Original Article

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PALLIATIVE PROFESSIONALS: STRESSORS IMPOSED ON THE TEAM IN THE DEATH AND DYING PROCESS

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ABSTRACT

Objective: to know the multidisciplinary palliative care team's perception about stressors in the death and dying process.
Method: a qualitative, exploratory-descriptive study, carried out from the perspective of Betty Neuman's theory. Data were collected using online semi-structured interview with nine palliative professionals from two health institutions between February and November 2020.
Results: a grid of analysis composed of the three Neuman System Models was organized, i.e., environment, person and health, emerging the categories: Self-perception for care in death and dying; Communication between team, patient and family - minimizing stress in palliative care; Personal and professional stressors and health structure.
Conclusion: the main stressor source referred to communication as an intrateam relationship and with patient and family. The pandemic was considered as a potential impact of relational and communication difficulties, and the fragility of health management support was linked to palliative multidisciplinary teams.

DESCRIPTORS: Health personnel. Professional practice. Stress, psychological. Death. Palliative care.

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PROFISSIONAIS PALIATIVISTAS: ESTRESSORES IMPOSTOS À EQUIPE NO PROCESSO DE MORTE E MORRER

RESUMO

Objetivo: conhecer a percepção da equipe multiprofissional de cuidados paliativos acerca dos estressores no processo de morte e morrer.
Método: abordagem qualitativa, exploratório-descritiva sob a perspectiva da teoria de Betty Neuman. Dados coletados por entrevista semiestruturada na modalidade remota e com nove profissionais paliativistas de duas instituições de saúde entre fevereiro e novembro de 2020.
Resultados: organizou-se uma grelha de análise composta dos três Modelos de Sistemas de Neuman, ou seja, ambiente, pessoa e saúde, emergindo as categorias: Percepção de si para o cuidado na morte e no morrer; Comunicação entre equipe, paciente e família - minimizando o estresse em cuidados paliativos; Estressores pessoal e profissional e a estrutura de saúde.
Conclusão: a principal fonte estressora se referiu à comunicação enquanto relacionamento intraequipe, e desse com o paciente e família. Considerou-se a pandemia como potencial impositor das dificuldades relacionais e comunicacionais, e a fragilidade do suporte da gestão em saúde foi vinculada à equipe multiprofissional paliativista.

DESCRITORES: Pessoal de saúde. Prática profissional. Estresse psicológico. Morte. Cuidados paliativos.

PROFESIONALES DE CUIDADOS PALIATIVOS: ESTRESORES IMPUESTOS AL EQUIPO EN EL PROCESO DE MUERTE Y MORIR

RESUMEN

Objetivo: conocer la percepción del equipo multidisciplinario de cuidados paliativos sobre los estresores en el proceso de muerte y morir.
Método: enfoque cualitativo, exploratorio-descriptivo desde la perspectiva de la teoría de Betty Neuman. Los datos fueron recolectados a través de entrevistas semiestructuradas en modalidad remota y con nueve profesionales paliativos de dos instituciones de salud entre febrero y noviembre de 2020.
Resultados: se organizó una tabla de análisis compuesta por los tres Modelos de los Sistemas de Neuman, es decir, ambiente, persona y salud, emergiendo las categorías: Autopercepción para el cuidado en la muerte y el morir; Comunicación entre equipo, paciente y familia - minimizando el estrés en cuidados paliativos; Estresores personales y profesionales y la estructura de salud.
Conclusión: la principal fuente de estrés se refirió a la comunicación como relación intra-equipo y relación con el paciente y la familia. Se consideró la pandemia como una potencial imposición de dificultades relacionales y comunicativas, y se vinculó la fragilidad del apoyo a la gestión en salud con el equipo paliativo multidisciplinario.

DESCRIPTORES: Personal de salud. Practica profesional. Estrés psicológico. Muerte. Cuidados paliativos.

INTRODUCTION

Death has had several representations in society and has been experienced in different ways and contexts considering each belief and cultural reality[1]. With the advancement of health technologies, the relationship with death has undergone transformations. Death went through a hospitalization process, left people's social lives, was hidden, banned and[1] is currently shown as a taboo in society in the face of advances in health skills, especially in palliative care[2]. The curricula of undergraduate courses in the health area, mostly, address issues related to death in a fragile way. This affects health professionals who, still unprepared, are forced to deal daily with death in the hospital context[3]. In this context, considering the little experience obtained in graduation, there is the possibility of an emotional burden with negative feelings, such as the feeling of helplessness and guilt[4–5]. This situation was exacerbated in the face of the pandemic process resulting from the infection and consequent illness by the new coronavirus (COVID-19) give rise to studies that show anxiety, stress and depression affecting people's, families' and health professionals' mental health. This corroborates the influence exerted by dissemination of epidemiological and psychological data, evidencing difficulties in the cognitive, emotional and behavioral pattern[6].

Given the chronic exposure to these stressors, among many others present in the hospital context, there is serious damage to professionals, which can even lead to Burnout, especially when these professionals are facing patients in palliative care in the death process. It is a context that tends to bring emotional exhaustion, in addition to depersonalization and absence of professional achievement[7–8]. In this regard, palliative care enables a relationship with the death and dying process, in which a practice that qualifies assistance in the whole dying process is sought. The World Health Organization (WHO)[9] defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual." A new paradigm in the debate about dying, a process that is often accompanied by difficult coping symptoms such as pain, dyspnea and psychological symptoms (sadness, anger, apathy).

Thus, it is understood that palliative professionals are exposed to sufferings that can be absorbed by them, which is similar to what occurs among professional categories. In a team of palliative care professionals, regardless of the professional category, the reactions, relationships and bonds established with patients and families influence the levels of stress that workers will present. There are studies that explore interventions carried out with the health team, designed to alleviate the suffering caused by the work itself. Studies indicate the importance of interventions, considering that a psychologically sick professional may present symptoms such as apathy and depersonalization[8,10–11].

In order to support professionals' perception of their psychological distress in the midst of palliative care, the analysis of Betty Neuman's Systems Model was used[12]. Its choice is justified by the fact that it refers to the relationship that each individual has with stress, how they react to it and how external factors influence each person's level of stress[12]. Thus, through this framework, palliative care professionals are seen as an open system, which has the potential to modify the environment in which it is inserted, at the same time that it is modified by them. The environment has stressors (of an intra, inter or extra-personal nature) capable of reaching the client/people system, leading them to greater adaptation and understanding of their condition[12].

Considering the above and the importance of health professionals' mental health for care in the death process, this study is relevant as it aims to know the palliative care multidisciplinary team's perception about stressors in the death and dying process. This study is relevant when scoring: the intensification of studies on death and dying in academic and professional education; the development

of educational strategies on finitude; the organization and management of health services in the composition of professional teams that are trained for palliative care; and the development of actions for stressor prevention and management in health work and palliative care.

METHOD

This is qualitative, descriptive and exploratory research, based on Betty Neuman's theoretical concepts. Nursing theory known as the Systems Model is based on two fundamental components: stress and the reaction to it. The individual, family, community and group are open and dynamic systems in which there is the interaction between beings and environment; they affect each other, exchange and make adjustments. The environment-individual-environment influences are called intra, inter and extra-personal with variables related to physiology, biology, the sociocultural, spiritual and psychological context. Moreover, the theory features energy resources known as resistance lines, defense, defense flexible, stressors, reaction and primary, secondary and tertiary preventions. This framework was fundamental for palliative care workers' perception of stressors in death (end of life) and dying[13–14].

Study participants were nine professionals who were members of a palliative care committee who carried out activities at the hospital institutions studied. We included professionals who are members of a palliative care committee, from the permanent/effective staff of the institutions in the study area. We excluded professionals who were members of a palliative care committee who were on vacation and sick leave.

Entry into the field as well as data collection was adjusted considering the pandemic moment that was being experienced by study participants in health services. The study took place in two large public hospital institutions, between September and October 2020, in the city of Florianópolis, Santa Catarina. A teaching hospital with a mobile palliative care team since 2012 from the offer of residency in palliative medicine, during the period of development of this research with 5 members, three physicians, a nurse and a chaplain. The other institution is an oncology hospital with a specific palliative care unit since 1982, consisting of 12 beds and an isolation bed with the entire palliative care team. The team is composed of nurses, nursing technicians, nursing assistants, oncologists, nutritionists, pharmacists, occupational therapists, social workers, psychologists and physiotherapists and chaplain.

Data collection occurred through a semi-structured instrument/interview with closed-ended questions related to the profile of participants and open-ended questions that sought to know the palliative care multidisciplinary team's perception about stressors in the death and dying process. The instrument contained questions that characterized participants such as: age; sex; working time and training; specificity in palliative care and specific questions about the reasons that led professionals to work with palliative care; description of the activity performed; intra-team palliation relationships; inquiry about how they felt in the process of communication between the team, family and patient; perceived influences on mood in the work process; palliative care model developed at the institution; support for professionals; innovation strategies for palliative care in the pandemic; and perception of death itself. The data saturation point was estimated based on occurrences of recurrence and complementarity of information. From the perspective of the criteria, of inclusion of differences within the researched group, considering training time, specialty in palliative care, professional category and flexible resistance lines of each individual.

Semi-structured interviews were conducted individually remotely in two formats. To contact the team of one of the institutions, WhatsApp® was used, provided by the coordinator of the palliative care team's unit. When the objective of this study was explained to professionals, the participation in the research and the option to carry out the interviews via voice message via WhatsApp® or via Google Forms. In this institution, only one professional chose to send audio message via application. In the second institution, contact was made only with the nursing manager, who was one of the study

researchers, she spoke individually with participants, explaining the objective. The researcher provided a Google Forms link for access to the research instrument to professionals who agreed to participate in the study. For all professionals who agreed to participate in the research, a message was sent via podcast, via WhatsApp®, explaining the semi-structured instrument. Considering that only one message was sent through WhatsApp®, this was the only transcript carried out by the researchers, given that the others were already described through Google Forms. The return of the interviews varied between seven and 20 days, the audio-recorded interview lasted an average of 10 minutes. The development of data collection as well as contact with professionals was conducted by two researchers previously oriented and trained to carry out this stage: one was a nursing student and the other was studying a PhD course in palliative care. Confidentiality was maintained throughout the process. The identification of professionals followed the first letter of the professional category and the order number of the interview instrument (e.g., physician 1 (P1), nurse 1, (N1)) and successively with the other professionals who participated in the research.

For data content analysis, the steps proposed by Bardin[15] were used for pre-analysis, by text skimming when the information organization and systematization were performed to elaborate the first impressions on the theme. Sequentially, data exploration was carried out based on the coding of emerging utterances forming a subdivided analysis grid from the perspective of the person (Figure 2), environment (Figure 3) and health (Figure 4) systems, as recommended by Neuman. In the last stage, treatment of results and analysis based on the thematic presence of respondents' statements took place when interpretive relationships based on the frequency of appearance and depth stated and the interface to the Neuman Systems Model were performed (Figure 1).

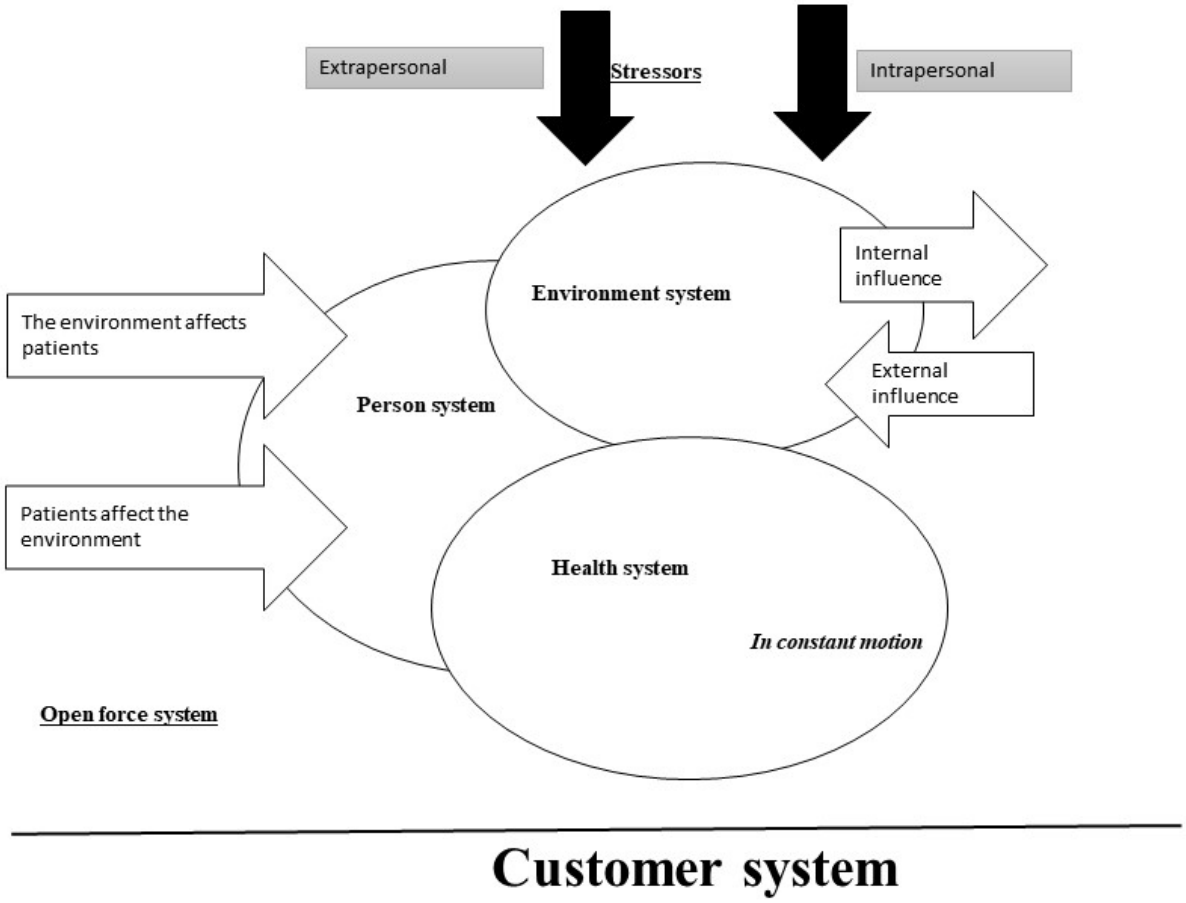

Figure 1 – Relationships between interpretation, frequency and depth. Florianópolis, SC, Brazil, 2021. Source: Neuman Systems Model[12].

The statements correspond to the records of categories' meaning and structure, showing the themes arising from the data. The methodological description of this study was guided by the COnsolidated criteria for REporting Qualitative research (COREQ)[16]. The research project, in turn, followed the ethical requirements, having been approved by the Research Ethics Committee with human beings. Participants signed the Informed Consent Form in an online form by which they became aware of the objectives, methodology, risks and benefits of participating in the study. All participants were given the freedom not to answer questions, and anonymity was guaranteed by applying the first letter of the professional category followed by the order number of the answer.

RESULTS

Participants in this study were three physicians, three nurses, two nursing technicians and one chaplain, seven female and two male professionals. The age ranged between 29 and 58 years, with an average age of 45 years with an approximate time of training of 14.5 years, ranging from three to 28 years. Working time in palliative care ranged from five months to 20 years, with an average of six years working in palliative care. Of the nine participants, only two had specific training in palliative care. The weekly workload of assistance to people and families in palliative care ranged from eight to 60 hours with an average of 28.5 hours per week of assistance and home care. Based on the entire analytical process, an analysis grid was listed according to Bardin following the Neuman Systems Model, in which the recording units are presented in three figures that characterize each Neuman System in the formation of the categories as follows: 1. Self-perception for care in death and dying; 2. Communication between team, patient and family: minimizing stress in palliative care; 3. Personal-professional stressors and health structure.

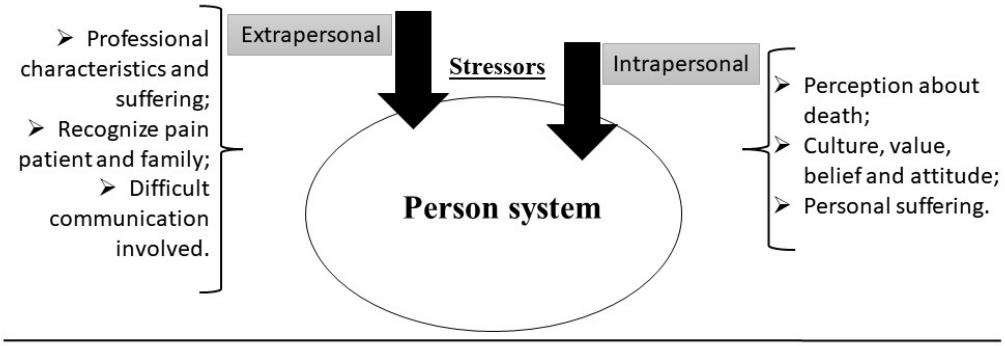

Figure 2 – Analysis grid: Person System - Registration units. Florianópolis, SC, Brazil, 2021. Source: Adapted from the Neuman Systems Model[12].

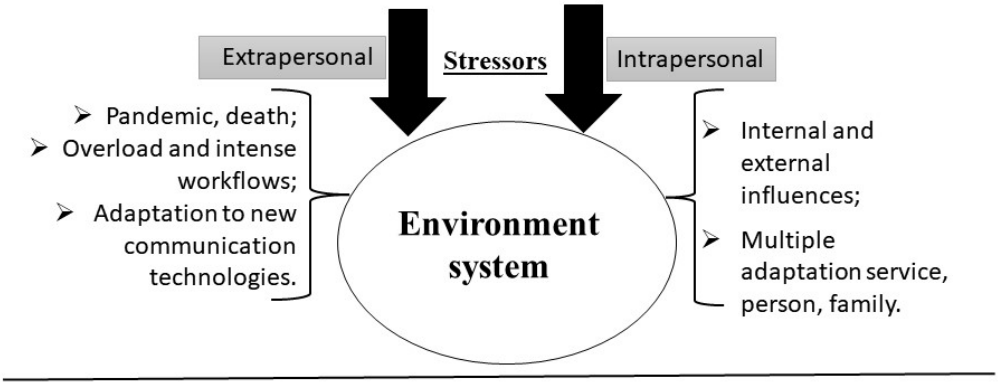

Figure 3 – Analysis grid: Environment System - Registration units. Florianópolis, SC, Brazil, 2021. Source: Adapted from the Neuman Systems Model[12].

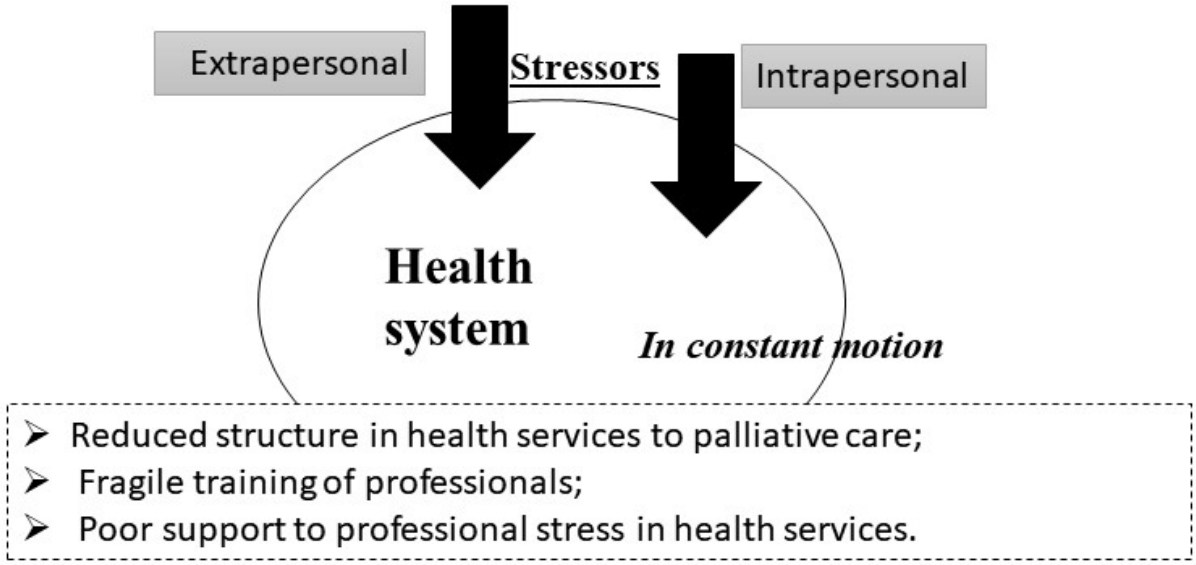

Figure 4 – Analysis grid: Health System - Registration Units Florianópolis, SC, Brazil, 2021. Source: Adapted from the Neuman Systems Model[12].

Self-perception for care in death and dying

The category reveals the professionals' perception as a human being in the face of the need to experience palliative care with the multidisciplinary team, patient and family. The search for knowledge to support their care practice and emotional, psychological, spiritual and physical fragility arises. It also shows feelings of ambiguity, at the same time that it perceives this work as rewarding.

[...] *I sought the specialty of palliative care due to the perception of the need to learn about palliative care to be able to provide a more qualified and humane service* (P1).

[...] *I think the impossibility of giving a better service.* [...]. *It is frustrating to know that a patient could have a better care, but this does not happen, because there is not enough structure for this* (P2).

[...] *I try to be spiritually prepared and theologically and biblically founded* (C1).

[...] *surely there are days of weariness, sadness, helplessness. One thing that makes me very distressed today is when an inpatient and we see that he is palliative, but the assistant physician does not transfer and they continue to invest in the patient even without results, without any benefit* (N3).

Communication between team, patient and family: minimizing stress in palliative care

The intra-team communication palliative care process between health professionals, family and patient is one of the fundamental strategies in the scenario so that there can be understanding by patients and family of the reality presented by the health team as well as for the team, and so that there is continuity in care, security in communication and credibility with the family. Good communication directed to individuals who are involved in palliative care favors interpersonal relationships, in addition to providing harmony, companionship, welcoming and trust.

[...] *this part of communication, I'm taking my first steps. I have evolved, but it is a complex part,* [...] *some situations that could end in conflict, ended in an adjusted way, because the communication was worked properly* (P2).

[...] *we have the family's trust and we make the situation less unbearable when communication is good* (NT2).

[...] *I can currently talk more naturally and guide the patient and family more safely. Despite the growth*, [...] *I still have a lot to learn* (P1).

In the face of the pandemic and social distancing, professionals bring up the need to quickly adapt to remote technologies as a communication tool. Considering that the process involving palliative care has as its central proposal the integration between patient, family and team, since new arrangements potentiate stress among multidisciplinary team, patient and families. The statements show that the team seeks strategies to ensure continuity of care and support for family and patient.

[...] *the video call between patient and family helped a lot in the comfort of both patients and families, in seeing their loved one and feeling that they were well taken care of, despite not being able to be with the family* (P1).

[...] *we had to develop communication strategies using alternative avenues, such as video calls and the use of telephone; it wasn't something we were very used to and we saw that maybe something would be lost,* [...]*, but we manage to conduct these communication processes through these alternative forms* [...] *sufficiently satisfactory, although not ideal* (P3).

[...] *my greatest difficulty was communication, as it required the communication of bad news to be given by telephone or video calls, increasing the complexity of the required communication and reception skills* (P1).

Personal-professional stressors and health structure

The category reveals the coping imposed by the health team in hospital structures. It also shows how difficult it is for these professionals who are on the front line of this care not to have support in terms of structure, physical space and support to deal with the emotional and psychological distress imposed on them in palliation. This structural deficit generates impotence, frustration and anguish. Such feelings, accompanied by emotional impacts generated by palliation, potentiate emotions related to sadness and frustration in the team.

[...] *I think the impossibility of giving a better service.* [...]*. It is frustrating to know that a patient could have better care, but this does not happen, as there is not enough structure for this* (P2).

[...] *what affects my good mood the most would be the health structure deficiencies; I think that's what ends up affecting me the most. I think my work could be better performed if we had a better public structure* [...] (P3).

[...] *very little, the team needs more support* (N3).

DISCUSSION

The human capacity for resilience establishes an understanding of attitudes in which people find themselves at certain moments of life. In a compassionate context, a coping is established, sometimes with positive, sometimes negative thoughts and attitudes predominating; given the circumstances experienced, the conflict is noticeable considering the reports and the expression of feelings in the speeches. In the course of life, the death and dying process is dynamic and implicit.

Participants were mostly young adults with an average time in palliative activities of six years. In view of these data, it is understood that they are professionals who already have a significant active life in the health environment. However, they are professionals who already experience the death and dying process in their personal and professional environment. Thus, attention, sensitivity, technique and technology are necessary for the care of these people, given that they are in an active personal life phase, in addition to being in constant contact with the loss of patients and assistance in palliative care. Studies point to the need for the team to be prepared in their personal and professional training in the health area for a quality service of human finitude, in addition to the importance of these professionals being welcomed and cared for in the face of their weaknesses in this process[17–18].

Participants expose the need and importance of training to develop skills that can ensure emotional support and balance in coping with reality with patients and family members. It reiterates the necessary permanent training that deepens and supports professionals in the process. Neumann[12] refers to balance or homeostasis as a process that is established for health maintenance. Professionals as well as people and the family that live the death and dying process are open systems. That is, systems of possibilities for identifying, interacting and transforming the health condition at work in people undergoing palliative care, both in the dying and death process. From this perspective, the relationship with Neuman's framework presents a healthy interaction between the professional individual and the environment and, also, work spaces, signaling disease prevention and adaptation strategies for health care qualification in palliative care.

The working period and the time of involvement among the palliative care team members are shown to be significant for a scientific and death-sensitive assistance that depends on each one's homeostatic balance. In the two institutions studied, it was observed that women appear professionally involved with the specialty of palliative care, which is not pointed out in this study as a decisive or differential factor in terminal care. The self-perception of personal suffering in the care of patients and families who experience situations close to death is related to the degree of reaction according to Neumann[12] about the set of resistance forces found in professionals. It is close to emotional self-management, sharing ideas with regard to dying, which provides support[17].

Multidisciplinary work is in line with one of the principles of palliative care, multidisciplinary action, in which patients facing a threat to life present multifaceted suffering with physical, psychosocial and spiritual symptoms. Working together goes beyond the number of people in a team, as it provides spaces for discussions and arguments for decision-making with the person and the family. In the reality studied, it was possible to observe this commitment to communication and humanized care. Nursing occupies a specific place within the team, as it is the only category that already has academic training focused on the art of caring and not healing.

Topics related to death and dying are rarely addressed during undergraduate education. Medicine has the role of coordinating communication between patients, family members and staff, guiding patients about treatment options, the risks and benefits of each option, respecting patients' autonomy. Palliative care is a challenge for physicians, when the focus is no longer on the disease and is on patients.

There is a movement closer to individuals on the part of physicians with regard to knowledge about the philosophy of palliative care. This shows that there should be an effective multidisciplinary insertion in the palliation scenario[8–9]. This study corroborates what the literature presents about the fragile insertion of other professional categories in the palliative care context. Participants recognize the importance of teamwork as well as a broad formation of human life and the death process.

In the phase of adaptation and reaction to stressors, palliative care professionals perceived the care they were developing as gratifying. It is a paradox established between the type of work amidst the suffering and pain, which is exhausting for health professionals, and moments of satisfaction and assistance in pain management. The attitude depends on professionals' available energy for assistance with death and dying, greater than that which makes the other suffer. It surpasses the intellectual capacity of professionals, covering the psychological, emotional and sensitive dimensions[19].

Health work promotes the emergence of factors that compromise professionals' psychological health[20]. The manifestations of malaise that in psychological distress are shown through psychological reactions in the face of external events, when they trigger verbal and behavioral reactions and psychosomatic diseases, in addition to Burnout.

The political-social system influences workload psychically, cognitively or physically. The hospital environment has the fragility of the disease and the potential of health, being antagonistic forces present in professionals, when the context involves palliative care and the death and dying process. Each individual represents an open system in interaction with stressors in the environment, in which workloads can be stressors, and where professionals' systems are inserted[12].

Each system is unique, presents its own reactions and adaptations to each stressor. It is not a question of studying the relationship between stressors and psychological distress as a cause-effect relationship. The reaction of each subject/system to each stressor is subjective, varies according to available energy and defense mechanisms. The philosophy of palliative care itself is a reduction of defense mechanisms[21].

Participants evidence the degree of availability to assist these people, as they understand with satisfaction the importance of palliative care in the end of life process[22]. This explains the soft view they have of finitude, since exposure to the other's death puts them face to face with the fact that they will die[23]. Palliative care makes the reflection about one's own finitude something natural for professionals, death is no longer a taboo, and thinking about death is not associated with negative aspects. When assisting a dying patient and verifying the effectiveness of care and the improvements associated with patients, professionals feel fulfilled and accomplished. Recognition and satisfaction in palliative work are factors that generate motivation for workers[24].

Feelings of gratification, stress, suffering and the difficulty in dealing with patients who die were present among the nursing techniques. Studies[24–26] indicate that this category remains in a longer period of contact with patients, is exposed to suffering and deals with dense psychological loads. In terms of aspects addressed by Neuman[12], the nursing category presents a higher risk of the system being invaded by a stressor. The attitude of avoiding dialogue with patients indicates an interpersonal stressor related to communication and causes a reaction in the person's system, manifested by defense mechanisms, which, in turn, result in patients' distancing as an adaptation to the environment.

The professionals in this study present psychological distress linked to the work environment and not to the care provided to patients. The preparation and knowledge about palliative care, in addition to the forms of communication with patients and families, impact the perception of their actions and links to the death and dying process[27]. Intra-team communication is a harmonious scenario, a positive point in the work process, strengthening work and enhancing reflective capacity. Based on Neumann[12], intra-team communication contributes to a harmonious external environment for people's systems and fortifies lines of defense. Communication with patients and family members can be considered challenging, given the complexity of this interaction.

The literature presents the concrete fragility in professional training in relation to the preparation for communicating bad news. There is evidence that communication is poorly addressed throughout the undergraduate course, with curricula mostly focused on technical and biological aspects[22,24]. This has repercussions on professional practice, where communication becomes a challenge, as previously mentioned, causing professionals to present defense mechanisms that distance them from patients[24]. Intra-team communication contributes to the harmony of the external environment, communication with the family, and patients emerge as a trigger of stressors for professionals. Stressors can be interpersonal, linked to the relationship established between professional - patient - intrapersonal triad. The difficulties encountered in the communication process can bring up anxieties that are specific to professionals[19,22].

The communication process complexity involves several factors, such as information provided by the physician, information retained by patients, how much patients know about the disease, how much they would like to know and, also, the degree of satisfaction with the information received. Communication, when well conducted, is a therapeutic tool and operates as a strategy of integral and humanized care in the terminality of life[19,22,24].

Palliative care training strengthens professionals in their reflection on communication and the development of methods to conduct their activities with patients and families, in addition to strengthening the systems' lines of defense.

Motricity reduces the harmful potential of stressors present in the environment. The environment is understood as both the internal environment of professionals (feelings, emotions, thoughts, among others) and the external environment, shared with other people. It was possible to identify that, despite being challenging, good communication strategies strengthen the lines of defense, protecting them from the effects of stressors.

In Brazil, the current situation in relation to facing the pandemic in the health sector can be considered an extra-personal stressor. The lack of material and human resources, depending on the situations presented, may arise as a stress factor for health professionals, or may not arise. The reduction in expenses, approved in the Proposed Constitutional Amendment 95 in 2016, also known as "*PEC do teto*", exacerbated the problems that had already been settling for some years in the progressive scrapping of the Unified Health System (SUS - *Sistema* Único *de Saúde*). We also point out the fragility of inputs and professionals that causes overload to services due to the high number of patients hospitalized for COVID-19[25,28].

Study professionals highlighted the adaptations that were made in the communication process, verbal communication through remote technologies (video calls) and non-verbal communication with touch restriction. They were an obstacle in the professional-patient relationship and increased, in turn, the solicitude in the environment[29].

The studies have limitations on the way in which all these changes in communication processes affected assistance in the death process during the pandemic. There are studies[25,28–30] on the increase in the psychological burden of health professionals who, exposed to others' suffering, are concerned about the risk of contamination of themselves and their families. The stressors related to fear of contracting COVID-19 were not expressed by participants in this research. Difficulties in maintaining communication and establishing a quality bond with patients and families, given the limitations of social distancing, represent the greatest stress factor[30].

FINAL CONSIDERATIONS

The stressors involved in the palliative care scenario in the death and dying process are revealed in the uncertainties of finitude and in the experience of suffering the other's death. Also, in this study, the understanding of dying is a natural process and part of the experiential cycle.

The identified stressors are related to fragility in professional training and communication as a unique strategy to minimize the suffering experienced in families. These are associated with stressors related to the COVID-19 pandemic, especially social distancing, intensifying the farewell's suffering and loneliness.

In the resizing of care actions in the death process, palliative professionals suggest a more targeted and in-depth training of strategies for emotional self-management. Palliative workers show that gratification for the care provided is the strength and emotional balance for working in palliative care. Added to this, the hospital structure as a physical and human space that helps in emotional support to these palliative professionals.

It is understood the imperative need for managers to work with the multidisciplinary team, especially in relation to emotional and psychological support for these professionals. Furthermore, strategies for dialogue in support groups, attentive listening, offering natural practices that strengthen serenity and coping and self-management of emotions, minimizing occupational stressors.

The limits in the study are reflections of the COVID-19 pandemic condition that weakened the dialogic process directly with the participants of this research and the remote data collection, resulting in little participation of professionals.

The contributions of this study are aimed at supporting the planning of actions and strategies to strengthen humanity in care oriented towards in-depth assistance in the clinical, psychological and emotional aspects of professionals, patients and families who experience palliative care. Health professionals experience, paradoxically, psychological distress due to communicational limit and gratification in qualitatively caring for people in the death process, which is shown as a differential of this study in relation to the literature on the subject.

REFERENCES

1. Faria SS, Figueiredo JS. Aspectos emocionais do luto e da morte em profissionais da equipe de saúde no contexto hospitalar. Psicol Hosp [Internet]. 2017 [cited 2021 Feb 13];15(1):44-66. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1677-74092017000100005&lng=pt&tlng=pt
2. Nyatanga B. Fatigue in palliative care. Br J Community Nurs [Internet]. 2018 [cited 2020 Oct 10];23(10):518. Available from: https://doi.org/10.12968/bjcn.2018.23.10.518
3. Ramón FM, López FR, León AC, Zamora RMA, Ruíz MAV, Hernández NG. Actitudes del personal de enfermería ante la muerte de sus pacientes. Rev Cuidarte [Internet]. 2020 [cited 2021 Jan 26];12(1):e1081. Available from: https://doi.org/10.15649/cuidarte.1081
4. Cardoso MFPT, Martins MMFPS, Trindade LL. Attitudes in front of death: nurses' views in the hospital environment. Texto Contexto Enferm [Internet]. 2020 [cited 2021 Jan 18];29:e20190204. Available from: https://doi.org/10.1590/1980-265x-tce-2019-0204
5. Monteiro DT, Mendes JMR, Beck CLC. Perspectivas dos profissionais da saúde sobre o cuidado a pacientes em processo de finitude. Psicol Cienc Prof [Internet]. 2020 [cited 2021 Jan 24];40:e191910. Available from: https://doi.org/10.1590/1982-3703003191910
6. Crepaldi MA, Schmidt B, Noal DS, Bolze SDA, Gabarra LM. Terminalidade, morte e luto na pandemia de COVID-19: demandas psicológicas emergentes e implicações práticas. Estud Psicol [Internet]. 2020 [cited 2021 Jan 25];37:e200090. Available from: http://doi.org/10.1590/1982-0275202037e200090
7. Barbosa APM, Santo FHE, Hipólito RL, Silveira IA, Silva RC. Vivências do CTI: visão a equipe multiprofissional frente ao paciente em cuidados paliativos. Enferm Foco [Internet]. 2020 [cited 2021 Jan 12];11(4):161-6. Available from: https://doi.org/10.21675/2357-707X.2020.v11.n4.2990
8. Fernandes MA, Borba JCQ, Zaccara AAL, Andrade FF, Marinho HLM, Costa SFG. Patients at the end of life receiving palliative care: experiences of a mutiprofessional team. Rev Fun Care Online [Internet]. 2020 [cited 2021 Feb 12]; 12:1227-32. Available from: https://doi.org/10.9789/2175-5361.rpcfo.v12.9453
9. World Health Organization. National cancer control programmes: policies and managerial guidelines [Internet]. 2nd ed. Geneva, GE(CH): World Health Organization; 2002 [cited 2021 Jun 27]. 10 p. Available from: https://apps.who.int/iris/handle/10665/42494
10. Taylor C, Xyrichis A, Leamy MC, Reynolds E, Maben J. Can Schwartz Center Rounds support healthcare staff with emotional challenges at work, and how do they compare with other interventions aimed at providing similar support? A systematic review and scoping reviews. BMJ Open [Internet]. 2018 [cited 2021 Mar 10];8:e024254. Available from: https://doi.org/10.1136/bmjopen-2018-024254

11. Kapoor S, Morgan CK, Siddique MA, Guntupalli KK. “Sacred pause” in the ICU: evaluation of a ritual and intervention to lower distress and burnout. Am J Hosp Palliat Med [Internet]. 2018 [cited 2021 Feb 26];35(10):1337-41. Available from: https://doi.org/10.1177/1049909118768247

12. Neuman B. The Neuman system model. In: Neuman B, Fawcett J, editors. The Neuman systems model. 5th ed. Upper Saddle River, NJ(US): Pearson; 2011. p. 378-380.

13. Breckenridge D. The Neuman Systems model and evidence-based nursing practice. In: Neuman B, Fawcett J, editors. The Neuman systems model. Chapter 17. 5th ed. Upper Saddle River, NJ(US): Pearson; 2011. p. 374-377.

14. Albuquerque RN, Borges MS. Comportamento suicida: uma compreensão sob a ótica de Betty Neuman. Rev Baiana Enferm [Internet]. 2021 [cited 2022 Jul 6];35:e43812. Available from: https://doi.org/10.18471/rbe.v35.43812

15. Souza VRS, Marziale MHP, Silva GTR, Nascimento PL. Translation and validation into Brazilian Portuguese and assessment of the COREQ checklist. Acta Paul Enferm [Internet]. 2021 [cited 2022 Jul 6];34:eAPE02631. Available from: https://doi.org/10.37689/acta-ape/2021ao02631

16. Bardin L. Análise de conteúdo. São Paulo, SP(BR): Edições 70; 2016. 118 p.

17. Ventura G, Silva B, Heinzen KV, Bellaguarda MLR, Canever BP, Pereira VP. Enfrentamento de enfermeiras frente à morte no processo de cuidar em emergência. Enferm Act Costa Rica [Internet]. 2019 [cited 2020 Dec 13];37:142-54. Available from: https://doi.org/10.15517/revenf.v0ino.37.35525

18. Bellaguada MLR, Moraes CLK, Canever BP, Silva AO, Broering JV, Martendal T. Emergency communication to the family member of the traffic accident victim. Glob Acad [Internet]. 2021 [cited 2021 Jan 6];2(1):e65. Available from: https://doi.org/10.5935/2675-5602.20200065

19. Silva R, Lage I, Macedo E. Vivências dos enfermeiros sobre morte e morrer em Cuidados intensivos: uma reflexão fenomenológica. Rev Portuguesa Enferm Saúd Mental [Internet]. 2018 [cited 2020 Feb 26];20:34-42. Available from: https://doi.org/10.19131/rpesm.0224

20. Esperidião E, Saidel MGB, Rodrigues J. Mental health: focusing on health professionals. Rev Bras Enferm [Internet]. 2020 [cited 2020 Feb 10];73 Suppl 1:e73supl01. Available from: https://doi.org/10.1590/0034-7167.202073supl01

21. Wittenberg E, Reb A, Kanter E. Communicating with patients and families around difficult topics in cancer care using the comfort communication curriculum. Semin Oncol Nurs [Internet]. 2018 [cited 2020 Mar 23];34(3):264-73. Available from: https://doi.org/10.1016/j.soncn.2018.06.007

22. Pinho ACC, Silva VSM, Souza AM, Corrêa VAC. On the way to look for care of people under palliative care. Cad Bras Ter Ocup [Internet]. 2019 [cited 2020 Jun 23];27(1):118-26. Available from: https://doi.org/10.4322/2526-8910.ctoAO1654

23. Siqueira ASA, Teixeira E. Oncological paliative care and its psychic influences in the perception of nurses. REME Rev Min Enferm [Internet]. 2019 [cited 2020 Sep 16];23:e-1268. Available from: https://doi.org/10.5935/1415-2762.20190116

24. Bellaguarda MLR, Knihs NS, Canever BP, Tholl AD, Alvarez AG, Teixeira GC. Realistic simulation as a teaching tool in critical situation communication in palliative care. Esc Anna Nery [Internet]. 2020 [cited 2020 Aug 10];24(3):e20190271. Available from: https://doi.org/10.1590/2177-9465-EAN-2019-0271

25. Fernand LMFA, Anjos LMA, Rodrigues MSS. Sofrimento psíquico da equipe de enfermagem no processo morte e morrer da criança oncológica. Acta Ciênc Saúde [Internet]. 2018 [cited 2021 Jun 28];1(1):13-23. Available from: https://www2.ls.edu.br/actacs/index.php/ACTA/article/view/173

26. Dal'Bosco EB, Floriano LSM, Skupien SV, Arcaro G, Martins AR, Anselmo ACC. Mental health of nursing in coping with COVID-19 at a regional university hospital. Rev Bras Enferm [Internet]. 2020 [cited 2021 Jun 17];73 Suppl 2:e20200434. Available from: https://doi.org/10.1590/0034-7167-2020-0434

27. Silva RS, Trindade GSS, Paixão GPN, Silva MJP. Family conference in palliative care: concept analysis. Rev Bras Enferm [Internet]. 2018 [cited 2021 May 12];71(1):206-13. Available from: https://doi.org/10.1590/0034-7167-2016-0055

28. Schmidt B, Crepaldi MA, Bolze SDA, Neiva-Silva L, Demenech LM. Saúde mental e intervenções psicológicas diante da pandemia do novo coronavírus (COVID-19). Estud Psicol [Internet]. 2020 [cited 2021 May 18];37:e200063. Available from: https://doi.org/10.1590/1982-0275202037e200063

29. Witiski M, Makuch DMV, Rozin L, Matia G. Communication barriers: perception of a healthcare team. Ci**ê**nc Cuid Saúde [Internet]. 2019 [cited 2021 Jun 26];18(3):e46988. Available from: https://doi.org./10.4025/cienccuidsaude.v18i3.46988

30. Moreira WC, Sousa AR, Nóbrega MPSS. Mental illness in the general population and health professionals during the covid-19 pandemic: systematic review. Texto Contexto Enferm [Internet]. 2020 [cited 2021 Jun 13];29:e20200215. Available from: https://doi.org/10.1590/1980-265X-TCE-2020-0215

NOTES

ORIGIN OF THE ARTICLE

This study is part of a Course Completion Work - *Sofrimento Psíquico de Profissionais Paliativistas na Assistência no Processo Morte-Morrer*, presented to the undergraduate nursing course at the *Universidade Federal de Santa Catarina*, 2021.

CONTRIBUTION OF AUTHORITY

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Discussion of results: Böger R, Bellaguarda MLR.
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APPROVAL OF ETHICS COMMITTEE IN RESEARCH

Approved by the Ethics Committee in Research of the *Universidade Federal de Santa Catarina*, under Opinion 4,146,710, CAAE (*Certificado de Apresentação para Apreciação* Ética - Certificate of Presentation for Ethical Consideration) 33378920900000121.

CONFLICT OF INTEREST

There is no conflict of interest.

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