Health Professionals' Mental Health:
A Look at their Suffering

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Abstract

This study aimed to recognize the characteristics of work within the hospital context and their potential effects on mental health of professionals who provide health care for end-of-life patients. The descriptive and qualitative study relied on interviews and observations. Thirty-four physicians and nurses who work in clinical medicine or emergency medical services in a teaching hospital in Rio Grande do Sul were interviewed. The results, obtained through content analysis, showed that in clinical medicine health professionals suffer more when patients die or their condition gets worse, such suffering being a threat to mental health. In emergency medical services, death causes suffering only when it is traumatic. Intercurrences which are characteristic of emergency medical services and work organization are the major source of stress for such professionals, thus affecting their mental health. Therefore, the mental health of these professionals is weakened due to the demands in health care work. It is thus necessary to rethink the institution's organization, redefine attitudes and implement procedures that are coherent with the professionals' needs, in search of better working conditions and improved mental health.

Keywords: Attitude towards death, healthcare staff, comprehensive health care, mental health.

A Saúde Mental dos Profissionais da Saúde:
Um Olhar ao Sofrimento de quem Cuida

Resumo

Este estudo teve como objetivo conhecer as características do trabalho no contexto hospitalar e os possíveis efeitos na saúde mental dos profissionais que realizam o cuidado de pacientes no fim de vida. Realizou-se um estudo descritivo e qualitativo com base em entrevistas e observações. Foram entrevistados 34 médicos e enfermeiros que atuam nas unidades de clínica médica e pronto-socorro

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em um hospital de ensino do Rio Grande do Sul. Os resultados, obtidos a partir da análise de conteúdo, mostraram que na clínica médica há maior sofrimento quando acontece a morte ou a piora do paciente, fontes de prejuízo à saúde mental. No pronto-socorro, a morte gera sofrimento apenas quando traumática. As intercorrências próprias da emergência e da organização do trabalho são as maiores fontes de estresse para os profissionais, afetando sua saúde mental. Logo, a saúde mental dos profissionais encontra-se fragilizada frente às exigências do trabalho em saúde. É necessário repensar a organização institucional, redefinir ações e agir coerentemente com as necessidades dos profissionais, buscando melhorias no trabalho e na saúde mental.

Palavras-chave: Atitude frente à morte, pessoal de saúde, assistência integral à saúde, saúde mental.

La Salud Mental de los Profesionales de la Salud: Una Mirada al sufrimiento de quien Cuida

Resumen

El objetivo de este estudio fue conocer las características del trabajo en el contexto hospitalario y los posibles efectos en la salud mental de los profesionales que realizan el cuidado de pacientes al final de la vida. Se realizó un estudio descriptivo y cualitativo basado en entrevistas y observaciones. Se entrevistó a 34 médicos y enfermeros que actúan en las unidades de clínica médica y de servicios médicos de urgencia en un hospital de enseñanza de Rio Grande do Sul. Los resultados, obtenidos a partir del análisis de contenido, mostraron que en la medicina clínica hay mayor sufrimiento cuando ocurre la muerte o el empeoramiento del paciente, factores de daño a la salud mental. En los servicios médicos de urgencia, la muerte genera sufrimiento solamente cuando es traumática. Las intercurrencias propias de la emergencia y de la organización del trabajo son las mayores fuentes de estrés para los profesionales, afectando su salud mental. Por lo tanto, la salud mental de los profesionales se encuentra debilitada ante las exigencias del trabajo en salud. Es necesario repensar la organización institucional, redefinir acciones y actuar coherentemente con las necesidades de los profesionales, buscando mejoras en el trabajo y en la salud mental.

Palabras clave: Actitud frente a la muerte, personal de salud, atención integral de salud, salud mental.

Workplace environments can be a source of health or illness, in relation to both general health and mental health (Seligmann-Silva, 2011). Suffering occurs when one's possibilities of adapting or adjusting to the work organization become exhausted, in accordance with the individual's wishes (Dejours & Aldboucheli, 1994). Along these lines, Dejours (1994) points out that suffering implies a state of struggling, on the part of the individual, against work organization-related forces that lead to mental illness. Hence, in order to transform a fatiguing job into an equilibrium-producing one, organizational flexibility is necessary (Dejours, 1992); otherwise, the work will entail suffering.

Suffering arises from a specific context, made up of relationships established in the workplace and the interiorization of processes of domination. Over time, workers can lose hope and exhaust their possibilities of action (Werlang & Mendes, 2013). In this sense, all workers can be exposed to harm to their physical and mental health, harm generated by workplace conditions, including the work organization. Satisfying work produces pleasure, happiness and health. Nonetheless, if the work goes unrecognized or is meaningless or a source of risks to one's physical or mental integrity, it can produce suffering (Glina & Rocha, 2010).

Hospital personnel are in direct contact with life and death, and the suffering caused by such circumstances is intense and loaded with symbolism because, to both health professionals and the hospital, death is, above all, a failure.

Governed by established norms and procedures, hospital functioning allows for little possibility of dialogue between the individuals involved in the end-of-life process or of the expression of their feelings. Through the development of resources aimed at maintaining and prolonging life, medicine has produced a new way of dying in hospitals that is medically monitored, controlled, unconscious, silent and hidden (Menezes, 2004).

It is a fact that health professionals exhibit discomfort in the course of their work, and such professional impotence reveals their powerlessness and insecurity, evidencing the need for networking (Furtos, 2007). Hence, the importance of such professionals' mental health is obvious. We are not dealing here with an "absolutely healthy" state of mind, but rather, as stated by Furtos (2005), a sufficiently healthy state, along the lines of being capable of living and suffering in a given environment and being transformable without destructiveness, yet not without protest, thus achieving a unique, death-focused job that allows for greater capacity to live in relation both to death and to oneself, being able to invest and create in the hospital environment, even atypical, non-normative creations. This means including the capacity to suffer and the notion of an adaptable environment, that is, an environment that always offers the possibility of transformation (Furtos, 2007).

Accordingly, the circumstances of the work must not only be viewed from a technical standpoint, via objective and instrumental data, but also from a social (relationships of cooperation and comprehension) and subjective standpoint. Such circumstances involve mobilization, personal investment, singularity, cognition, imagination and creativity, factors that are indispensable to making the work effective (Oliveira, 2009). Analyzing the relationship between man and work, Dejours (1992) points out the importance of listening to workers with the aim of understanding how they experience their work and what it means to them. Suffering can lead to different situations, involving, for example, elimination of spontaneous acts, stagnation of creativity, apathy, alienation, and mental and physical illness. In the opposite direction, suffering can also produce creative problem-solving strategies, thus preserving the worker's mental health. Through language, workers can express the manner in which they live, suffer, build, and construct themselves in and through their work and how they interact in their work (Sznelwar, 2008).

Death still has no place in hospital organization. One says that the patient passed away, expired, perished, but never that the patient died. Nonetheless, death is present, silenced, a fact that can increase the suffering of health professionals, who experience death in their daily routine. We are dealing with hidden suffering: "Social suffering stems from this paradoxical situation, the result of forced autonomy without socially available support" (Werlang & Mendes, 2013, p. 753). One must take into account the fact that the work process in health care is carried out by human beings that have needs and weaknesses. Hence, unsatisfactory working conditions, involving both disregard for professional aspirations and a technical, bureaucratic perspective, disqualify the care given, the caregiver and the humanization of the caregiver's practices (Fontana, 2010).

Worsening the situation, Brazilian Constitutional Amendment EC 95/2016 tends toward the destruction of public services and policies because it freezes social expenditures and investments for twenty years, even paralyzing investments in health care and thus increasing the job insecurity mentioned above and causing the deterioration of public health care. In this sense, capitalism seeks to exclude the worker from the process, for it intensifies attacks against worker organization and promotes the elimination of hard-earned social rights. Consequently, neoliberal ideology and occupational restructuring maintain labor exploitation, which has escalated in recent decades. Workers are placed in a precarious, degrading condition involving long workdays. As a result, one sees workers that spend a lot of time on the job and have little time and scarce

resources for developing their intellectual and spiritual abilities (Silva, 2017), conditions that impair their mental health.

In general, the hospital staff is overburdened by various factors: the complexity of the tasks performed, an insufficient number of available professionals, changes in duty shifts, a large number of patients in hospital units, and other factors (Kovács, 2010). The staff perceives itself to be more active when it observes favorable effects of its activities. Furthermore, handling patients that exhibit multiple symptoms for which the prognosis is unfavorable makes things difficult, and conflicts arise as to what to do in such situations: continue the treatments or withhold them (Kovács, 2010).

Worker health is an area of knowledge, investigation and intervention. This area's development occurs via two dimensions: the first involves a new world order of capital over labor, influenced by contemporary patterns of capital accumulation, in which one observes work restructuring, without understanding its impact on health; and, in the second dimension, there are legal and political advances related to the recognition of an expanded conception of health, its regulatory adaptation to universal rights and the inclusion of worker health in the field of collective health and in public policies. The concept of worker health emphasizes both the capital-labor relationship and the recognition of the worker as a political individual. The social aspect is considered determinant of health conditions, given that illness must be treated and new diseases must be prevented, placing emphasis on initiatives promoting health. Health programs must include the comprehensive protection, recuperation and promotion of worker health, focusing on all workers. Such initiatives should be conducted within a transdisciplinary, intersectoral context featuring worker participation (Mendes & Wünsch, 2007). That said, the present study is part of a doctoral research project that investigated the perceptions, meanings, feelings and difficulties related by the health professionals of a public hospital concerning the care provided during the end-of-life process of patients. The cross-

section presented here aims to demonstrate the characteristics of hospital work and their potential effects on the mental health of professionals who care for terminal patients.

Method

The present research is a descriptive study of a qualitative nature (Minayo, 2008), for it provides an understanding and an interpretation of the meaning and significance given to a phenomenon. Hence, the study's design incorporates meaning and intentionality as being inherent to acts, relationships, and social structures, which, due to their advent and transformations, are considered significant human constructions (Bardin, 2009).

The hospital in which the study was conducted is a public, general, tertiary-level teaching hospital, which only treats patients through Brazil's Public Health System (SUS, in Portuguese). The research was performed with prior institutional consent. The units we studied were the emergency department and the medical clinic (internal medicine).

The present study's participants were physicians and nurses working in the hospital's medical clinic (internal medicine) or emergency department. With respect to the medical clinic, we opted for interviewing all of the professionals, given that this unit consisted of two health areas and the number of professionals was relatively small: 18 professionals in all (eight physicians and ten nurses). One nurse chose not to participate, leaving a remainder of 17 interviews. Medical residents were included in the study due to the fact that this unit's residency program is internal medicine-specific and residents stay for up to three years, working in the area of oncology. Furthermore, there is little resident turnover in the unit. Regarding the emergency department, we opted for excluding resident physicians because they spend only two months of their residency in the emergency department and such residency is not emergency-specific. Short periods of experience in the department could provide superficial information concerning the theme. The emergency department consisted of

a total of 40 professionals: 13 physicians and 27 nurses. The same number of professionals was interviewed in both of the units.

Two instruments were employed for data collection: systematic observation and semistructured interviews. Observation began with familiarization and was concluded upon completion of all the individual interviews, which were logged directly in a field journal. In the medical clinic, observation began during the first half of July 2016 and lasted until August. In the emergency department, it was conducted between August and October 2016. Observation in the emergency department lasted longer due to several intercurrences in administering the interviews. In both units, observation was conducted during both shifts (day and night), at different times, so that differences between shifts could be observed. On several weekends, the researcher was also present. It is worth emphasizing the use of observation and field journal annotations to comprehend the units' work organization, a procedure that enabled us to link facts and phenomena related to the research theme. Observation fulfills the purpose of getting acquainted with work interfaces in the hospital context when it enables one to perceive the working conditions (especially in the emergency department), the patients' needs, the number of workers, the workload, and other elements that arise from the work itself and reveal the true working conditions, over and above what the employees themselves say.

In order to conduct data collection, the thesis project was first submitted to the research ethics committee of the Federal University of Rio Grande do Sul. Subsequently, we presented our research to the directors of the medical clinic and emergency department for sector approval. Next, the project was submitted to the Cabinet of Studies and Projects of the institution in which data collection was performed. After all protocols had been satisfied and the project had received favorable assessments, data collection began.

Data collection first began in the medical clinic unit, in which it was possible to interview the entire staff of professionals. Since the emergency department has a larger number of professionals, we opted for interviewing the same number of participants in both units, aiming at forming a homogeneous sample. Accordingly, upon completing the interviews in the medical clinic, with a total of 17 professionals (one nurse refused to participate in the survey), data collection in the emergency department began, likewise with eight physicians and nine nurses. The participants in the latter unit were invited randomly, from both work shifts (day and night). We conducted a total of 34 interviews in the two units and performed three and a half months of observation.

For data analysis, the interview narratives were first transcribed, in order to identify the statements that were most significant, either because they were repeated often or due to their emotional charge or their degree of consistency with or divergence from the other narratives. Based on the periods of observation and the interviews, research theme-related categories for data analysis were formed. In order to combine both methods (observation and interviews), data triangulation was then conducted as part of the process of checking data reliability, aiming at achieving magnitude in the description, explanation and comprehension of the object of study. As a starting point in triangulation, one begins with the presumption that it is not possible to conceive the isolated existence of a social phenomenon (Triviños, 2015).

Data analysis was based on content analysis, focusing on categorical analysis, which refers to a set of communication analysis techniques, employing systematic, objective procedures for describing the content of the statements. We chose this method because of its focus on characterizing individuals' experiences and their perceptions regarding the object and its phenomena (Bardin, 2009).

We complied with all of the ethical recommendations set forth in Brazilian National Health Council Resolution No. 510/2016 (2016), which stipulates ethics in human research. We also understood that, because we were dealing with research in the field of psychology, the ethical standards required of professional

psychologists by Brazil's Federal Psychology Council also had to be taken into consideration. Such ethical rigor on the part of the academic council complements the comprehension of Resolution No. 510/2016. Appropriately, the study was conducted in accordance with Federal Psychology Council Resolution No. 016/2000 (2000), which defines regulatory guidelines and norms for research involving human beings.

Accordingly, the interviewees participated voluntarily, without institutional or psychological coercion, signing an informed consent form. They were assured that their personal identities would remain anonymous, given that their names or any kind of information that could possibly identify them were not to be disclosed. Field activities were conducted only after approval by the Research Ethics Committee, via decision no. CAAE 52749816.2.0000.5334.

The participants' confidentiality was maintained (and shall be in future publications) through the use of initials to identify their statements ("P" for physicians and "N" for nurses, plus a number, followed by the initials of the unit in which they work ("MC" for medical clinic and "ED" for emergency department). The following is an example: "P1, MC" or "P2, MC" when the participant was a medical clinic physician; and "N1, MC" or "N2, MC" when the participant was a medical clinic nurse. Similarly, when the participant worked in the emergency department, initials such as "P9, ED" or "N10, ED" were employed, and so on.

Results and Discussion

Data analysis brought to light two categories that describe the professionals' mental health: "Health Professionals' Mental Health" and "Work in the Field of Emergency Services: The emergency department as a source of mental illness."

Health Professionals' Mental Health

Work plays a central role in people's lives; through it, they seek to satisfy their needs, such as self-esteem and achievement. In the hospital environment, professionals experience conflicting situations, characterized by high demand for medical treatment, exigency, agility, and rapidity in procedures. In addition to experiencing death on a daily basis, which causes different impacts on the lives of those involved (Simões, Otani, & Siqueira, 2015), such professionals are exposed to chronic stressors in their day-to-day routines, resulting in vulnerability to risks, physical illnesses and injuries, stress, and mental distress, thus justifying consideration of the psycho-emotional dimension (Santos, Aoki, & Oliveira-Cardoso, 2013). Furthermore, the psychosocial elements of the workplace environment potentially jeopardize different areas of the professional's health and quality of life (Kogien & Cedaro, 2014), as one observes in the following account:

> . . . *if only our life could be like that of an architect, who is only sought out in happy moments, when you're expanding, looking to give some color to your home, but that's not what it's like in the emergency department. You come across something stressful in relation to a living person; and then, the emptiness of death; the emergency department is pretty heavy.* (P13, ED)

When one considers the suffering undergone by such professionals, one's attention generally focuses on narratives about the patient's treatment, sudden illness, agonizing decline, premature death and uncertainties. The emotional impact caused by directly treating a patient needs to be recognized so that interventions can be made, with time reserved for talking about death, in high-intensity settings, where the professionals daily struggle with ethical dilemmas and end-of-life dynamics (Best, 2016). The greatest strain of such professionals is not the long hours worked, but rather the emotional intensity that demands their maximum effort, for such effort signifies caring for the lives of other people. Nonetheless, most of the time, the conflict between the emotional sphere and the rational sphere is unknown to both the professionals and society (Souza, Pessini, & Hossne, 2012). Constant exposure to the stress caused by daily contact with death and dying can affect the professionals' mental health

(Santos & Hornanez, 2013), as demonstrated by the following accounts:

> Sometimes I get home and feel like I need to plug myself into the power outlet to recharge myself, because, like, my energy ran out, you know, as if someone had drained me; and it's not physical exhaustion; it's mental exhaustion, because there are so many problems, so many things, all day long, only problems. (P3, MC)

> I believe it affects our health because, judging by the number of doctor's certificates for depression we have, and that's something that goes on accumulating somehow, or like I told you, we often remember the striking people. They come and go in our minds, you know; despite it all, we still keep going, professionally . . . Somehow, we're sad sometimes and don't know why; I don't know; and then, suddenly, somehow, it's all so fragile, so sad . . . if you're present, we always say, "I don't want to be present, on duty, when that person passes away". (N1, MC)

The professionals stress how greatly hospital work can affect their mental health. The work demands are related both to the work organization and to issues involving the end of the lives of patients, which is something that absorbs all one's energy, as is emphasized in the first account above, causing stress and increasing the number of medical certificates for depression, as evidenced by the second and third accounts. Corroborating the present study's findings, a study conducted by Oliveira, Mazzaia, and Marcolan (2015) of nurses that work in a hospital emergency department found that 90% of the ED professionals had fallen ill due to depression, an extremely significant number. Such data warrant consideration and interventions aimed at improving the working conditions and mental health of such professionals. Substantiating the findings, the data provided by the hospital in which the study was conducted confirm the great amount of medical certificates for mental health reasons: In 2016, 1374 doctor's certificates were issued for mental and behavioral disorders among the hospital's entire professional staff.

It is also worth highlighting the work performed by medical residents. In the present study, residents working in the medical clinic were considered. We were able to perceive the great stress they are subjected to, which could be the result of "frontline" work; that is, there is only one physician responsible for the unit, and most of the treatments are thus carried out by residents, who must meet the demands of patients suffering in the oncology department at the same time that they are in training, which can result in greater harm to their mental health. Regarding negative mental symptoms, Best (2016) relates that, at a conference that was held, 50% of the medical residents indicated that they knew of at least one suicide among health professionals. Residents experience, at first hand, the arbitrary nature of life and death. Physicians are taught (and even take an oath) to put the patient first. The many losses experienced during the course of the profession take a great toll on health professionals. It is thus necessary to be attentive of the increase in the physician suicide rate, for it is higher than that of the general population (Santa & Cantilino, 2016). During data collection at the hospital, a health professional attempted suicide, within the hospital itself. It was not related to the departments we were researching; nonetheless, this fact demonstrates the great extent to which special attention to such professionals is necessary, for they could be experiencing great suffering yet remaining silent as to their personal agony. Furthermore, such a fact causes commotion among the other professionals, who, moved by the situation, identify with the suffering.

The Physician's Oath states, "The health and wellbeing of my patient will be my first consideration" (World Medical Association, 1948/2002). This oath puts the professional's health, at best, in second place. However, if physicians (and nurses can also be included here) are not healthy, mentally or physically, then how can they fully care for their patients? It is necessary to be attentive of health professionals, for the mental distress inherent to hospital work can lead to somatization, absenteeism and the development of mental

disorders such as anxiety and depression. Emotional distress, responsibility for providing care, fear of committing errors, contact with pain and suffering, and fatigue make up a complex scenario in relation to health professionals and characterize an occupational situation that has significant psychological repercussions and results in feelings of dissatisfaction (Kilimnik, Bicalho, Oliveira, & Mucci, 2012), as illustrated by the following statement by a physician:

> *Very stressful, and all my colleagues show signs of stress all the time; there are people that become ill, people that request dismissal, people that ask to leave, people that present a psychiatric medical certificate to get out of the emergency department; nobody knows that, right? No one knows what doctors are like; I think even society doesn't know, and it doesn't recognize the importance of the emergency department; you only recognize its importance when you're ill, severely ill; society doesn't remember those who are in the emergency department; it only remembers when a fatality like this occurs.* (P13, ED)

The strategies that health professionals use to minimize work stress consist of individual resources that each person has. However, such strategies are not always effective, potentially leading to problems for those who are unable to endure everyday situations without the help of others (Kohls eta al., 2017). Individualization of suffering gives rise to solitary solution-seeking efforts that often are nothing more than acts of pouring out one's heart and informal friendship-based conversations (Santos & Moreira, 2014). The institution needs to perceive health professionals' stress as a challenge that requires coping strategies capable of reducing such stress, through permanent or continuing education or via health-promoting initiatives (Simões et al., 2015).

Moreover, the worker's health must be considered a public issue rather than an institutional, hospital-specific issue. The increase in job-related mental disorders makes it necessary to consider public policies that involve three Brazilian ministries: the Labor and Employment Ministry, the Health Ministry and the Social Security Ministry, which need to formulate operating-plan initiatives that solve the aforementioned problems. The effectiveness of this process depends on a global approach; i.e., it is pointless to implement individual-focused interventions that do not modify illness-producing working conditions and work organization (Lancman, Toldrá, & Santos, 2010).

Work in the Field of Emergency Services: The Emergency Department as a Source of Mental Illness

Stressors can be tied to the institutional context, highlighting the great patient demand, the work overload, the insufficient number of professionals for the sector, and the lack of material resources. Stress can also be related to the way the work process is organized and to interpersonal relationships established between health professionals and between health professionals and patients and their companions (Simões et al., 2015). For these reasons, it is necessary to discuss work in the field of hospital emergency services separately from work in the medical clinic. This is because during data collection it was perceived that, although the death and end-of-life processes of patients cause health professionals to suffer, in the emergency department their suffering is tied much more to the environment of the department than to death itself, for there is simply no room for elaborating death in the midst of so many other problems that the professionals must deal with. Meeting the high patient demand is a constant, stressful challenge for such professionals.

Patient deaths are not the biggest problem in the emergency department, as was related by the professionals. Among the units, the emergency department's singular organization emerges as an important factor that differentiates them. Death produces suffering in the emergency department when it is more closely related to tragic, exceptional situations involving young patients. In other cases, death is obscured amidst the great demand that must be met. The professionals feel they have reached the limit of

their energies, exhausted by the intense pace and discouraged with any possibility of change, as one observes in the following accounts:

> It's really intense! It's very stressful, and it used to be calmer . . . but now it's a tight schedule; the emergency-room patient demand has increased immensely. The pressure is increasing more and more all the time: external pressure to send us more patients and internal pressure because there's nowhere to put anyone anymore. . . . Nobody's able to cope with the emergency room anymore; bearable limits have been exceeded for a long time now . . . Lately, mental health is shakier because of everything I just mentioned, because of pressure from all sides. Everybody, I think practically 100% of my colleagues in the emergency department want to get out of here, because they just can't take it anymore. . . . I don't want to stay here anymore. I've already told the hospital's administration that I've reached my limit and that I also intend to be transferred to some other place. (P14, ED)

> I think that if you were to ask me what the emergency department's greatest problem is, I think it's the stress, not from death, but from the suffering . . . You have to provide full care, and you know you'll only be able to provide 80% because the infrastructure doesn't allow for that, and the patient wants 120%. . . . The main problem in relation to working in the emergency department is the stress, and the perception that the boat you're in is punctured, but you have to keep rowing, so the mental health of those who work here is greatly affected by this. (P9, ED)

The accounts presented above are extremely shocking, for they demonstrate professionals under great stress that are completely discouraged about remaining in the unit, no longer enjoying their work activities, which can lead to occupational hazards. What also stands out in the accounts is that there is no motivation for other professionals to begin and/or keep on working in the emergency department, especially among physicians, thus reducing the number of professionals and increasing the workload for those who remain, for example increasing the number of duty shifts during the swing shift. The emergency department requires vast knowledge and work methods for dealing with emergency-care situations. This unit differentiates itself through work involving limited time, countless tasks, and clinical situations involving patients that require quick treatment in order to reduce the imminent risk of death (Kohls et al., 2017). Working under conditions of urgency and emergency can contribute to increasing one's exposure to occupational hazards, for in most cases the ED setting is a highly stressful, risky environment for the staff (Loro & Zeitoune, 2017).

In the data we collected, most of the participants mentioned a high level of stress due to the work performed in the emergency department, especially in relation to the work overload resulting from overcrowding. They know and feel that the great demands of the job could be affecting their mental health. Nonetheless, when asked (in the interviews) about how they keep themselves healthy and/ or take care of their mental health, most of them mentioned leisure activities or personal conversations with friends or family members.

With respect to factors that affect a professional's mental health, ten of the participants (over 58%) mentioned stress. Physical and mental fatigue and overload are associated with work that involves high job demands, and one may infer, from the context of the interviews, that such symptoms are also related to overcrowding of the unit. Frustration and impotence were mentioned due to the difficulty of providing better-quality health care, while anxiety and dissatisfaction were cited in relation to the lack of hope for changes in the work organization. The participants also mentioned the little time they have with the patient because of the large number of patients hospitalized, a fact that impairs humanized health care in the unit, thus demonstrating that such a work-intensification process, which is harmful to mental health, has an impact on the

care provided and on health care that is focused on the users of the service. There is a lack of time for listening to patients and their companions or even exchanging information with the entire staff, which can jeopardize the safety of patients requiring interventions.

With respect to the attention the participants give to their own mental health, only one physician mentioned that he attends therapy sessions conducted by a qualified professional so as to keep himself mentally healthy. Another physician reported taking an antidepressant drug in order to be able to handle the excessive workload. In the participants' accounts, one observes a greater amount of individual leisure strategies or informal conversations, aimed at attempting to maintain their well-being. Regarding group strategies in the workplace, some participants cited using humor – via playing around with colleagues or telling jokes – to tone down the "heavy" atmosphere. Nonetheless, organizational strategies that could contribute to reducing stress were not mentioned.

Several physicians' accounts are so intense that one may infer that the professionals could be suffering from burnout syndrome, which is characterized by emotional exhaustion, reduced physical capacity, emotional fatigue, depersonalization and low professional performance. This is different from mere stress, for it is a response to chronic occupational stress, involving negative attitudes and behavioral alterations related to the workplace environment (Ferreira, Aragão, & Oliveira, 2017). Mental disorders and suffering are made up of subjective and individual aspects, which makes it difficult to understand them. The dividing line between suffering and mental disorders is vague (Lancman et al., 2010); hence, identification of the symptoms of mental distress and depression is extremely important so that action can be taken to prevent the illness and promote the well-being of professionals that work in the emergency department (Antunes, 2017).

Among the things reported by the professionals, several statements drew attention due to their content. A few small excerpts of significant statements that could lead one to think

in terms of harm to the mental health of these emergency-room professionals are presented below:

> When we're overcrowded to that extent, the highest level, we get more stressed out, we get more short-tempered; I'm tired of, when at that level of stress, calling the pharmacy and chewing everybody out . . . we just don't go nuts because we lay our head on the pillow [at night] and think, "I gave my maximum". (N13, ED)

> I've already seen an employee having a psychotic outburst, a doctor having a psychotic outburst, hysteria; I don't know if you've ever heard of this, but it happens; it happens in the everyday routine, but it doesn't appear in the media; so, the mental health of the emergency-room staff and physicians is indeed greatly affected. (P11, ED)

Based on the aforementioned, one can appreciate the great extent to which such professionals need to be cared for, either by the institution itself or by other professionals that are qualified to implement an intervention in the unit, as well as recommending individually seeking qualified help when necessary. It is essential to make it possible to assimilate knowledge about the reality the professionals are a part of. Old habits dictated by outdated work processes can be transformed insofar as the professionals perceive themselves to be individuals that are a part of the work process (Loro & Zeitoune, 2017). On the other hand, work restructuring accentuates rejection of the notion of work as a value, as an act that spans across social relations, as production that is necessary to human existence, consolidating the reordering of financial strategies along the lines of undermining both the guarantees and the human aspect of work (Ferreira & Santos, 2017). One must thus focus on the importance of implementing actions to reduce factors that cause suffering on the job, making it possible to improve the quality of life of the worker (Antunes, 2017) – actions that provide solutions, not as a specific institutional problem of the hospital, but as a public health issue evidencing

the need for Brazilian public policies. Along these lines, considering workers' health/illness and Work-Related Mental and Behavioral Disorders (WRMBDs), Semêdo (2017) stresses the importance of: expanding the psychosocial services provided by an organization's occupational health and safety staff; promoting greater interaction between Brazil's Labor and Employment Ministry, Health Ministry and Social Security Ministry for the purpose of implementing intersectoral programs to improve occupational well-being; and providing greater public incentive to conduct WRMBD-related research and studies, for all employment relations.

Conclusion

Health professionals' mental health is becoming fragile, which is indicative of a disturbing issue that should receive foremost attention in institutional organization. In the emergency department, there is overcrowding, physical space limitations, and work overload, factors that often relegate death to the status of a mere occurrence, not permitting room for feelings. In the hospital medical clinic, the staff's closeness to the patients, their identification with them and the weight of a cancer diagnosis all contribute to the professionals' suffering when a patient dies.

Regardless of the hospital department, several professionals claimed that they no longer enjoy mental well-being. Others mentioned their desire to give up the profession. Unfortunately, these health professionals only find a listening ear to get such concerns off their chest during a research interview. Their needs must receive attention institutionally, collectively and socially, as a Brazilian public health issue. For the time being, their suffering is only elaborated individually and silently, a course of action that is proving to be ineffective.

In the emergency department, despite death being a tragic experience for such professionals, they are overburdened with the department's overcrowding and physical conditions, a fact that eliminates death's role as a means for them to form closer ties with patients and their families and to engage in reflection. They are abandoning the department, requesting a transfer, because they can no longer cope with the high demands required of them. In the emergency department, the main problem is not death, but rather the amount of patients to be attended to in the corridors. The professionals are exhausted, and stress is synonymous with working in the emergency department. Regardless of how much they may like the department, the physical and mental exhaustion and the lack of recognition for their work are discouraging. Mental health falls extremely short of what it should be. This is no longer a satisfactorily healthy way to work; the professionals are already stagnating in relation to their duties, and they no longer have creative solutions or attempt to make changes. Day after day, their main endeavor is to be able to meet the demand, which is no longer possible. Death is suppressed in the midst of a routine that is characterized by countless tasks that need to be accomplished.

These professionals are not being perceived as individuals that suffer and have needs and desires. No matter how much the institution obliges periodic training, other changes in the organization are not occurring, including in relation to the need to hire more professionals to meet the demand. Furthermore, employee health must be considered a public health issue – an issue that is becoming increasingly neglected in Brazil due to budget cuts and reduced investments in health for the following decades. Quite disturbing, this scenario will degrade both the health care of the patients and the mental and physical health of the employees themselves, leaving them at the mercy of their suffering. Without effective public policies that are shared via networking among the various agencies that are qualified to handle occupational matters, it will be impossible to improve the mental health of the worker. Moreover, precarious working conditions for the health professional also make health care precarious for the patient, who remains unassisted in relation to psychosocial factors, thus dehumanizing hospital care even more. We thus call attention to the invisibility

of workers' suffering. It is absolutely necessary to redefine strategies and implement initiatives that are coherent with the professionals' needs, aiming at greater job quality and, consequently, improved mental health.

We stress the importance of further studies concerning WRMBDs. Also, the present study is limited to two hospital departments alone. We thus recommend a more comprehensive survey of factors that are harmful to health professionals' mental health in future studies, for such professionals have been undergoing suffering that is socially unperceived and disregarded.

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