepção do enfermeiro acerca da finitude de quem é cuidado

Percepción del enfermero acerca de la finitud de la persona cuidada

Bianca Caroline de Souza Mattos[1], Marta Pereira Coelho[2], Alaianne Moreira de Souza[2]
Bruno De-Bruym Ferrarine[2], Adriana Nunes Moraes Partelli[2]

Received: 28/04/2026 **Accepted:** 08/10/2026 **Published:** 19/11/2026

Abstract:
Objective: to understand how nurses deal with patients for whom no further therapeutic options exist, and to identify the resources used to cope with the process of dying and death. **Methods:** a descriptive qualitative study based on Alfred Schutz's sociological phenomenological approach, examining "in-order-to" motives and "because" motives. Data collection took place at the São Mateus Maternity Hospital, in the state of Espírito Santo, Brazil, throughout 2018. Phenomenological analysis was used. **Results:** eight nurses participated, and four categories emerged regarding the nurses' perspectives on patient finitude: 1) *Feelings when facing a terminally ill patient*; 2) *The meaning of death*; 3) *Personal resources for coping with death*; and 4) *The meaning of providing care to a terminally ill patient*. **Conclusion:** it was understood that the participants, through their "because" motives, perceive the process of dying and death as a natural biological phase. Religiosity and spirituality were identified as coping mechanisms for dealing with death. Within the nurses' own intersubjective frameworks, death is perceived as a negative experience, not something they would desire for their patients.
Keywords: Nursing; Emotions; Terminally III; Death.

Resumo:
Objetivo: compreender como os enfermeiros lidam com o paciente fora de possibilidade terapêutica e identificar os recursos utilizados no enfrentamento do processo da morte e morrer. **Método**: pesquisa qualitativa descritiva baseada na fenomenologia compreensiva sociológica de Alfred Schutz, entendendo os "motivos para" e "motivos porque". A coleta de dados se deu no Hospital Maternidade São Mateus, Espírito Santo, ao longo de 2018. Utilizou-se a análise fenomenológica. **Resultados**: participaram oito enfermeiros e quatro categorias foram produzidas em relação aos enfermeiros e à finitude dos pacientes: *1) Sentimentos diante de um paciente terminal; 2) Significado da morte; 3) Recursos pessoais para o enfrentamento da morte;* e *4) Significado do cuidado com o paciente termina*l. **Conclusão**: compreendeu-se que os participantes, por meio dos "motivos porque", lidam com o processo de morte e morrer como uma fase natural biológica. Identificou-se influência da religiosidade e espiritualidade como forma de enfrentamento da morte. Na compreensão do enfermeiro com suas intersubjetividades, a morte é uma experiência negativa e não é o que almejam para seus pacientes.
Palavras-chave: Enfermagem; Emoções; Doente terminal; Morte.

Resumen:
Objetivo: comprender cómo los enfermeros afrontan la atención del paciente sin posibilidades terapéuticas e identificar los recursos utilizados para afrontar el proceso de muerte y morir. **Método:** investigación cualitativa descriptiva basada en la fenomenología sociológica comprensiva de Alfred Schutz, considerando los «motivos para» y los «motivos por qué». La recogida de datos se realizó en el Hospital Maternidad São Mateus, Espírito Santo, durante 2018. Se utilizó el análisis fenomenológico. **Resultados:** participaron ocho enfermeros y se establecieron cuatro categorías relacionadas con los enfermeros y la finitud de los pacientes: *1) Sentimientos ante un paciente terminal; 2) Significado de la muerte; 3) Recursos personales para afrontar la muerte;* y *4) Significado del cuidado del paciente terminal*. **Conclusión:** se comprendió que los participantes, a través de los «motivos por qué», afrontan el proceso de muerte y morir como una fase biológica natural. Se identificó la influencia de la religiosidad y la espiritualidad como forma de afrontar la muerte. Desde la comprensión del enfermero y sus intersubjetividades, la muerte constituye una experiencia negativa y no es lo que desean para sus pacientes.
Palabras clave: Enfermería; Emociones; Enfermo terminal; Muerte.

Corresponding Author: Bruno De-Bruym Ferrarine - bruno.ferrarine@edu.ufes.br

1. Municipal Health Department. Conceição da Barra/ES, Brazil
2. Universidade Federal do Espírito Santo. São Mateus/ES, Brazil

INTRODUCTION

Death – a topic rarely discussed and often avoided, despite being a natural process of human existence – is frequently perceived as the opposite of life, as it represents its end. From a biological perspective, it is characterized by the irreversible cessation of vital functions; however, it also encompasses social, cultural, and emotional dimensions that influence how it is understood and confronted. In this context, the process of dying involves ethical, cultural, religious, and psychosocial aspects, highlighting the need for better preparation among nursing professionals, both during their academic training and in their professional practice[1].

Over the years, theorists and researchers have sought to understand and explain human behavior in the face of death and dying, analyzing the various factors related to how individuals perceive and cope with the finitude of life[2].

According to the Mortality Information System (*Sistema de Informação sobre Mortalidade* – SIM), the number of recorded deaths in Brazil has been increasing over the years. Data from the Informatics Department of the Unified Health System (*Departamento de Informática do Sistema Único de Saúde* – DATASUS) indicate that the number of deaths rose from 946,686 in 2000 to over 1.3 million in 2016. Using the International Classification of Diseases (ICD-10), it is observed that the leading causes of death in the country are related to diseases of the circulatory system, followed by neoplasms, external causes, and diseases of the respiratory system. Consequently, a large proportion of these individuals were in direct contact with healthcare professionals during the course of their illness and at the end of life[3].

Given this, it is essential to conduct research on the extent to which healthcare professionals encounter experiences related to the process of dying, especially considering the rising prevalence of chronic illnesses and the prolonged trajectory of disease, which entails suffering, vulnerability, and the need for continuous care for both patients and their families[2]. Nursing is characterized as a profession focused on holistic human care. This care encompasses both technical aspects and a humanized approach, which together constitute the essence of professional nursing practice[4].

Nursing professionals must work in an integrated and humanized manner, combining technical competence with sensitivity in caregiving. Beyond the proper execution of procedures, it is essential to cultivate skilled listening, empathy, and effective communication, which fosters the development of a bond of trust with the patient. This relationship contributes directly to treatment adherence and improved health outcomes, demonstrating that humanization is an essential element in the quality of nursing care[5].

To understand the meanings that nurses attribute to their experiences with death and dying, this study is grounded in the Social Phenomenology of Alfred Schütz[6]. This theoretical perspective seeks to understand human actions based on the meanings that individuals themselves assign to their experiences within the world of daily life, recognizing that such experiences are constructed through intersubjective relationships formed over the course of one's personal and professional journey.

According to Schütz, every action is guided by "because" motives – linked to experiences and knowledge accumulated throughout life – and "in-order-to" motives – which represent future-oriented expectations and intentions. Thus, social phenomenology enables an understanding of how nurses interpret, experience, and assign meaning to the care of patients nearing the end of life, taking into account their life context, education, and professional experiences[6].

The end of life is a widely discussed topic globally. However, there remains a scarcity of studies that address this phenomenon through the lens of Alfred Schütz's Social Phenomenology[6], particularly within the context of nursing. This approach allows for an understanding of the meanings that nurses attribute to their experiences while caring for patients who are in the process of dying, while valuing their perceptions, intersubjective relationships, and the ways in which these experiences influence their professional practice[6].

The guiding question for this study is: *How do nursing professionals feel when dealing with the dying process of their patients?* Thus, this study aims to understand how nurses care for patients for whom no further therapeutic options exist, and to identify the resources they use to cope with the process of death and dying.

METHODS

This is a qualitative study grounded in phenomenology – a field centered on the study of essences – which pertains to the meaning attributed to something, providing a shared understanding of the phenomenon under investigation[6].

As a theoretical and methodological framework, phenomenology serves as a significant alternative for understanding human beings in their totality. It fosters a more sensitive perspective on lived experiences, placing value on the intersubjective relationships present in daily life. By adopting an interpretive approach, this perspective has been widely utilized in health research; it recognizes that nursing is essentially composed of human relationships and, therefore, requires an understanding of the individual as an integrated whole, moving beyond

the fragmentation of care into isolated parts and accounting for the complexity of lived experience[7].

The understanding and interpretation of human conduct – also understood as "action" – in a given situation become possible only through the analysis of "in-order-to" motives and "because" motives, as proposed by Alfred Schutz[6]. "In-order-to" motives refer to a future-oriented subjective dimension, linked to an individual's intentions and expectations, whereas "because" motives are associated with past experiences, rooted in the individual's life history and accumulated life experiences. Human actions are understood through the interplay between past and future, allowing for a deeper analysis of behavior within a social context[6].

Human beings possess an awareness of their own existence and finitude; they orient their actions toward the future while simultaneously carrying with them the experiences gathered throughout their life journey. This approach seeks to articulate the connection between past and future, as prior experiences influence the intentions and expectations that guide human action[6].

Data collection took place at the São Mateus Hospital and Maternity Center, located in the northern region of the state of Espírito Santo, Brazil, following formal authorization. The institution is philanthropic and also receives funding from the Unified Health System (*Sistema Único de Saúde* – SUS). It has been operating in the municipality since 1957, providing care to pregnant women from the northern region of Espírito Santo. The hospital has 57 beds, 37 of which are allocated to the SUS, while 20 are for private patients. Currently, the hospital's private wing serves approximately 17 health insurance plans. It performs cesarean sections and elective surgeries.

The study was conducted with nurses working at the hospital, and data saturation was reached by the sixth interview. Professionals from all shifts participated, covering both even and odd-numbered rotation schedules, as well as day and night shifts, to encompass the various work routines within the institution.

The study included clinical nurses who were actively performing their duties at the time of data collection, regardless of gender or length of experience in their field, provided they voluntarily agreed to participate by signing an Free and Informed Consent Form (FICF). Individuals who were away from their professional duties due to vacation or any type of leave, as well as those with no experience working in a hospital setting, were excluded.

After the relevance of the research was explained, each participant was provided with a copy of the Free and Informed Consent Form.

Subsequently, the participating nurses – selected at random – were interviewed using a semi-structured questionnaire. This included guiding questions regarding their personal and professional profiles, such as age, place of birth, marital status, religion, time since graduation, and areas of specialization. In addition to these issues, six phenomenological guiding questions developed by the authors and evaluated by two nurses who did not participate in the study were included: "*What are your feelings when facing a terminally ill patient?*", "*What is it like to care for a patient in a terminal state?*", "*What does death/dying mean to you?*", "*What goes through your mind when you realize you are about to lose a patient under your care?*", "*What coping resources do you use to deal with a patient's death?*", and "*What does nursing care entail, and what is its significance for a patient in the terminal phase?*"

The responses were audio-recorded at the participants' workplace, at times chosen by them, ensuring reliability and confidentiality.

This study took place between September and December 2018. As it involved human subjects, the research was approved by the Ethics Committee on July 15, 2018 (protocol no. 2,771,321).

To protect the nurses' identities, the pseudonym "N" was used, followed by a number corresponding to the order in which they participated (e.g., N1, N2). Following data collection, the interviews were transcribed in full and subjected to a multi-stage analysis aimed at understanding the essential nature of the actions experienced by the participants.

Data analysis was conducted through a comprehensive description of the accounts, seeking to capture the unique nature of the experiences lived by the nurses while caring for patients at the end of life. The analytical process followed the principles of contemporary phenomenological qualitative research, in which the phenomenon is understood by interpreting the meanings that the subjects themselves attribute to their experiences[6,7].

In this phase of phenomenological research, a dialogue emerges between the researcher and the participant; the analysis is not limited to logical or rational knowledge but also encompasses intuitive, subjective, and experiential dimensions. Understanding the phenomenon requires valuing the subject's lived experience, with intersubjectivity serving as a central element in the construction of meaning within the field of qualitative health research[8].

A fundamental requirement of phenomenological research concerns how the study material is gathered, specifically through interviews that prioritize the subjects' spontaneous and sincere accounts of their experiences. To ensure that this information is authentic and closely reflects the lived experience, it is essential for the researcher to adopt an ethical and welcoming stance, fostering an environment of trust that encourages free expression[9].

A comprehensive analysis of the participants' accounts, focusing on the "typical lived experience" identified within the nurses' statements, was conducted, yielding insights into the perception and unveiling of their "in-order-to" motives and "because" motives.

The research employed categories for analysis and interpretation, grounded in the intersubjectivity of each participant. To grasp the typical nature of the subjects' actions and describe their lived experiences, the interviews were transcribed immediately, ensuring the preservation of the subjectivity inherent in the face-to-face interaction between the researcher and the participant. Subsequently, a careful and thorough reading was performed to transform subjective elements into objective ones, by grouping the identified meanings into categories.

RESULTS

Eight nurses, selected randomly across various shifts, participated in the study. Regarding their profiles: seven were married (n=7); their ages ranged from 26 to 48 years; seven were female; three were originally from the state of Minas Gerais; six had more than two years of experience working in a hospital setting; five held a specialization in Occupational Nursing, and four in Obstetrics and Neonatology; four identified as Evangelical and three as Catholic; and some had previously worked as nursing technicians in a hospital environment.

Based on the recorded descriptions, four categories were developed: 1) *Feelings when caring for a terminally ill patient*; 2) *The meaning of death*; 3) *Personal resources for coping with death*; and 4) *The meaning of providing care to a terminally ill patient*.

Feelings when caring for a terminally ill patient

The feelings mentioned by nurses when faced with the process of death and dying of their patients were: sadness, helplessness, compassion, pain, solidarity, grief, a sense of injustice, guilt, and empathy:

A feeling of sadness and helplessness, from caring for someone who, as I see it, is going through a very difficult time in their life. [N2]

A sense of compassion, and guilt for not being able to do more than what our human limitations allow. [N5]

My feeling when facing a terminally ill patient is often one of pain, sometimes even feeling their pain as if it were my own, a form of empathy, of trying to put myself in their shoes. You cannot push the sadness away, and you feel helpless. [N7]

Some remarks mentioned a desire to do the best for a terminally ill patient and to provide the highest quality of care, ensuring that the patient’s dignity is upheld until the very last day of their life. This touches upon the concept of humanization, shaping these individuals into professionals increasingly better equipped to deal with life, and, by extension, with death:

Initially, there is a sense of powerlessness, as one cannot change the patient's condition. Then, there is a desire to do one's best; to provide the best possible care to ensure that the patient's dignity is upheld until their very last day. [N8]
...a terminally ill patient does not offer much in terms of life expectancy, which makes caring for them somewhat challenging; the focus is simply on providing care, offering the best possible attention during this phase. [N6]

Other remarks mentioned the religious dimension as a means of coping with death:

I am a Christian, and this is a very strong part of who I am. Consequently, I integrate my faith into my profession; I am deeply moved by others' experiences, and I strive to offer as much comfort, care, and tenderness as I possibly can. [N3]
Grief, sadness, and, in certain circumstances, a sense of struggle to come to terms with what has happened; yet, I try to believe that everything occurs for a purpose. [N4]

The need arose to understand what it is like to care for a patient in a terminal state. The feeling of sadness surfaced once again, as reflected in the following statements:

Very sad, because we know there will be no improvement; our care is aimed at alleviating their suffering and distress. [N1]
Distressing; a situation that, at times (or perhaps almost always), leaves us feeling depressed and deeply moved. [N2]
It's difficult because you often have to carefully choose your words, trying to pull the patient away from that reality, trying to ensure they don't feel like a "terminal patient"... You try to treat them as if they were an ordinary, typical patient, but deep down it hurts, knowing that their days are numbered. It's very complicated! [N7]
Sad and liberating. Sad, because you know that at any moment that person will cease to live; and liberating, because facing "death", or the prospect of it, leads me to reflect more on life, on what useful things I have done, and on how insignificant I truly am. [N8]

In the statements cited, despite the sadness and the certainty that death was imminent, the care provided by nursing professionals remained focused on alleviating the suffering and anguish experienced by the patients in their given situation:

It is very difficult, because since these patients have no future life expectancy, you feel very limited.
Everything you do for such a patient is palliative. [N6]
It requires specific skills and techniques, as well as an attentive gaze focused on the patient's clinical condition. [N5]

It is understood, then, that knowing how to handle a patient's end-of-life phase goes beyond the use of specific techniques; it requires skill and an attentive perspective focused on the patient's needs.

The meaning of death

This category reveals the subjectivity involved in describing the meaning of death/dying. The professionals define death based on their understanding of the term, while also taking their professional experience into account. The "in-order-to" motives emerge when death becomes a subject of reflection; by putting themselves in the patient's shoes, they come to realize that the act of providing care is essential.

For N2, death signifies separation from a loved one – whether a friend or a family member. N4 describes it as the end of a journey – a journey that, in the case of those who die young – or even as children – often did not have the time to fully blossom. N8 speaks of the fear of undergoing the dying process, noting that this experience prompts reflection on her own life, thereby highlighting the "in-order-to" motives that characterize the lived experience of this participant:

The cessation of all organ function, the absence of vital signs. [N1]

Separation from someone – family members or friends – whom we love. [N2]

The conclusion of a journey that, at times, did not have enough time to fully blossom. [N4]

Sorrow, felt primarily by those who remain. As a professional, it prompts reflection and a fear of experiencing this myself. [N8]

The statements reveal how each participant understood the question regarding the meaning of death, taking into account their individual religious dimensions, though N6 did not provide a definitive answer as to whether or not they believe in the existence of life after death or in spirituality:

I am a Christian... For me, dying is not the end; it is the beginning of an eternity by Jesus' side. [N3]

The beginning of life. [N5]

It's over. Life has ended; the person lived what they were meant to live, and now they have died. And since some say there are other lives beyond death, well, who really knows, right? [N6]

Another meaning of death is presented:

...when you begin to be trapped by a situation or some form of incapacity, I think you start to die... And death is when you are truly dependent on everything and lack the ability to function. You need help with everything. You are completely dependent and trapped; trapped in a bed, unable to do anything at all. So, I believe that is where the meaning of death begins to emerge. [N7]

Personal resources for coping with death

Coping resources in the face of death encompass religious dimensions, as observed in the statements of N3, N4, and N7. Faith emerges as a means to confront and navigate situations involving finitude. N2 reveals the use of emotional control as a coping strategy. The "because" motives are manifested in the subjects' actions, while the "in-order-to" motives are revealed in the continued use of these resources, in light of their overall experience and typical ways of living through such situations. No reference was made to distancing as a way of coping with death, as can be seen in the following statements:

All the necessary resources within my reach, especially emotional control, as well as psychological and even social support for family members, should be offered with empathy. [N2]

My faith. [N3]

Faith in a God who knows all things and understands what is best for each of us. [N4]

It is primarily a matter of psychology – clinging to God – because this is a situation we all know we will eventually face, yet we are never truly prepared for it. So, at times, we seek strength solely in God to overcome and learn how to cope with the situation. [N7]

N8 addresses the approach to death, humanization, and empathy:

Putting myself in their shoes! Something I once heard, and I have never forgotten, the principle of "treating others the way I would like to be treated." In my 13 years of nursing, I have lost count of how many patients I have seen pass away. Especially in recent years, even though I have become "used to" this, as it is a routine part of the hospital environment, and I know it is the ultimate end for everyone, I have begun to reflect more deeply on the subject. Today, when I encounter a terminally ill patient, I try to imagine who that person was, how important they are to someone else, the life story they carry, or the potential they might have had (for instance, when a child passes away). That is why I always give my best. [N8]

The meaning of providing care to a terminally ill patient

The statements point to the fact that support for the family during the end-of-life phase is essential to make the experience less painful. Humanized care at this stage is necessary to alleviate suffering – whether physical or mental – for both the patient and their family. It is emphasized that the individual receiving care requires respect, a humanized approach, empathy, and love:

[...] *alleviating pain, guiding family members through this phase and the patient's illness, and helping them cope with this moment of pain and the loss of a loved one.* [N1]

It involves countless aspects of care, humanized care... sometimes we even look after the family members who are present, as they are also suffering. The care is emotional; it's about having a humanized relationship with both the patient and their family. We end up doing it all – taking on the roles of psychologist, nurse, caregiver – everything. [N6]

The "in-order-to" motives are characterized through the statements of N2, N3, N5, N7, and N8, as they refer to the care that must be provided by nursing professionals – that is, they specify actions to be carried out in the face of finitude:

Providing appropriate support to the patient at the moment they need it. Offering care that can help alleviate their suffering. [N2]

Nursing truly makes a difference at this time, as all the comfort possible to improve this experience comes from us [the nursing staff]. [N3]

Care is provided in a way that ensures a dignified death. [N4]

... The meaning of care: Loving without boundaries. [N5]

The terminal phase is a stage in which the patient requires greater support. Since nursing staff are with the patient 24 hours a day, empathy is essential, as is the effort to ensure the patient feels well and at ease, despite their circumstances. Therefore, I believe that the humanization of care in this situation is paramount. [N7]

It is about offering support, comfort, privacy, respect, dignity, tranquility, and relief from pain, suffering, and fear to a patient in the terminal phase. We are the ones closest to them; we form the strongest bonds – if we don't provide this

care, it simply won't be provided at all. I believe this is the phase in which we hold the most significance for the patient. [N8]

DISCUSSION

The individuals surveyed are in the early stages of their careers, a fact that reflects the social construction of care as a "feminine" activity – a notion linked to the sexual division of labor and cultural representations of the act of caring[10].

Through phenomenological analysis, it became clear that the experiences of nurses regarding the process of death and dying are permeated by subjective meanings constructed throughout their personal and professional trajectories. Phenomenology allowed for an understanding of these experiences based on the "lived world," placing value on the meanings that the subjects themselves attribute to their experiences. Intersubjectivity and biographical trajectories play a central role in interpreting human actions, as meanings are socially constructed over the course of one's life[6-7,11].

Feelings of sadness and powerlessness emerged as predominant, demonstrating that frequent contact with finitude does not neutralize the emotional impact experienced by these professionals. On the contrary, such feelings are natural human responses to the suffering of others and the inability to reverse a clinical condition. The process of death and dying can help professionals better navigate their own emotions, fostering more empathetic care. Furthermore, healthcare professionals themselves require care; constant exposure to death-related situations can lead to psychological distress and emotional exhaustion, making the provision of psychological support and dedicated spaces for listening essential[2,12-13].

Empathy and the humanization of care stand out as core elements in the treatment of terminally ill patients. Nursing care extends beyond the technical dimension, encompassing the capacity to listen, provide a welcoming presence, and build bonds, especially in situations of heightened vulnerability. Upholding a patient's dignity until the very end of life reinforces the importance of comprehensive care that addresses physical, emotional, social, and spiritual dimensions. However, studies show that healthcare education still maintains a strong technical focus, which may contribute to a sense of detachment from the patient and the fragmentation of care[14-16].

Spirituality and religiosity have emerged as important coping strategies used by healthcare professionals. Faith was frequently mentioned as a source of comfort and emotional support when facing imminent death. This finding reinforces that spirituality is a significant dimension within the healthcare context, linked to the integrity of care and the humanization of services.

Religious experience can contribute to reducing anxiety and strengthening coping strategies in situations of suffering. Considering cultural diversity, religion can also be understood as a universal phenomenon present across different societies, manifesting through a variety of beliefs and practices[17-19].

Regarding the meaning of death, a diversity of perceptions was observed, ranging from purely biological conceptions to existential and spiritual interpretations. Death was understood both as the end of life and as a transition, highlighting that this phenomenon is socially and culturally constructed, and thus influenced by individuals' personal experiences and life contexts[20-21].

Palliative care was recognized as fundamental in the support of terminally ill patients, contributing to their quality of life, the relief of suffering, and support for their families. Nevertheless, challenges such as inadequate communication, a lack of time, and the concentration of decision-making within the healthcare team can hinder the facilitation of a dignified death. In this scenario, nursing plays a central role, as it involves continuous contact with the patient and encompasses a large portion of caregiving activities. Adequate preparation of the healthcare team to work with patients and their families is essential, as it directly influences the experience of the end-of-life process[22-24].

Among the coping resources employed by the professionals, in addition to spirituality, emotional control and empathy stood out. Unlike in other studies, emotional distancing – a common defense mechanism – was not identified here; this suggests a tendency toward greater engagement as a means to enhance the quality of care. In this context, empathy contributes directly to the humanization of care and the establishment of therapeutic bonds[25-26].

The meaning of providing care to terminally ill patients was strongly associated with comfort, dignity, and respect, and also encompassed support for family members. Such care was understood as a practice that integrates technical knowledge with human sensitivity, with empathy serving as a fundamental element in this process.

Nursing care, within the context of finitude, emerges as a complex and profoundly human endeavor, one forged through relationships with others and mediated by intersubjectivity, a core element in understanding the experiences lived within the social world. Furthermore, reflecting on death and the process of finitude helps prepare healthcare professionals to better navigate such situations, underscoring the importance of education regarding death within the healthcare field[27-29].

CONCLUSION

The study made it possible to understand nurses' perceptions of the process of death and dying in the hospital environment, showing that all participants had already experienced situations involving patients undergoing the end-of-life process throughout their professional or academic careers.

Although they recognize death as a natural event inherent to the life cycle, professionals face difficulties in dealing with this process, both because of the emotional burden involved and the lack of discussions and preparation during academic education and professional practice. In some accounts, difficulties in expressing experiences and feelings were observed, suggesting that death is still treated as a subject that is rarely explored and often avoided.

Nurses are exhausted due to work overload, and the topic of death remains stigmatized, which may indicate that they do not give it the importance it deserves. At the same time, they attribute special meaning to the care provided to terminally ill patients, seeking to offer assistance based on humanization, welcoming, empathy, and respect for the dignity of patients and their family members.

Despite the feelings of helplessness, sadness, and suffering triggered by the prospect of death, their commitment to providing comfort and minimizing suffering during this delicate moment was demonstrated. Furthermore, religiosity represented an important coping strategy, functioning as a resource that helps strengthen professionals emotionally and maintain the quality of care provided, without compromising the care given to other patients.

The evidence found reinforces the importance of broadening the debate on the process of death and dying in the field of nursing, since these professionals accompany individuals throughout all stages of the life cycle, including the end-of-life stage.

As future perspectives, there is a need to strengthen continuing education initiatives by offering courses, training sessions, and professional development programs focused on palliative care, breaking bad news, and emotional management in the face of end-of-life situations; as well as psychological support strategies for nursing professionals, aiming to reduce emotional exhaustion and prevent occupational illness.

As a limitation, the study was conducted with a small number of participants, despite data saturation, and in only one hospital institution, which restricts the possibility of generalizing the results to other healthcare settings. As this is a qualitative study based on individual perceptions and experiences, the findings reflect particular experiences that may be influenced by the institutional context, professional background, personal beliefs, and characteristics of each healthcare service. Nevertheless, the results make relevant contributions

to understanding nursing care in the face of the end-of-life process and may support further research on the subject.

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Associated Publisher: Heloísa Cristina Figueiredo Frizzo

Conflict of Interests: the authors declared there is no conflict of interests

Financing: none

Contributions:
Concept – Coelho MP, Mattos BCS, Souza AM, Ferrarine BD
Investigation – Coelho MP, Mattos BCS, Souza AM, Ferrarine BD
Writing – first draft – Coelho MP, Ferrarine BD, Mattos BCS, ANM Partelli, Souza AM
Writing – revision and editing – Coelho MP, Ferrarine BD, ANM Partelli, Souza AM

How to cite this article (Vancouver)
Coelho MP, Mattos BCS, Souza AM, Ferrarine BDB, Partelli ANM. Nurses' perception regarding the finitude of those under their care. Rev Fam, Ciclos Vida Saúde Contexto Soc. [Internet]. 2026 [cited in *insert day, month and year of access*]; 14:e026029. DOI: https://doi.org/10.18554/refacs.v14i00.9085

How to cite this article (ABNT)
COELHO, M. P.; MATTOS, B. C. S.; SOUZA, A. M.; FERRARINE, B. D-B.; PARTELLI, A. N. M. Nurses' perception regarding the finitude of those under their care. **Revista Família, Ciclos de Vida e Saúde no Contexto Social**, Uberaba, MG, v. 14, e026029, 2026. DOI: https://doi.org/10.18554/refacs.v14i00.9085. Access in: *insert day, month and year of access*.

How to cite this article (APA)
Coelho, M. P., Mattos, B. C. S., Souza, A. M., Ferrarine, B. De-B, & Partelli, A. N. M. (2026). Nurses' perception regarding the finitude of those under their care. Rev. Fam., Ciclos Vida Saúde Contexto Soc., 14, e026029. Retrieved in *insert day, month and year of access* from https://doi.org/10.18554/refacs.v14i00.9085

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