

## A percepção de residentes multiprofissionais da área da saúde sobre o processo de morte

### Healthcare multiprofessional residents' perception towards the dying process

### Percepción de residentes multiprofesionales de la área de salud acerca del proceso de muerte

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**RESUMO:** A morte e o processo de morrer estão constantemente na rotina dos profissionais de saúde, porém, estes nem sempre estão preparados para lidar com estas questões. O objetivo do estudo é verificar a percepção dos profissionais residentes da área da saúde sobre a morte. Trata-se de uma pesquisa descritiva exploratória de abordagem quantitativa, realizada com 129 residentes em um hospital terciário, e contemplou nove profissões, com predominância feminina e idade média de 25anos (desvio padrão de 2,1 anos). Foi aplicada a Escala de Avaliação do Perfil de Atitudes Acerca da Morte (EAPAM). A maioria dos participantes (63%) apresentou aceitação neutra em relação à morte, seguido de aceitação religiosa (16%). Em terceiro lugar está o medo da morte (11%). Por último, o evitamento e a aceitação de escape tiveram resultado similar (5% cada). O perfil de atitude do profissional em relação à morte pode contribuir com o desenvolvimento da Síndrome de Burnout, prejudicando sua saúde e qualidade do serviço prestado.

**Palavra-chave:** Morte, Educação em relação à morte, Profissionais da saúde, Regulação emocional.

**ABSTRACT:** Death and the dying process are constantly in the health professionals' routine, though they are not always prepared to deal with those issues. The objective of this study is to check the healthcare resident professionals' perception of death. It is a descriptive exploratory research with quantitative approach made with 129 residents in a tertiary hospital, and it covered nine professions, with female predominance and average age of 25 (standard deviation of 2.1 years). The Death Attitude Profile Revised (DAP-R) was the instrument used. Most participants (63%) had

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neutral acceptance of death, followed by religious acceptance (16%). In third place is the fear of death (11%). At last, the avoiding of death and the escape acceptance had similar results (5% each). The professional's attitude profile toward death can contribute to the development of the Burnout Syndrome, which is harmful for their health and for the quality of the service done.

**Keyword:** Death and Dying, Death education, Health professional, Emotional regulation.

**RESUMEN:** La muerte y proceso de morir están constantemente en la rutina de profesionales de salud, pero no siempre están listos para hacer frente a esas cuestiones. El objetivo del estudio es verificar la percepción de profesionales residentes del área de salud sobre la muerte. Se trata de una investigación descriptiva exploratoria con abordaje cuantitativa, efectuada con 129 residentes de hospital terciario, e incluyó nueve profesiones, con predominio del sexo femenino y edad media de 25 años (desviación estándar de 2,1 años). Se aplicó la Escala de Evaluación del Perfil de Actitudes sobre la Muerte. La mayoría de los participantes (63%) tuvieron una aceptación neutra en relación a la muerte, seguido de aceptación religiosa (16%). En tercer lugar encuentra-se el miedo (11%). Por último, evitación y aceptación del escape obtuvieron resultado similar (5% cada uno). El perfil de actitud del profesional en relación a la muerte puede contribuir al desarrollo del Síndrome de *Burnout*, perjudicando su salud y calidad del servicio prestado.

**Palabras clave:** Muerte, Educación com relación a la muerte, Profesionales de la salud, Regulación emocional.

## 1 INTRODUCTION

Since the early days, the theme death follows man<sup>1</sup>, although, despite being an ancient phenomenon of nature, it still remains without a gold standard definition<sup>2</sup>. Death is seen as a universal experience, which must be considered as part of the human experience, even though each person faces it alone and in a particular way<sup>3</sup>.

Different cultures have always sought answers to the mystery of death through myths, philosophy, art, and religion<sup>1,4,5</sup>. This way, due to the great variety of cultures that existed in the world and the change of thought through the centuries, different ways of facing death and dying through the various periods of history are distinct<sup>6</sup>.

In the Middle Ages, death was an event that involved the whole community. The dying man himself, when he became aware of his death, gathered himself with his relatives, friends and neighbors meeting the ritual of asking for forgiveness for his sins, bequeathing his goods and taking all necessary precautions for his burial<sup>1,7,8</sup>.

From the XI century, man began to seek assurances for the afterlife, through rites of absolution of sins, prayers, alms, donations and masses. The following centuries, in Europe, are marked by the period of the Black Death, in which there were plagues and epidemics in all the regions. At that time, burials were carried out outside the city walls, and whenever possible, cremation was done. Between the XIV and XVIII centuries, death was seen as a threat to all in the same way, being most important to guarantee life after death and the salvation of the soul<sup>8</sup>. At this moment, it was sought progressively to isolate, separate, and exclude the dead from the living<sup>9</sup>. In the second half of the

XIX century, death came to be seen as shameful and became veiled<sup>1</sup>.

With the development of health practices in the XX century, the patterns of falling ill and dying have changed. Currently, death is institutionalized and medicalized, and high-tech devices are used to keep the body of the patient functioning. Because we are part of a capitalist culture, the patient is marginalized because he/she has lost his/her functional role. In this way, there is a need to hide death and the dead of society, justifying the fact that this occurs in the hospital environment in the present day<sup>6,10</sup>.

However, one of the aggravating factors of our culture is that health professionals are unprepared to deal with issues related to death and the dying process<sup>11</sup>. According to a study by Silva Junior et al.<sup>6</sup>, the feelings commonly aroused by health professionals in the face of death are frustration, sadness and impotence, which arise as a result of their own oriented formation, which is usually directed towards recovering life. For Campelos<sup>1</sup>, doctors and nurses who are commonly in contact with terminally ill patients show, often, avoidance behaviors and other forms of self-protection, tending to abandon them because they cannot cope or feel powerless.

Occupational risks in hospital units are due, in particular, to the direct assistance provided by health professionals to patients at various levels of severity, to the emotional tension arising from living with pain, suffering and, often, loss of life<sup>12</sup>.

Thus, death, the process of dying and grief are constantly in the routine of health professionals<sup>1</sup>, since they have a greater contact with the patient, accompanying him/her until his/her death and taking care of the body<sup>5</sup>. These professionals, therefore, are subject to chronic stressors and psychic impairments, caused by their own occupational daily life, which results in vulnerability to risks, physical illnesses and grievances, stress and mental suffering<sup>7,13</sup>.

In order for end-of-life care to take place in a more dignified way, it is necessary for health professionals to reflect on and question the rite of passage from life to death and to recognize what disturbs them most and awakens uncomfortable fears and feelings, preventing a behavior of escape and avoidance of the patient at the end of life or that the professional himself/herself gets sick<sup>5,14</sup>.

Considering this, the relevance of the present study is the need to discuss the issue of death and dying. The American Occupational Therapy Association<sup>15</sup> describes occupational performance as the act of performing and achieving a selected action (performance skill), an activity or occupation and the results of the transactional dynamic relationship between client, context, and activity. Within performance skills there is the capacity for emotional regulation, which can affect the ability of an individual to respond effectively to the demands of the occupation<sup>15</sup>. That is, the occupational performance of the health professional may be related to his/her capacity for emotional regulation in situations of death and dying. It is necessary, then, to mount the reflection on this theme and

to discuss the need of an intervention with the professionals working, of continuing education or when they enter the hospital scenario in order to elaborate strategies that aid in the capacity of emotional regulation and, consequently, that it improves its occupational performance before a situation of death in the work environment, reducing occupational risks.

## **2 DEVELOPMENT**

### **2.1 Objective**

This study aims to verify the perception that the residents of the health area have about death.

### **2.2 Methodology**

This is a descriptive-exploratory research with quantitative approach, carried out with 129 residents of the Multi-professional Residency Program in Hospital Care (PRIMAH) of a tertiary hospital in southern Brazil. Initially, the questionnaire would be applied to all 137 residents in activity at the time of the study, however 8 chose not to participate. This is a post-graduation with specialization level, which lasts two years. Currently, in this program of residence are available six areas: cardiovascular; urgency and emergency; women's health; adult and elderly care; child and adolescent care; oncology and hematology. There are vacancies for the following professions: nursing, clinical pharmacy and biochemical pharmacy, physiotherapy, nutrition, dentistry, psychology, social work and occupational therapy.

Data collection was carried out from February to April 2015, through two self-applied instruments: a sociodemographic questionnaire and the Profile Rating Scale of Attitudes About Death (EAPAM). After approval by the Research Ethics Committee (n° 931.188 of 01.11.2015), data were collected during the academic activities of the residents.

The Sociodemographic Questionnaire, elaborated for the present study, contains nine items, relevant for outlining the profile of the participants of the research.

The Profile Rating Scale of Attitudes About Death (EAPAM) is the portuguese version translated and validated by Loureiro<sup>16</sup> of the Death Attitude Profile Revised, by Wong, Reker, and Gesser<sup>17</sup>, which in turn, is a revised and expanded version of the earlier version of 1987 of the same authors<sup>5</sup>.

The responses of EAPAM cover five dimensions: religious acceptance, neutral acceptance, acceptance of escape, fear of death, and avoidance of death. This scale consists of 32 items, with Likert type structure, from 1 to 7, where 1 = completely disagree and 7 = strongly agree<sup>3</sup>. For each

dimension, it is also possible to have an average score that can be calculated by dividing the total score by the number of items that form part of each dimension<sup>17</sup>.

Data from the questionnaires applied were recorded in Microsoft Excel 2010 spreadsheets and the analysis was performed using the simple descriptive statistics method, with raw data analysis, frequency, mean, median and percentage.

### 2.3 Resultados

The sample consisted of 129 participants, as presented in Table 1, and eight invited residents did not agree to participate. The mean age was 25 years old, ranging from 22 to 35 years, and 93% of the participants (n=120) were female. In relation to the marital status, there is a predominance of singles (80%; n=103). With regards to religion, 50.3% (n=64) are catholic. The majority of participants (75%; n = 97) came from the state of Paraná.

**Table 1.** Demographic characteristics of the population

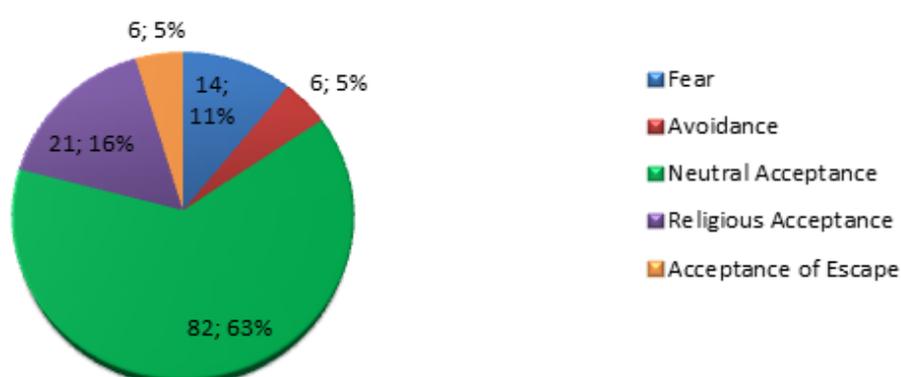
Variables	Participants (n=129)	
	N	%
Sex		
Female	120	93,02
Male	9	6,97
Marital Staus		
Single	103	79,84
Married	21	16,27
Others	5	3,87
Religion		
Catholic	64	50,39
None	28	22,04
Evangelical	13	10,23
Spiritist	12	9,44
Agnostic	6	4,72
Others	6	4,72
Origin		
Paraná	97	75,19
São Paulo	7	5,42
Santa Catarina	6	4,65
Others	19	14,72

The numbers of professionals of each category and area are shown in Table 2. Most graduated in the year 2012 and the average experience in hospital setting was five months before entering the residence. There were 38 (29.5%) participants who had completed their two-year residency (R3), 40 (31.0%) are in the beginning of the second year (R2) and 51 (39.5%) just entered the course (R1).

**Table 2. Professional Profile**

Variables	N	Participants (n=129)
		%
<b>Professional category</b>		
Nursing	17	13,17
Biochemical pharmacy	8	6,20
Clinical pharmacy	17	13,17
Physiotherapy	21	16,27
Nutrition	18	13,95
Dentistry	2	1,55
Psychology	27	20,93
Social service	2	1,55
Occupational therapy	17	13,17
<b>Program</b>		
Adult and Elderly Care	34	26,35
Oncology and Hematology	30	23,25
Urgency and emergency	22	17,05
Cardiology	18	13,95
Attention to Women's Health	14	10,85
Child and adolescent health care	11	8,52

Most of participants (n=82; 63%) presented neutral acceptance of death, followed by religious acceptance (n=21; 16%). In third place is the fear of death, which accounted for 11% of the sample (n=14). The avoidance and acceptance of escape had the same result, presenting 5% (n=6) of the sample each. These data are exposed on Graphic1.

**Graphic 1. Overall result**

According to Wong et al.<sup>17</sup> there are two types of attitude towards death: acceptance or fear, that is, man accepts or fears his/her death, taking into account the way he/she lived and accepted his/her journey through life and meanings which was attributed<sup>3</sup>.

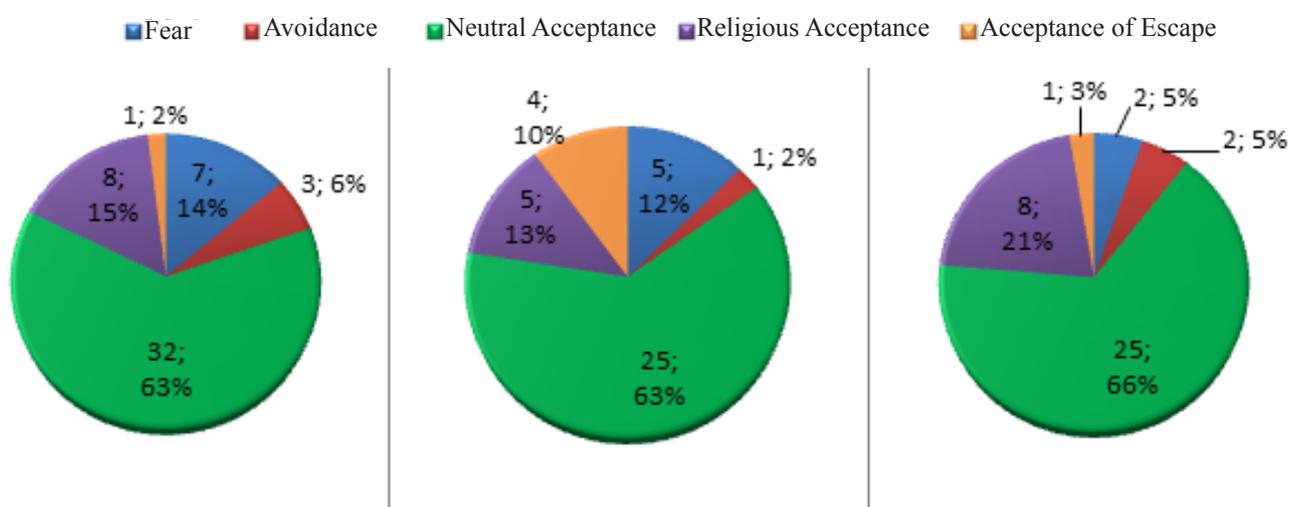
In neutral acceptance, death is understood as an integral part of life. An individual with this

kind of acceptance does not fear death, but does not desire death either<sup>16</sup>. Religious acceptance implies a certain religious and/or spiritual belief in a life full of happiness beyond death, happiness that will be eternal<sup>17</sup>. In the acceptance of escape death arises as a flight from suffering, that is, it is when the conditions of life bring pain or suffering to the most diverse levels and death can mean relief or an alternative escape to earthly difficulties<sup>16</sup>.

The fear of death would emerge from the inability of the individual to find a personal and objective meaning for his/her life and death. The avoidance of death is when the individual avoids any contact, thought or attitude about death in order to reduce anxiety before death<sup>17</sup>.

In the results per year of residence experience (Graphic 2), the predominance of neutral acceptance before death was maintained, with a higher percentage of residents who completed their two-year residency (R3), with 66%. Both the residents of the second year (R2), and those who have just entered the residence (R1), 63% showed neutral acceptance. Regarding religious acceptance, 15% of R1, 13% of R2 and 21% of R3 presented this type of acceptance. Acceptance of escape was higher in R2, corresponding to 10%, in R3 are 3% and in R1 only 2%. The fear of death appeared more in the R1, corresponding to 14%, followed by 12% of R2 and only 5% of R3. Avoidance also occurred more in R1, being 6%, followed by R3 with 5% and R2 only 2%.

**Graphic 2.** Results by Year of Experience in Residence

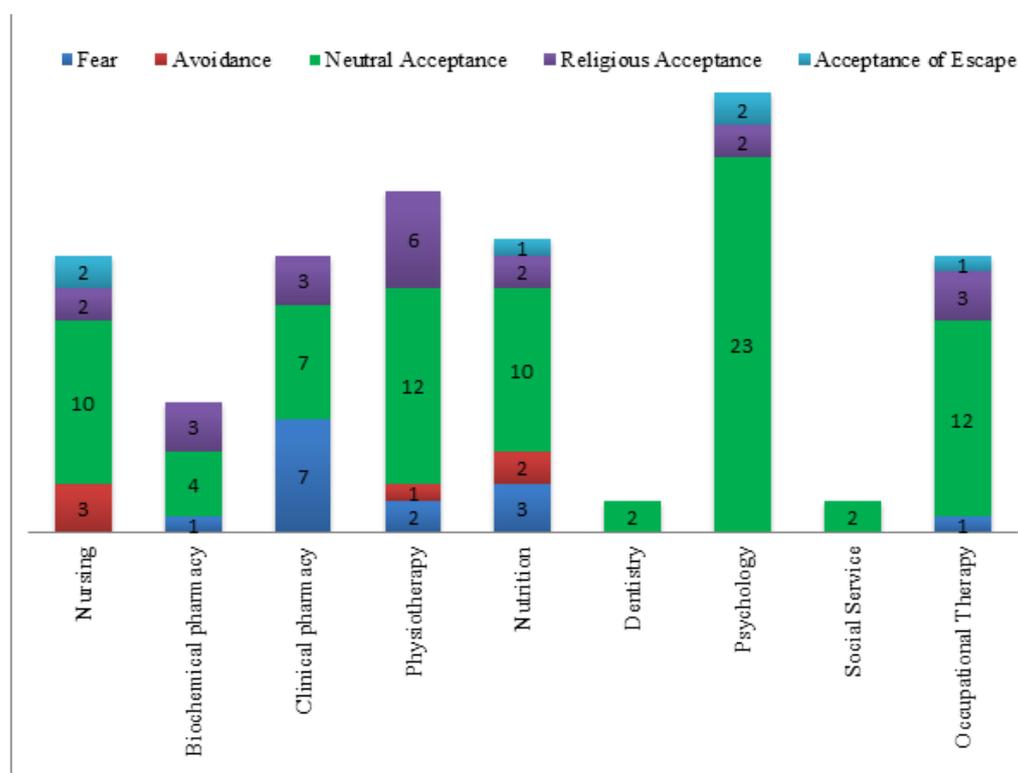


The graphic on the left represents the R1 (residents who have just joined the residence), the middle graphic represents R2 (residents starting the second year); and the graphic on the right represents the R3 (residents who are completing the second year).

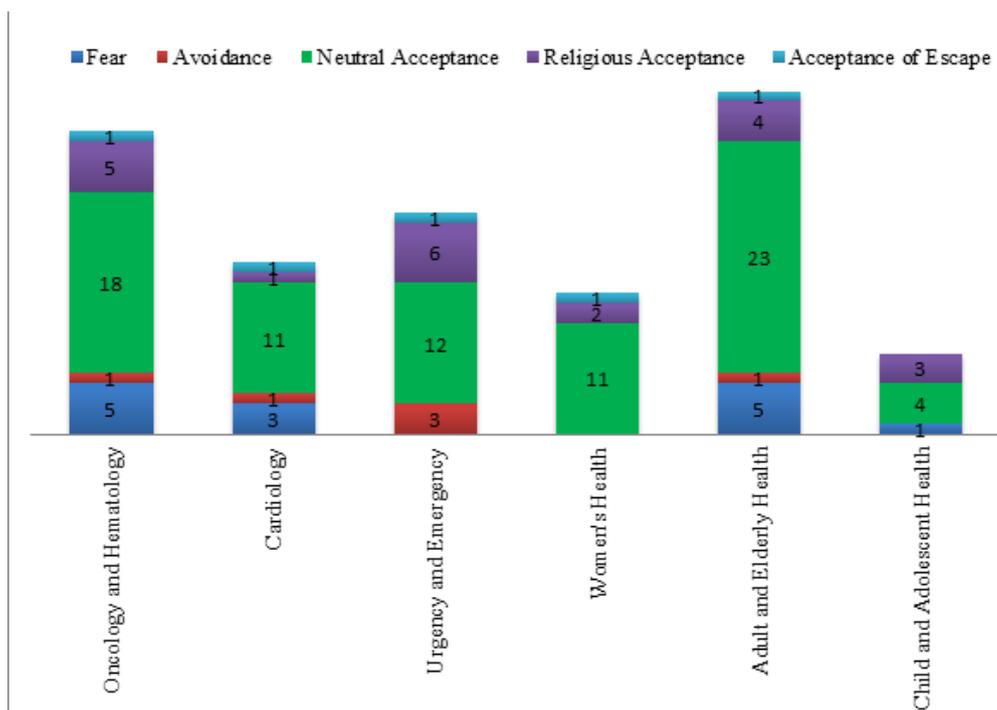
Also in the results by professional category, neutral acceptance appeared predominantly (Graphic 3). In nursing, 10 (58.9%) presented neutral acceptance, 2 (11.7%) religious acceptance, 2 (11.7%) acceptance of escape, 3 (17.6%) presented avoidance and did not appear fear. In the Biochemical Pharmacy, only 1 (12.5%) showed fear of death, 3 (37.5%) had religious acceptance and 4 (50.0%) neutral acceptance. The Clinical Pharmacy was the profession with the highest

number of professionals who presented fear of death, totaling 7 (41.2%), the same number of those who presented neutral acceptance (7, 41.2%), and 3 (17.6%) religious acceptance. Among the physiotherapists, 12 (57.1%) presented neutral acceptance, 6 (28.6%) religious acceptance, 2 (9.5%) presented fear and 1 (4.8%) avoidance of death. The two (100%) dentists of the group presented neutral acceptance, as well as the two (100%) of the social service. Psychology only showed acceptance of death, with 23 (85.2%) presenting neutral acceptance, 2 (7.4%) religious acceptance and 2 (7.4%) acceptance of escape. Among occupational therapists, 12 (70.6%) presented neutral acceptance, 3 (17.6%) religious acceptance, 1 (5.9%) acceptance of escape and 1 (5.9%) fear of death.

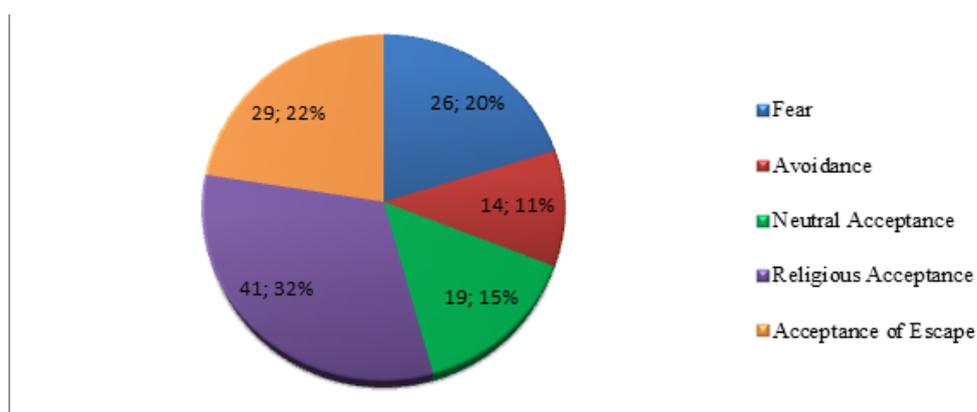
**Graphic 3.** Result by occupation



Graphic 4 shows the results by area. In Oncology and Hematology, there were 18 (60.0%) participants with neutral acceptance, followed by fear of death and religious acceptance, with 5 (16.7%) professionals in each. In cardiology 11 (64.7%) professionals presented neutral acceptance, followed by 3 (17.6%) with fear of death. The Adult and Elderly Health Program also had neutral acceptance followed by fear of death, with 23 (67.6%) and 5 (14.7%), respectively. Urgency and Emergency had 12 (54.5%) professionals with neutral acceptance, followed by 6 (27.3%) with religious acceptance, as well as in women's health, which had 11 (84.6%) and 2 (15, 4%), respectively. In the Child and Adolescent Health program, 4 (50.0%) professionals were neutral, 3 (37.5%) were religiously accepted, and only 1 (12.5%) presented fear of death.

**Graphic 4. Result by Area**

The results were analyzed more in-depth, considering the dimensions that would be the second most scored in each professional. Graphic 5 shows these results in general, with 15% (n=19) of the participants having neutral acceptance as the second most scored, 32% (n=41) showed religious acceptance, 22% (n=29) presented escape acceptance, 11% (n=14) have as an attitude avoidance and 20% (n=26) presented fear of death as the second most punctuated dimension.

**Graphic 5. Secondary Results**

## 2.4 Discussion

As seen in the results, the vast majority of residents presented neutral acceptance before death. This type of acceptance of death is characterized by a more naturalistic approach<sup>118</sup>, and people who have this form of acceptance tend to work better adapted because death is seen as something unalterable and inevitable in their lives, thus achieving, living with quality and making

a satisfactory use of their days<sup>17</sup>. In this research, religious acceptance appeared in second place, with 16%, followed by fear, with 11%. Some authors claim that the fear of death is lower in individuals with strong religious convictions, regardless of whether or not they defend their full belief in a continuity of life after death<sup>8</sup>. Acceptance of escape and avoidance were tied, with the least appearing, with 5% each. In the acceptance of escape, death is not necessarily felt to be good, but life is felt to be evil and avoidance is considered a psychological defense mechanism to prevent the theme from reaching consciousness<sup>8</sup>. We can associate this fact to the very context in which the research was done and where the residents perform their work, because it is very difficult to avoid death or to get in touch with the suffering coming from the sickness being in a tertiary hospital.

The fear of death was most evident in R1. We can infer that the R1, because they did not have or had very little contact with the hospital context, did not experience death in their professional life, which is a mystified subject and little discussed, which creates fear. On the other hand, the R3, by spending 2 years in this context, and experiencing death in their work environment, managed to demystify and improve the elaboration of this phenomenon. An indication of this improvement may be the percentage of neutral and religious acceptance in R3 (66% and 21%). What is worthy of attention are the high values of escape acceptance in R2 (10%) and avoidance in R1 and R3 (6% and 5%). These values may be associated with the discourse dissociation defense mechanism, negation or rationalization. This way, the emotional attitude reveals a difficulty in facing the death situation, unlike what is seen in the discourse<sup>19,20</sup>.

When we analyze data by profession, we perceive that all professional categories presented neutral acceptance as predominant. However, it is worth mentioning some findings. Psychology was the only profession that presented only forms of acceptance of death, followed by Occupational Therapy, with only 1 professional presenting fear. In Nursing, 3 residents present the avoidance of death attitude. In the clinical pharmacy the number of professionals who presented fear is quite high, being equal to those that have neutral acceptance, that is, 7 pharmacists. These data are relevant, since health professionals with high levels of emotional exhaustion are not satisfied with their employment and feelings of self-depreciation, besides presenting greater consumption of alcohol and drugs, more sleep disorders, greater difficulties in communicating with patients, and a greater desire to stop exercising their profession in the future<sup>8</sup>.

According to Vachon<sup>3</sup>, in 1987, there is a strong personal motivation, or personal life purpose, associated to the choice of the professional area with the greatest exposure to death and that this can influence individual attitudes towards death<sup>8</sup>. In this sense, the resident professionals of the health of women, a program in which there are more births than deaths, presented only forms of acceptance of death. In the Urgency and Emergency program, in which there are the highest number of deaths, although there are 3 professionals who presented avoidance, the number of religious acceptance presented by 6 professionals is significant. Even with this motivation we can

3 Vachon ML. Occupational Stress in the Care of the Critically Ill, the Dying and the Bereaved. Washington: Hemisphere Publishing Corporation; 1987 apud (8).

still see that, in Oncology and Hematology, there are 5 professionals who are afraid of death and 1 presents an avoidance attitude. In cardiology there are also 3 professionals who present fear of death and 5 in the adult and elderly program.

However, when we analyze the questionnaires in greater depth, it is possible to perceive a significant change. This analysis is important because it allows an evaluation beyond the superficial, that is, for the content that is veiled by the discourse of the subject. The types of acceptance are still predominant, however, avoidance and fear become relevant, being 11% and 20%, respectively. Religious acceptance doubles its value, from 16% to 32%, the acceptance of escape that was only 5% is equal to 22%, and the neutral acceptance that corresponded to 63%, decreases to 15%. This leads us to believe that acceptance is only part of the discourse because it is not consistent with the avoidance and fear presented when the results are looked at in a deeper way. In the discourse there is present the rationalization or intellectualization, a defense mechanism that responds through the resources of the intellect, being that the emotion is repressed and is not elaborated, generating, in the long term, tension, anguish, stress and psychic suffering<sup>19,20</sup>.

Professionals from different areas are, thus, exposed to a constant and intense type of wear and tear, presenting special difficulties when facing the unpredictability of life, human frailty and patient termination. Denial remains present in health professionals who avoid terminally ill patients and talk about patients' deaths or feelings aroused in them when they occur<sup>21</sup>. Kubler-Ross<sup>22</sup> questions how it would be possible for a health professional to help a terminal patient if he himself does not face death with serenity. As presented in the study by Steinhauser, Clipp, McNeily, Cristakis, McIntyre, & Tulsy<sup>4</sup>, in 2000, there is a sense of sadness and guilt on the part of team professionals towards patients who died in distress<sup>8</sup>.

Therefore, depending on the attitude profile that the professional has before death, he/she may manifest factors considered to be risk factors for the development of the Burnout Syndrome, such as emotional exhaustion, depersonalization and reduced sense of accomplishment, stress, dissatisfaction and non-elaboration of losses, which generates anguish and tension, guilt and sadness. When this happens, there is an affective cooling that interferes with your interpersonal relationship and reduces your productivity. The presence of Burnout in health professionals impairs the quality of the service provided and has consequences for the life of the worker, such as depression, absenteeism, presenteeism, and difficulties in family and social relations. The individual then becomes unable to become emotionally involved in his or her work environment<sup>23</sup>.

### 3 CONCLUSION

This study allowed to verify the perception that the residents of the health area have about the death. We were able to compare the differences between the professional categories, as well as

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4 Steinhauser K, Clipp E, McNeily M, Cristakis N, McIntyre L, & Tulsy J. In Search of a good death: observations of patients, families and providers. *Annals of Internal Medicine*. 132 (10): 825-832. 2000 apud (8).

similarities on the subject that vary according to the area of action and the population that attends in the hospital area.

In addition, it was possible to perceive that there is an apparent discourse of an attitude of neutral acceptance before death, that is, that it is understood as an integral part of life, being something unalterable. However, when analyzing the questionnaire in a deeper way, it was somewhat veiled, since there are significant percentages of religious acceptance, acceptance of escape, and fear of death. As seen, this picture can lead to the development of Burnout Syndrome, the reduction of quality of work and care provided, difficulty in relationships, avoidance, distancing of patients, absenteeism and presenteeism. Thus, the need for a careful look at the residents, with the promotion of discussion groups, spaces for reflection and sharing, welcoming, educational activities, orientation on stress and coping strategies and prevention of Burnout is highlighted. As a limitation, it should be stressed that the questionnaire was not reapplied to the same participant at different times during his/her residence, which would enable us to verify if there is a change in attitude towards the death of the same resident during this process.

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