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Palliative care and the intensive care nurses: feelings that endure

Cuidado paliativo e enfermeiros de terapia intensiva: sentimentos que ficam

Cuidado paliativo y los enfermeros de cuidados intensivos: sentimientos que se quedan

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ABSTRACT

Objective: to know the feelings of nurses regarding palliative care in adult intensive care units. **Method:** qualitative study, which adopted the theoretical framework of Social Representations, carried out with 30 nurses of the state of Santa Catarina included by Snowball sampling. Data were collected through semi-structured interviews conducted from April to August 2015, organized and analyzed through the Collective Subject Discourse. **Results:** the results showed how central ideas are related to feelings of comfort, frustration, insecurity and anguish, in addition to the feeling that the professional training and performance are focused on the cure. **Conclusion:** the social representations of nurses regarding the feelings related to palliative care are represented mainly by negative feelings, probably as consequence of the context in which care is provided.

Descriptors: Palliative Care; Nursing Care; Nursing; Social Perception; Intensive Care Units.

RESUMO

Objetivo: conhecer os sentimentos dos enfermeiros acerca dos cuidados paliativos em unidades de terapia intensiva de adultos. **Método:** estudo qualitativo, cujo referencial teórico adotado foi o das Representações Sociais, realizado com 30 enfermeiros do estado de Santa Catarina incluídos por amostragem Bola de Neve. Os dados foram coletados por meio de entrevistas semiestruturadas realizadas de abril a agosto de 2015, organizados e analisados por meio do Discurso do Sujeito Coletivo. **Resultados:** os resultados apontaram como ideias centrais estão relacionadas aos sentimentos de conforto, frustração, insegurança e angústia, além do sentimento de que a formação e atuação profissional estão voltados para o curativo. **Conclusão:** as representações sociais dos enfermeiros acerca dos sentimentos relacionados aos cuidados paliativos estão representadas principalmente por sentimentos negativos, provavelmente consequentes ao contexto em que se dá o cuidado.

Descritores: Cuidados Paliativos; Cuidados de Enfermagem; Enfermagem; Percepção Social; Unidades de Terapia Intensiva.

RESUMEN

Objetivo: conocer los sentimientos de los enfermeros sobre los cuidados paliativos en unidades de cuidados intensivos para adultos. **Método:** estudio cualitativo que adoptó el marco teórico de las representaciones sociales, y se llevó a cabo con 30 enfermeros en el estado de Santa Catarina que fueron incluidos por muestreo tipo bola de nieve. Los datos fueron recolectados a través de entrevistas semiestructuradas realizadas entre abril y agosto de 2015, organizados y analizados utilizando el Discurso del Sujeto Colectivo. **Resultados:** los resultados mostraron que las ideas centrales están relacionadas con sentimientos de comodidad, frustración, inseguridad y angustia, y la sensación de que la actividad profesional y la formación se centran en la curación. **Conclusión:** las representaciones sociales de los enfermeros sobre los sentimientos relacionados con los cuidados paliativos están representadas principalmente por sentimientos negativos, probablemente consecuentes del contexto en que se da la atención.

Descriptores: Cuidados Paliativos; Cuidados de Enfermería; Enfermería; Percepción Social; Unidades de Cuidados Intensivos.

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INTRODUCTION

The intensive care unit (ICU) has as its primary function the care of critical and high complexity patients directed by a care model that is biologicist, Cartesian, curativist, fragmented and mechanized. This sector concentrates an apparatus of technological resources and is considered an environment fraught with pain and suffering, since the patients requiring intensive care are generally affected by diseases in acute condition and in critical conditions of life(1).

In the unit, technique and instruments prevail, involving specific and specialized skills and technological knowledge of professionals. This occurs so they develop their practice effectively and therapeutically; however, in addition, they must deal with the concept of finitude, patients' fear, as well as their families' fear. Although this technology is essential for maintenance of life in the environment of intensive care, it is a factor that challenges the staff in seeking to combine humanitarian values to technological resources(2).

Socially and culturally, hospitalization in ICU means uncertainties concerning treatment and recovery, conveying to patient and family a poor prognosis and considerable risk of death. It is a unique process and a stress generator, since relatives feel far from their loved ones, limited, powerless, expressing anxiety, suffering and sadness(3).

A quantitative study with American patients claims that the use of intensive care at the end of life continues to increase; however, many professionals working in intensive care are not adequately trained or educated to provide care to these patients(4).

In end-of-life situations, especially those in which the patient is considered out of scope for cure, the role of ICU professionals is to engage in changing this purely technical scenario. Therefore, the objective is to implement less aggressive care, in seeking quality of life or of death, if it were to occur(5).

Palliative care (PC) in Brazil is still an emerging mode of care in terminality of life(6). PC consists in practices directed to the patient, excluding the curativist idea. At this stage, it is understood that the disease is installed, progressive, irreversible, and not responsive to established treatment. Therefore, professionals must provide adequate and comprehensive care, aiming at quality and comfort in the final moments of life(7).

Changing the paradigm between cure and palliative care is a process that depends on the professionals working in the area and on academic institutions, as well as on professional knowledge geared towards this care interface. Therefore, it needs to be a practice based on professional training and guided by established scientific principles(5).

The working environment of nursing professionals subjects them to many stressful situations that may be related to labor activity, as well as to psychological and physical processes of the individual. This situation limits the professional's performance and conception at the time of the dying process and of death(8).

Knowing the conceptions related to the implementation of palliative care, as well as the process of finitude, would enable nurses to have a better understanding of their values and beliefs in this process, feeling ready at the moment of work, dealing with patients and relatives who would be in this situation.

Reporting the feelings experienced by nurses in relation to palliative care should help in interpreting the significance of such care according to nurses and to identify factors that facilitate and hinder this type of care.

OBJECTIVE

Considering the aforementioned, the research aimed to know the feelings in relation to palliative care of nurses working in intensive care of adults.

METHOD

Ethical aspects

This study was submitted to assessment by the Committee of Ethics in Research with Human Beings (CEPSH), via Plataforma Brasil sistema CEP/CONEP. Only after approval from the CEPSH the first contact with potential participants was conducted. The project met the recommendations of Resolution. 466/2012, of the National Health Council, which regulates research involving human beings in Brazil. The condition of anonymity of the participants was respected. Their names were replaced by the letters: N (Nurse), followed by numbers that correspond to the sequence of interviews (N1, N2, ...).

Theoretical framework and type of study

It is a descriptive, exploratory research founded on the Theoretical Framework of Social Representations, with nurses with professional experience in adult intensive care unit in the metropolitan region of Florianópolis/SC, Brazil.

The Social Representations Theory (SRT) permeates and enables the collection and interpretation of the study participants themselves in relation to the reality that is the object of research, enabling the researcher to know, based on the attitudes and behaviors of the social group, about the reality in question(9).

Social representations are individual social entities bearing significance to the extent that they are constituted as guides used by individuals to guide their collective and social interactions, justifying, therefore, the use of this framework in this study(10).

Study background

As the objective of this research was to know the meaning established by the nurses who work or worked in the ICU concerning the topic in question, the institution in which these professionals worked became irrelevant. Thus, the intention is to form a "chain of informants", located in different spaces and times, yet connected by a common thread -the Palliative Care in ICU.

Thus, the study was not conducted in a specific location. In order to determine the participants, we used the network sampling strategy (snowball), respecting the following inclusion criteria: male nurse; be exercising their labor activities in the period of data collection; and have at least one year experience in assisting adult PC patients in ICU, which may be current or past experience. This period was was determined based on the belief that professional experience of less than one year is not sufficient for the nurse to apprehend what PC represents in the context of intensive care. The research did not include professionals who were not residing in the metropolitan region of Florianópolis, who were on vacation or license of any nature during the period of data collection.

Data source

A total 30 nurses participated in the study. It is recommended that in studies of opinion, as in the case of Social Representations, the number of inclusion involves approximately 20 to 30 participants(11). All participants were provided with information on the research and signed an informed consent.

Data collection and organization

The data were collected in the period from April to August 2015, through semi-structured interview, conducted individually, after approval of the research project by the Research Ethics Committee of the Federal University of Santa Catarina.

The data collection instrument included questions related to characterization of the participants and their perceptions, feelings and experiences about palliative care. The interviews were recorded on an audio device and had average duration of 34 minutes.

The data were organized and analyzed according to the technique of Collective Subject Discourse (CSD), using the Qualiquantisoft software version 1.3c.

The CSD data analysis technique comprises four methodological figures. The first are the key expressions (KEs), which are sentences or verbatims of the original discourse and that represent the essence of the content of the question under analysis and are presented around a Central idea (CI). The second are the CIs, brief and objective descriptions of the meanings of the key expressions. The third methodological figure is the Anchoring (AC), used by the subject to elaborate the discourse, which can be a theoretical expression, an ideology or belief. Finally, the collective subject discourse (CSD) itself is defined as a synthesis discourse, written in the first person singular, structured by the KEs in the interviews, which have CIs or ACs with the same significance or complementary significance(10).

RESULTS

Of the total participants, 26 were female and 4 were male. The age ranged from 26 to 53 years. As for training, 16 are specialists, 13 have a master's degree in nursing and 1 is a PhD. Of the 16 specialists, six were students in academic or professional master's degree programs or in a doctorate program. Career time in intensive care ranged from 1 year and 4 months to 24 years (mean of 8 and a half years).

In the data collection period, of the 30 nurses, 25 were working in adult ICU and five had worked, but at the time worked in other sectors of the hospitals. All worked exclusively in public hospitals that had no palliative care service; however, they attend intensive care patients who need such care. Among the hospitals, two seek to systematize, in the intensive care unit, the care provided to patient in palliative situation by initiative of some professionals of the unit.

Data analysis led to the definition of four central ideas about the feelings of nurses concerning palliative care and had both positive and negative connotation. The CIs with the respective number of participants can be found in Table 1.

It is noteworthy that the CSD allows that the discourse of a single participant, when analyzed, give rise to more than one central idea. Therefore, it is observed that in Table 1, despite the inclusion of 30 participants, there are 31 referenced in the central ideas.

Table 1 – Central Ideas related to the feelings of nurses when providing nursing care to patients under Palliative Care, Florianópolis, Santa Catarina, Brazil, 2016

Question: In your daily work in the Intensive Care Unit, what do/did you feel when providing nursing care to patients under Palliative Care?

Central Ideas	n	%
Central Idea – A: The feeling of comfort when providing nursing care to patients under palliative care	16	51.6%
Central Idea – B: The emotional involvement and the feeling of frustration	7	22.6
Central Idea – C: The lack of information and of communication in the multiprofessional team cause insecurity and anguish at the time of care	6	19.4%
Central Idea – D: The curative professional training and performance	2	6.4%
Total	31	100%

Source: Prepared by the authors, 2016.

CI-A, resulting from analysis of the nurses' discourses, originated the first collective subject discourse and had the expressive participation of 51.6% of the answers of participants. The CSD expresses the professionals' feeling of comfort when providing care.

CI – A: The feeling of comfort when providing nursing care to patients under Palliative Care

> CSD1: *I provide the same care as if the patient was not under palliative care. I maintain change of decubitus, bath, I follow the prescription and all care. I feel good and comfortable because I understand that I am offering quality and lessening the suffering of the patient and the family. Minimizing the pain and suffering I feel good, I put myself in the patient's place. I feel a bit more responsible for the patient, because there is no way of knowing how long the patient will remain in this model of care, and then, it seems that nursing has to be even more active to be able to provide comfort and avoid complications arising from prolonged hospitalization. I have the impression that the patient is going to be a little less observed by the clinical team. And then the patient is kind of returned to the care of nursing, since in a palliative situation this care doesn't diminish at all, but intensifies. The moment you have this understanding that the best care for the patient is well-being, comfort and pain relief, then it's something we can work in a peaceful way. I feel good knowing I'm giving comfort and letting the patient pass away understanding that all therapeutic options have been exhausted I consider it a relief, not for having accomplished my duty, but rather for reducing the suffering. I feel good when I see that the conduct is right, clear, and in agreement with the team and family.* (N1, N2, N5, N7, N8, N10, N11, N12, N18, N22, N23, N25, N26, N28, N29, N30)

The second CI presented originated another collective subject discourse, CSD2. This had a participation of 22.6% of the participants' answers.

CI – B: Emotional involvement

> CSD2: *It makes me sad when I come across a patient who does not have a good prognosis, which is a reserved prognosis, but I know it won't be the first nor the last time, so I have to do it the best way possible. I end up getting closely involved with the history of people, becoming more emotional because I follow it since the beginning, you know? ... Then the emotion comes, but I know I have to give enough comfort so this moment is not painful, physically painful, because it's going to be emotionally painful. There are two sides to the coin, on the one hand it's sad in a way, knowing that I'm taking care of a person who is going to pass away, sometimes, it's a more immediate palliative care that I know it will happen soon and, sometimes, the person is discharged from the ICU here to the room under palliative care, but I know the patient is not going to improve. Because of that, there's the feeling of frustration of nursing a patient* under *palliative care. It's frustrating because I see the suffering of the family, it's frustrating because I know there's nothing else to invest in that patient, it's frustrating because I see the patient suffering, and, sometimes, I suffer together.* (N2, N14, N15, N16, N17, N20, N27)

CI-C originated the third collective subject discourse presented below. This discourse had participation of 19.4% of the participants' answers and brings a critique of the lack of information and of communication that still exists in the multidisciplinary team in the sphere of intensive care and sometimes causes feelings of insecurity and anguish in the professionals that are conducting this care.

CI – C: The lack of information and of communication in the multiprofessional team cause insecurity and anguish at the time of care

> CSD3: *The lack of information makes me anguished. I think that with the career time that I have I feel better to work accordingly, but I don't work alone, I feel that each person follows individual principles, causing insecurity at the time of care. First because I don't know if that patient is under full palliative care or not. If I had to define how I feel inside the intensive care unit, it would be anguished for not knowing what's going on and simply following a prescription that, often, I also don't agree, since it is not discussed as a team so that everyone is aware. I feel that I still don't have enough training for lack of more knowledge, more reading, more talking about the topic, I think the whole team still feels a little uncomfortable with this kind of care even because it started here in the ICU not long ago. I think I need more training to provide this care, although I belive I am qualified due to my experience, but the palliative patient demands some specific care that perhaps I have no structure to offer a service in the most appropriate way. For example, the family, visiting hours, space for these families to stay, and also the participation of the conversation with the family member, I think this is lacking, sometimes the physician informs the family member that the patient is under palliative care and sometime later I come to know, there is not quite this communication, this interaction within the team and things are lost.* (N1, N3, N4, N9, N13, N24)

The CI with lowest representativeness (6.4%) among the four gave rise to the collective subject discourse four. However, the representativeness of 6.4% does not detract from the importance of the reflection that this CI instigates. It leads to question to what extent the training process of higher education prepares the nurse to the feelings that will be faced in professional work. We observed good feelings, such as those presented previously, but also feelings of frustration, as in this discourse.

CI – D: The curative professional training and performance

> CSD4: *Of course there are situations I keep thinking: "Couldn't I have done more?" These doubts arise, I'm a human being... In general, these are patients who I really understand that, unfortunately, I can't do anything. So I feel very incompetent, I feel totally frustrated, totally "technical", I work in ICU and I come here to work with patients under intensive care with their full potential, and when this patient no longer has this care I feel frustrated. I'm ready for another end, not for this one.* (N6, N7)

DISCUSSION

CSD1 expresses that there is a need to offer the physical comfort care expressed by reducing pain/suffering with adoption of nonmedicamentary measures. These results corroborate another study that addressed integral care as being the essence of nursing work, having human health care as its main function. The care incorporates the idea of meeting the basic human needs, in a warm attitude by the professional in being empathic with the client and promoting the provision of these needs(12).

Similar result was found in another study, stating that for hospitalized individuals whose death is imminent the comfort care can relieve the distressing symptoms and improve quality of life. Such comfort measures should conform with the patient's wish. However, in the understanding of the same authors of the study, the expression "comfort care" is often employed in imprecise or even misleading manner, for example, when such care is regarded as a strict prescription to not resuscitate, often without discussion with the patient. Thus, comfort care is employed to exclude a range of palliative measures(13).

It is observed that given the impossibility of cure, the nursing professional expresses respect for the patient's life by committing to protect him or her from such vulnerability, since palliative care begins when curative care ceases to be the main purpose. Therapeutic activities without curative purpose mitigate the suffering and give comfort to the patient. However, in the terminal condition in which there is no probability of cure, the tendency of the focus of care is set aside and, in turn, becomes frivolous. Therefore, the care respects values and beliefs of individuals, preserves their dignity, acts ethically and empathetically, focusing not only on technical actions, but on the knowing and the doing(14).

Care involves a process of relationship and connection, being, therefore, inherent the emotional involvement among patient, family and nursing professional. Due to the empathy resulting from this involvement, the care provided as to the patient's needs is favored, as it enables the professional to know the patient better(15). Empathy was a concept which emerged in this study, being possible to identify it in the discourse. That feeling establishes a relationship of help, of doing something for the other, and also for their families, since they are comfortable due to perceiving that the loved person is not suffering.

A Korean study, investigating the factors that affect the performance of nurses in end-of-life care, observed that empathy is one of the significant predicting factors for this modality of care and a dimension that is necessary to the health professional so as to understand the other(16).

It is observed that pain is the starting point for the patient's care plan. Empathy, while dynamic process, is the ability to understand the experiences of others, promoting positive effects on the patient's well-being by avoiding futile therapies(17).

According to nurses, palliative care means identifying early the needs of patient and family so they can live with dignity and higher quality the end-of-life process, assisting them in the confrontation of death as a natural process(14).

The subjects death and dying process, although part of the health professionals' reality, cause embarrassment, as some professionals are not yet ready for this process. According to these professionals, especially nurses, the most comfortable and acceptable way of dealing with this process of finitude is to regard it as biological and natural, inevitable to all human beings(8).

Patients want professionals with technical ability, but also want improvements in the human aspect in the relations of health care(17). This health care condition addressed here increases the confidence and cooperation of patient and family in relation to the effectiveness of the therapeutic processes.

Considering the patient's vulnerability, we must consider the repercussions generated not only for patients under PC, but also for their families. Thus, it is crucial that the nurse understands the patient as a whole, identifying their needs through the establishment of a therapeutic relationship, based on effective communication. Therefore, regardless of where the patient is, effective communication among professionals, patient and family is essential(18).

As expressed in CSD2, there are histories and patients with which the emotional involvement of the professional is inevitable. Nurses are the professionals in the team that remain more hours with the patient during the period of hospitalization and, in addition, they sometimes experience the reality of patients and family members, the anguish and suffering, as well as joys and achievements that are often shared. Then, in this mix of emotions and feelings that nursing professionals are likely to experience, they identify death as a process that is inherent to life, but cannot be impassive to feelings that permeate this event.

A study conducted with sixteen nursing professionals, which aimed to understand the view of the nurse on patients' death/dying process, as well as to report the feelings experienced by these professionals corroborates the data found in CSD2. In this study, we observed that death generates feelings such as pain, sorrow, suffering, fear, powerlessness and failure. The triggering of these feelings may be the result of a curative academic training, leading professionals to always seek a cure, which causes frustration and guilt when that objective is not achieved(8).

In the view of participants of this discourse, it is necessary to develop a mechanism of defense against the personal anguish, since, in the hospital environment, it is common to internalize the patient's illness and problem. Thus, it is essential to share experiences of the context of professional activities(14,19).

Previous experiences with death and/or participation in end-of-life process do not prevent professionals from expressing bad feelings. On the contrary, it demonstrates that nurses need to understand this fact, resulting in less suffering, control of emotions and subsequent assistance to patients and family members(8).

This discourse highlights the emotional commitment of nurses with vulnerable patients. Therefore, nurses need preparation as for the provision of care(14) so their professional performance is not conditioned to the emotional factor, triggered by the relationship with patient and family.

CSD3 brings in its central idea aspects related to information and communication. Throughout the discourse, it is observed that, sometimes, the omission of aspects related to care is due to the lack of knowledge of some professionals and lack of dissemination of the philosophy of PC and its legislation.

It is possible that the training and performance of this professional are limiting factors for participation in the process of decision-making and implementation of PC. In this discourse, we observe a conditioning of the nurse's professional actions to other professionals and even the expression of lack of knowledge related to this type of care. Therefore, professionals should not feel obliged to have all answers, but be willing to seek new knowledge to support their conduct in the process of death.

The literature confirms that all these factors can influence the decision of the multidisciplinary team at the moment of establishing a palliative approach in intensive care, since it emphasizes as major factors the team's knowledge deficit about PC, the professional training geared towards cure and the difficulty in accepting that they cannot act avoiding death and ethical and legal dilemmas(20).

The lack of clarity regarding the definition of PC can generate different understandings of work in this modality of care. This notion of PC should be worked not only in hospital context but also in the training processes of healthcare students, in order for them to overcome the conflicts in the professional context when they become workers in the sector(14,21).

A study conducted with six members of the multidisciplinary team, seeking to know their experience in palliative care in hospital context, points out that, among the challenges for performance in PC, were described conflicts and needs of training of the team to identify the difficulties in dealing with the end-of-life process. That is, the team's lack of training was considered the fact that triggers conflict. Another factor pointed by the authors of this study that encourages conflicts was the difficulty of consensus on the actions of the multidisciplinary team, when performing procedures that possibly would not bring more benefits to the patient(22). This factor corresponds to the feeling of anguish reported by nurses participating in this study.

Another study conducted with intensive care nurses points out that professional maturity and years of experience in ICU are important to make a difference in the care and relief of suffering of patients. However, this same study points out that there is no effort from the team in order to seek transparent discussions to implement the palliative care philosophy to care in the context of ICU, emphasizing the absence of discussion as a factor that hinders the participation of nurses in this process(5).

The ability to communicate is essential to the multidisciplinary work, and can be a tool to overcome the difficulties encountered by the team during the performance in PC. Effective communication and respect among team members are proven to be factors that contribute to the quality of the of the care provided(22).

Communication is the transmission of information from one person to another. The need for transmission of information received and understood by the professionals of care is necessary for interaction of practitioners, nurses and other professionals involved in the palliative process, reducing the suffering of patients and families.

Another factor that has influence on the nurses in end-of-life decisions and that corroborates the results of this research points that it is not common that a practitioner call the team for discussion related to the implementation of PC. This shows the characteristics of the care and the relationships among team members in PC. This study also affirms that the power of decision regarding the PC appears centered on the medical staff(5).

In this context, the multidisciplinary team has an important role, participating in the essential decision of establishing boundaries between the prolongation of life and the possibility of improving quality of life(23-24). Nurses, in this sense, are members of the health care service that play a social role inherent in the provision of health care, in addition to being the professionals who spend more time with patients at the end of life.

The communicational attitudes of the nurse and the content of the information provided are significant aspects in the implementation and health care in palliative care. The communication process between nurse and family in PC context contributes to better intervention and care(18). The acceptance by professionals and family will change as the implementation of these measures is conducted. That is, in the absence of communication, it is natural that feelings such as insecurity and anguish are present in the practice of these nurses.

In CSD4, we observed the feeling of doubt expressed by the nurses when providing nursing care to patients under palliative care. It is observed that this feeling may be able to influence nurses in their work process and acceptance of the PC philosophy.

During higher education training, the subject of death is little addressed, leaving, thus, several gaps, and the professional is encouraged to believe that only the cure and recovery of the patient are characteristics of good health care. The work environment, its technologies and the process of incessant struggle for life often neither allow nor open spaces to question, talk and think about death(8). This occurs because the professor may feel insecure in the interpretation of the subject death and attempts to refrain from contact with the pain and the suffering and support the emotions about the purpose of finitude.

It is observed that the teaching model implemented by higher education institutions (HEIs) focused on health is still based predominantly on scientific technique logic centered in pathology, disregarding the individuality of the human being(25). The process of finitude and death still awakens feelings of fear, anger, powerlessness, insecurity, and, based on the assessment of those feelings, they may relate more to the loss and separation than to a natural process of life(8).

In an ethnographic study carried out with ten ICU nurses about the factors that influence the end-of-life processes shows that these professionals emphasized the importance that experience, knowledge and maturity acquired throughout the career are factors that help deal with situations involving the process of finitude in ICU. Moreover, the same study discusses that nurses, especially the younger ones, feel unprepared and unable to deal with end-of-life processes, including the comfort to the family. They believe that the development of this skill will require adequation of the professional training process(5).

Therefore, this training process can be considered an intervening factor in the care provided to patient under PC, generating the abandonment and undignified death in hospital institutions, in addition to the anguish experienced by family members. This demonstrates the need for educational systems that transcend the teaching of technological and curativist apparatus of health care practices(25).

It is necessary to reflect upon the practice of palliation, considering that the current biomedical model can interfere with performance and feeling of workers when coping with the anguish related to the end-of-life process and to death. This model encourages the therapeutic futility, and health professionals may believe that the success of the care is in curing or in saving the patient's life(14), in not accepingt death as a natural process, but as a frustration.

The nurses' understanding about PC is based on daily nursing actions, minimally representing this care and revealing the lack of knowledge about this type of care, in addition to ignorance of the society on the palliation(14). Despite this, the nurses addressed here identify palliation in their daily work. It is clear in their discourse that the professionals work supported by their subjectivity, cultural values and academic training geared towards cure.

This study presents as one of its limitations the fact that it was developed in hospitals that have no specific infrastructure and multidisciplinary team for PC. While contribution, it is reinforced the importance and necessity of nurses studying about the palliative care methodology and the end-of-life process, which are little addressed in higher education in health. This may provide them with personal and professional preparation in order to mitigate the uncomfortable feelings when experiencing these stressful situations daily.

FINAL CONSIDERATIONS

This study sought to understand the meaning of the nurses' feelings in palliative care practice in adult intensive care, and, based on the discussion, seeks to contribute so these professionals have a greater understanding of how their perception and feelings can interfere with the process of work. The aim was to foster reflection on the subject, in order to make them aware, since they will provide care to the person in life, but in the end-of-life process.

We observed different feelings expressed by nurses who work or worked with patients under palliative care. Furthermore, it is observed that sometimes this difference of feeling can be built and rebuilt during their professional career. Having, among team, institution and time of activity are factors that cause interference in this process. Therefore, it is inevitable that the nurses, along the trajectory, get involved emotionally, feel insecurity and anguish, frustration and powerlessness with regard to death, but also comfort and satisfaction in carrying out their work.

The results of this study pointed to unawareness as to PC by the nurses interviewed; however, they conduct this type of care in their daily work. This gap is justified by the lack of training processes both in the context of work and in higher education institutions.

Further study is recommended, in other institutional contexts, in order to determine issues such as palliative care management, little evidenced in the reality of this study. Further research on the topic is necessary, seeking as context teams that are already committed to PC, since, as established by this study, training, professional practice and knowledge may be influencing factors in the daily professional practice.

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