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Social representations of nurses about death and dying in the emergency department

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Abstract

This study aims to examine and analyze the social representations of nurses regarding end of life and dying in emergency services. It is a descriptive study, conducted from August to November 2023. Data were analyzed in light of the theory of social representations, using Iramuteq software. Interviews were conducted with 11 emergency nurses. The analysis generated seven classes, revealing that death causes suffering and a sense of helplessness, as it is perceived as a failure, reflecting unpreparedness and insecurity. Poor structural conditions often provoke feelings of revolt, and many nurses do not know how to approach patients and their families, leading them to avoid such interactions. The main representations of end of life and death are anchored in personal experiences, old age, care, and humanization. It is necessary to encourage discussion of this subject in academic and healthcare settings to prepare professionals to deal with terminality.

Keywords: Death. Nurses, male. Emergency services. Attitude toward death. Social representation.

Resumo

Representações sociais de enfermeiros sobre morte e morrer na emergência

Este estudo buscou conhecer e analisar as representações sociais de enfermeiros sobre fim de vida e morte no serviço de emergência, sendo um estudo descritivo realizado entre agosto e novembro de 2023. Realizou-se entrevista com 11 enfermeiros da emergência, e os dados foram analisados à luz da teoria das representações sociais, utilizando software Iramuteq. Da análise, emergiram sete classes, evidenciando que a morte gera sofrimentos e sentimento de impotência por representar fracasso, reflexo do despreparo e da insegurança. Precárias condições estruturais geram revolta e muitos não sabem como agir diante do paciente e de sua família, por isso evitam a aproximação. Percebe-se que as principais representações do fim de vida e da morte ancoram-se em experiências pessoais, na velhice, no acolhimento e humanização. É necessário estimular a discussão da temática em ambientes acadêmicos e nos serviços, a fim de preparar o profissional para assistir a terminalidade.

Palavras-chave: Morte. Enfermeiros. Emergências. Atitude perante a morte. Representação social.

Resumen

Representaciones sociales de enfermeros sobre la muerte y el morir en urgencias

Este estudio comprende y analiza las representaciones sociales de los enfermeros sobre el final de la vida y la muerte en urgencias. Es un estudio descriptivo realizado con 11 enfermeros de urgencias entre agosto y noviembre de 2023. El análisis de datos utilizó la teoría de las representaciones sociales mediante el *software* Iramuteq. Del análisis surgieron siete categorías, que evidencian que la muerte genera sufrimiento y sentimientos de desamparo por representar el fracaso, resultado de la falta de preparación y la inseguridad. Las condiciones estructurales precarias producen enfado, y muchos no saben cómo actuar con el paciente y su familia, por lo que evitan acercarse a ellos. Las principales representaciones del final de la vida y la muerte están relacionadas con experiencias personales, vejez, acogida y humanización. Es necesario estimular esta discusión en ambientes académicos y los servicios para preparar el profesional a actuar en el final de la vida.

Palabras clave: Muerte. Enfermeros. Urgencias médicas. Actitud frente a la muerte. Representación social.

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Research

Death arouses a lot of fear and a series of distressing feelings in the individual, being considered a taboo. The concept of death goes beyond the cessation of vital signs: it is broad and complex, and can have different meanings and confrontations according to the life experiences, bonds, religious, and sociocultural aspects of each person and group [1]. This can be understood as *the end of the human condition and of the vital, social, and psychic functions of the being and as an essential datum of human existence* [2]. End of life, nevertheless, is defined as the last days or hours of a person because of an irreversible disease, resulting in a progressive and inexorable decline, bringing it closer to death [3].

Dying is part of the life cycle of every human being. However, it is still a challenge for many health professionals, such as nurses, who, even dealing with the end of life daily, do not feel emotionally prepared to face death. This can be explained because the academic training of these professionals focuses on a salvationist model, which means that any situation that does not culminate in recovery and healing causes a feeling of frustration and failure [4].

In hospital sectors, such as the emergency department, in which all actions are aimed at maintaining life, this confrontation with death and the end of life becomes even more challenging. These are environments that are characterized by unpredictability due to a diversity of serious care, which demands from professionals specific practical-theoretical knowledge, skills, and expertise to deal with emergency situations of acute health conditions [5].

However, recently, a change in the epidemiological profile of illness in the population has been noticed, a consequence of the accelerated urbanization of aging and the increase in the technological apparatus in health, which has caused a higher incidence of chronic non-communicable diseases and neoplasms. This scenario has been reflected in the standard of care in emergency services, with a significant increase in admissions of patients in palliative care, which makes professionals experience the end of life in these places more frequently [6].

When thinking about an environment to perform care at the end of life, emergency services are not considered the most appropriate, as most of these units do not have a welcoming physical structure for this purpose, in addition to the socially constructed idea that this is a sector that has the obligation to save life at any cost. Moreover, professionals end up not being able to offer the necessary attention to that terminally ill patient and his family due to characteristics such as fast flow, high turnover, and a high workload [5,7].

In this sense, it is possible to understand their attitudes and behaviors in the face of the end of life and the death of the patient via the representations constructed by the social group and reconstructed by the nurse in his experience. The study of social representations (SR) helps to understand the processes via which individuals, in social interaction, construct explanations about social objects [8].

Thus, the study of SR on death and the end of life will help to understand these themes from the nurse's perspective to make these concepts more palpable and understand the impact on the professional's life and on the care provided to the patient and family who experience these processes. To this end, we seek to know and analyze the social representations of nurses about the end of life and death in the emergency service.

Method

This is a descriptive and exploratory field research, with a qualitative approach, which uses the Theory of Social Representations (TSR) as a theoretical-methodological reference as an approach to understanding the behavior of certain groups, in the case of this study, nurses. TSR is composed of images, symbols, and concepts that are generated by beliefs and ideas [9].

In general, SR can be characterized as elaborated and shared knowledge, favoring the construction of a palpable reality in a specific group [10]. They enable people to understand the situations that surround them, helping them to solve aspects of reality that involve its social existence [11].

The research was conducted in the emergency department of a General Hospital located in the southwest of Bahia, which provides medium and high complexity medical and hospital care, in the specialties of internal medicine, surgical, obstetric, and pediatric, on an outpatient, emergency, and inpatient basis. The participants were emergency nurses, who have already experienced death and the end of life in this sector and showed interest in contributing to the research. Professionals who worked for more than six months in the emergency service were included in the study, and those who were on vacation or away from work during the collection period were excluded.

A total of 18 nurses were invited to participate in the research, randomly, non-probabilically, and by convenience; Of these, seven were excluded due to absence from service. Thus, 11 nurses were interviewed because they had compatible schedules with the researcher, when data saturation was achieved, and was evaluated by the repetition of categories and statements, without the emergence of new subjects.

Data were collected between August and November 2023 by the main author of the study, via a semi-structured interview and a questionnaire in which the nurses' profile were identified, such as gender, age, religion, time of academic training, time working in the emergency sector, and specialization. The guiding questions prepared for the interview were: "Tell me about your experience facing death in the emergency room"; "How do you perform end-of-life care in the emergency?"; "What are the difficulties for end-of-life care in the sector?"; "What does death in the hospital emergency room represent to you?"; and "How do you feel about the end of life and death within the emergency?".

The interviews were recorded and conducted individually, in person or using the Google Meet platform, at the discretion of the interviewee, based on a semi-structured script. Subsequently, the content was transcribed faithfully, and the data from the transcriptions were entered into the lexical analysis software IRAMUTEQ (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*) and submitted to the correspondence factor analysis technique (AFC) [12].

The CFA uses a Cartesian plane that provides different words and variables correlated to each of the classes of the descending hierarchical classification (DHC) technique, enabling a more qualitative analysis of the data. The statements of the participants were coded based on the order number of the most significant elementary context unit (ECU) of each class, and the value of the association of the chi-square test with a given class [12].

For data analysis, Bardin's content analysis was used, a method that aims, via systematic and objective procedures for describing the content of the messages, to analyze and obtain indicators—which may or may not be qualitative—that enable the inference of knowledge related to the conditions of production/reception of these messages [13].

The research was approved by the research ethics committee. All participants signed an informed consent form. To ensure the anonymity of the participants, they were identified as subjects followed by numbering.

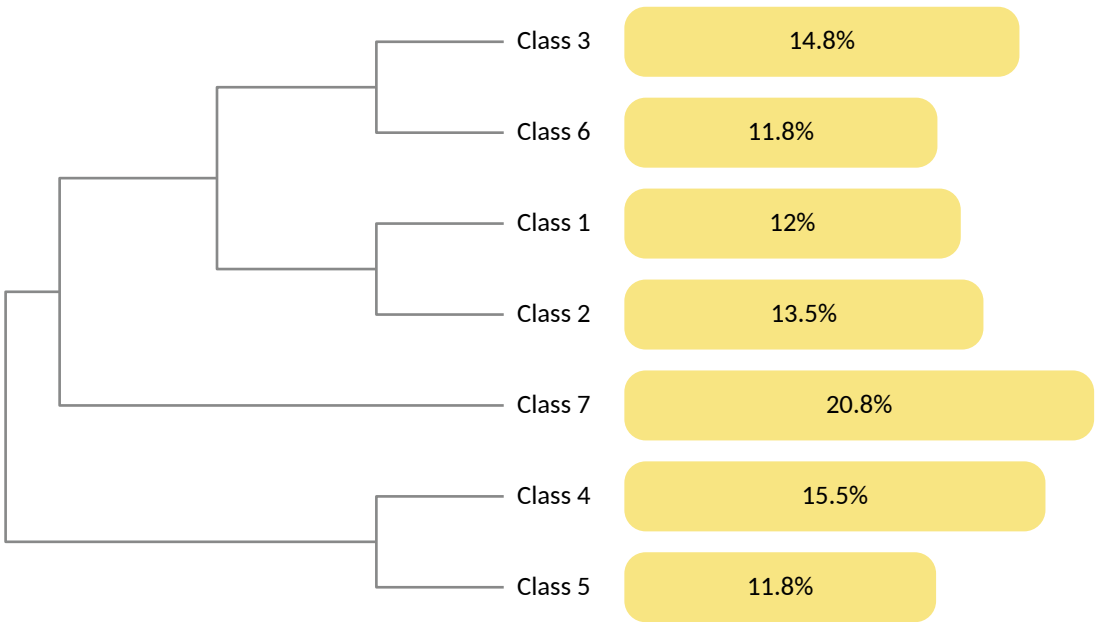
Results

Characterization of the participants

Of the 11 nurses interviewed, eight (72.7%) were female. The mean age was about 33 years, with an age range from 27 to 53 years. Five (45.5%) declared that they did not profess any religion. The time of academic training ranged from four to 11 years, with a mean of seven years, and most nurses reported having specialization (n= 7; 63.6%) in the areas of urgency and emergency (n=5; 45.5%), intensive care unit (ICU) (n=5; 45.5%), and collective health (n=3; 27.3%). Regarding the time of work in the emergency sector, the mean was about three years.

The general corpus consisted of 11 texts, separated into 451 text segments (TS), with 88.69% of the TSs being used. Figure 1 shows that 35,986,696 occurrences (words, forms, or words) emerged, and the analyzed content was categorized into seven classes: Class 1, with 48 STs (12.0%); Class 2, with 54 STs (13.5%); Class 3, with 59 STs (14.8%); Class 4, with 62 STs (15.5%); Class 5, with 47 STs (11.8%); Class 6, with 47 STs (11.8%); and Class 7, with 83 TSs (20.8%).

Figure 1. Descending Hierarchical Classification (CHD)



Class 1 – Difficulties in embracing family members who experience terminality in the emergency room; Class 2 – Unpreparedness to institute palliative care and to act in the face of death; Class 3 – Death: from the natural process of life to the feeling of professional powerlessness; Class 4 – Death in the corridor and the neglect of professionals in the face of the end of life and death in the emergency room; Class 5 – Nurses' attitudes and feelings towards the end of life in the emergency room; Class 6 – Care difficulties in the face of the experience of death in the emergency sector; Class 7 – Structural challenges to attending to terminal life in the emergency room

Class 1

Difficulties in embracing family members who experience terminality in the emergency room

This class comprises 12% (*f*=48 STs) of the total corpus analyzed. The words that emerged the most were "familiar" (x^2=64.62), "welcoming" (x^2=17.24), and "service" (x^2=36.66). This class addresses the difficulties of nurses in caring for family members who have experienced terminal life in the emergency room. However, despite the numerous care and bureaucratic demands, which generate overload, professionals seek to anchor their care for the family in embracing and humanization.

"(...) When I see the terminal patient, when I realize that the patient is in that terminal phase, I try to embrace the family member as much as possible, mainly, and give the maximum comfort to the patient as well, despite the adversities we have in the emergency" (Subject 2).

"(...) The end of life, in most cases, is very sad, it is not ideal. No end of life is ideal, right? (...) But I think that the person who is there, by the patient's side, should at least be in bed, have comfort, a more reserved bath, a more reserved moment, a brighter, less noisy environment. This changes the end of a person's life a lot (...) Not because it's bad there, but because we want to do it. It is the system itself, it is the service itself, the demand that does not allow it to be different" (Subject 7).

"(...) My difficulty perhaps (when there is a death) *is to embrace the family, this is my difficulty, I don't know if everyone has this same difficulty"* (Subject 4).

Class 2

Unpreparedness to institute palliative care and to act in the face of death

This class comprises 13.5% (*f*=54 STs) of the total corpus analyzed. The most frequent words

were "palliative" (x^2=16.36), "family" (x^2=10.33), and "nursing" (x^2=14.74). Many of the nurses interviewed reported not being prepared to approach and communicate to the family about palliative care and terminality. In addition to acknowledging the limitations of their own professional category, they reported that this is also a difficulty for the entire health team both to communicate and to institute end-of-life care in the emergency sector.

"Sometimes the patient is palliative, and none of the professionals are prepared. The multiprofessional team is not prepared, nor is the family. Another thing we see is trivialization. Sometimes there are patients who have not even determined palliative care, and then the measures of not investing in the patient begin, everything is taken away. That's a confrontation" (Subject 8).

"The second difficulty that, at least for me, is crucial is the instruction that the medical team ends up failing to give to the family. It's like this, it doesn't explain in detail, it doesn't speak the same language as the patient, it says 'palliative care', the family doesn't understand what palliative care is, and then we must explain it to the family members" (Subject 5).

There is an escape from more direct contact with family members when it comes to the end of life. Many professionals avoid facing the family at this time because they do not know how to act in the face of their reaction when informed about the death or possibility of death of their loved one. Others act in this way to preserve their own emotions, since they experience death routinely and need to be well to follow up on the bureaucratic actions of the post-mortem.

"I think the nursing team has a certain fear of what will happen in the sector, of the family screaming or crying and you don't really know what to do. At that moment you don't know what to expect" (Subject 8).

"When the family comes to talk, I try not to carry it for my life. Because as I deal with it all the time, if I take too much for myself, I will end up suffering, not that I don't feel the pain of the other, right? I see the suffering of the family, and I see how the family is when the patient is critical, so I try to welcome these patients in the best possible way" (Subject 10).

"We go to the end, but when the end comes, when the death is confirmed, I need to take steps forward from that, so, like, I need to run after the medical record, speed it up for the family, who are waiting for this body to be released" (Subject 4).

Class 3

Death: from the natural process of life to the feeling of professional powerlessness

This class corresponds to 14.8 % (*f*=59 STs) of the total corpus analyzed. The words that emerged most in this class were "change" (x^2=42.54), "life" (x^2=36.1%), and "die" (x^2=20.41). Within the emergency room, death is something constant and can generate ambiguous feelings in professionals, as evidenced by the interviewees' reports. Some, because they had to constantly deal with feelings involving the end of life, had the need to anchor death in a pre-existing thought system, less threatening. Thus, death is no longer an unexpected factor for these professionals and starts to represent a natural process of life.

"You know, since I entered the emergency department, my view of death has changed a lot. Because it ends up being something very present in our daily lives. So, for me, death today represents a phase of our life, a closed cycle" (Subject 6).

"Sometimes I feel a little helpless, and sometimes I feel like this process of death has changed a lot. With each year that passes in the emergency room, I feel that it changes, my view of death changes" (Subject 8).

"It comes a little from our culture, from common sense, to say that that person [elderly] *fulfilled their mission, that they fulfilled the entire life cycle and the time has come to grow old and die. I think that in a way it is the most expected, it is a calmer process than in the other patient who arrives due to trauma, due to sudden death"* (Subject 1).

However, there is still the understanding of some professionals that, in certain situations, regardless of what is done, death represents a failure in the team's leadership, which generates a feeling of powerlessness and failure.

"When I started working in the emergency room, death was a very bad process, because it gave the impression that it was a failure of our care process. Within the patient's needs, so I had the feeling that we could do more" (Subject 11).

"Whenever we can't save the patient's life, we always have that feeling that we could have done more, but we did everything within what was allowed at that moment" (Subject 6).

For some professionals, the years spent in the care activity made death, in the emergency sector, become a natural process, which sometimes borders on the trivialization of the end of life.

"In the emergency, death often represents sadness for us who get attached to the patient and see the suffering of the family as well. I think now it's easier, because in the past it was a matter of feeling sorry for mourning, today it's another one who died [laughs]" (Subject 3).

Class 4

Death in the corridor and the neglect of professionals in the face of the end of life and death in the emergency room

This class obtained 15.5% (*f*=62 STs) of the total corpus analyzed, consisting of words such as "corridor" (x^2=32.31), "son" (x^2=23.26), and "death" (x^2=10.92). The statements of this class reveal the reality of neglect of the multidisciplinary team regarding end-of-life care in the emergency, especially regarding some actions, or the lack of them.

"Yesterday a 34-year-old man arrived, and the doctor said: I'm not going to take you to do thoracentesis because you're going to die soon, soon. Why do that? You're going to die" (Subject 9).

"(...) *yesterday a patient at the end of life who was palliative arrived, he arrived at five o'clock in the afternoon, a companion said he was calling, he had poop up to his head and when I arrived the technician was on WhatsApp"* (Subject 9).

Moreover, the hospital is also deficient regarding the physical structure. The interviewees reported that patients spend days on stretchers and in the corridors, and some end up dying in these conditions, sometimes being perceived late by the professionals. In view of this, they feel powerless due to their inability to offer the family and the patient an environment conducive to dignified end-of-life care.

"(...) *Because think about it, your mommy dying in the hallway on a stretcher on the floor. Oh girl, it's too sad! There's no way. Even the oncological ones too, it hurts. Of course, some can go to the men's* [wing]" (Subject 3).

"(...) *He stays there and the end is right there, sometimes even on a stretcher in a corridor, when we pull him to the living room it's because it's serious, then we pull him to the living room, but we don't always put him in a bed"* (Subject 7).

"(...) *During the day, I passed in the corridor, and when I went to see him, he was already dead. So, the end of life in the emergency room for me, honestly, is to rethink what you could have done to be better, to be more human, to have given more peace"* (Subject 9).

Also, there is a lack of preparation and even a lack of empathy from some professionals to communicate bad news, which is sometimes transmitted directly, without the support of other professionals or in an inappropriate place.

"The doctor arrived around six forty, and I had arrived to receive the shift, and I was devastated by that crying, I said: 'Oh my God it is very inhumane. How do you say that to a father of a family just because you are a doctor? You're not aware that it's difficult, damn it?'. The person is having faith, believing that they will be able to stay there longer, then a professional arrives and

takes away all their hopes. It's very difficult, you know?" (Subject 9).

"(...) or he arrives very harshly and spits on the companion or even on the patient, what the patient has, he says: 'you won't live'" (Subject 9).

Class 5

Nurses' attitudes and feelings towards the end of life in the emergency room

This class comprises 11.8% (*f*=47 STs) of the total corpus analyzed. The main words were "God" (x^2=26.78), "colleague" (x^2=40.56), "strong" (x^2=22.7), and "talk" (x^2=10.66). Death, for the interviewees, arouses feelings ranging from sadness and compassion to revolt. Many report that, to protect themselves emotionally, they avoid staying with the family of patients at the end of life, in an attempt not to absorb the suffering, since death is so frequent in their daily lives. Others said that, with experience, they acquired strategies to deal with the family's pain in the face of loss, in addition to considering, at this time, the support of other professional classes, such as the psychologist.

"In the past, I used to run, I wanted to cry, I also avoided being with my family as much as possible. Depending on the situation, nowadays, I can already stay in this situation, lead the situation, the suffering. I call someone, I call the psychologist, I guide, I stay with the person and everything, and I can get stronger. Ten years ago, I couldn't" (Subject 7).

"(...) Because he has already died, and now I'm going to call the doctor to talk to you. I don't know, maybe if I had been in the High Complexity Oncology Units (UNACON), *it would be different, I would hug, kiss, I would cry together"* (Subject 3).

Thus, there is also a feeling of revolt, in the face of mistaken conduct, and insecurity due to the lack of a protocol for the care of terminal patients, especially when humanized care is not prioritized.

"Trying to be human, even in the face of very inhumane situations that we see, of us calling the doctor and him saying: 'I'm not going anymore, there's nothing else to do, let's just make a scene here'. See, you know, then we get like this... There are times when I get angry, you know?" (Subject 9).

"So the conduct is undefined, and we can't really follow a protocol, right? Give care to this patient" (Subject 4).

Nevertheless, with experience, nurses found some ways to alleviate the suffering linked to the experience of the end-of-life and death process in the emergency room. Some avoid commenting, in their homes, on the cases assisted in the hospital environment and seek to exercise spirituality. These strategies contributed to building the resilience of these professionals, even in periods as distressing as the COVID-19 pandemic, as mentioned in one of the statements.

"(...) many patients died during the period I was working on COVID, many of my colleagues got sick, and I, even so, managed to move forward, I could work, precisely for this reason, because I try to look, to have this more holistic view" (Subject 10).

"(...) But my feeling, as much as I want to be strong, to be a person who faces reality, I feel pain for the pain of the other, right? but I always ask God for direction" (Subject 10).

"(...) Even in my house, I don't talk about anything that happens here at work, absolutely nothing. Patients can die here, I don't comment at home, because I usually leave here everything I experience here, I leave it here at the hospital" (Subject 10).

Class 6

Care difficulties in the face of the experience of death in the emergency sector

This class comprises 11.6% (*f*=47 STs) of the total corpus analyzed, with words such as "experience" (x^2=22.7), "difficulty" (x^2=10.97), and "assistance" (x^2=16.67). When analyzing this class, it was found that the emergency

sector is understood as a place where people are struggling to live, and dealing with death situations, especially among younger patients, often becomes distressing. Questions also arose in relation to unexpected death in the emergency room, whether it is related to inadequate care, or if it was inevitable, issues that bring many concerns to these professionals.

"(...) In the case of a death, which is unexpected for the family, I have a little more difficulty, even because of personal experiences already lived. So I end up a little stuck in front of the family, not knowing much what to do" (Subject 1).

"I thought that the patient had the right day to die. After I entered the health area, I realized that some patients, due to lack of access, or because they did not have access at the moment, or a poor quality of care, had an early death because of this" (Subject 8).

Most of the interviewees referred to the importance of a professional conduct based on humanization, commitment and ethics, regardless of the sector in which the death occurs, which reflects personal values and principles and not only professional in the face of the end of life.

"(...) Regardless of where I am working, I think that the conduct and the assistance, should be the same" (Subject 1).

"(...) This is the person's, I think there are principles and values that are not brought from the profession, they are brought from your people, principles that you bring from your life" (Subject 10).

The interviewees reported the difficulties in assisting situations of death in a sector in which the routine is always unexpected, without an orderly flow, with a high demand for work and with behaviors that need to be conducted very quickly. The pressure and overload that pressure and overload generate makes these professionals act technically, especially when they are facing the death of a patient.

"(...) I find this flow a little disordered. I have already passed this on to the coordination, both the issue of service, the issue of improving the team, as well as the issue of trained professionals and training, so that we can improve more" (Subject 10).

"The emergency is very fast and you don't process the experience you had, because you already have to do something else, so you end up mechanizing your care a little" (Subject 8).

Class 7

Structural challenges to attending terminality in the emergency room

The latter class comprises 20.8% (*f*=83 STs) of the total corpus analyzed. The words that emerged the most were "comfort" (x^2=23.89), "space" (x^2=29.5), "environment" (x^2=21.9), and "context" (x^2=15.43). This class brings structural issues, such as overcrowding and the lack of a place that provides adequate comfort to patients and their families, thus becoming an important barrier to terminal care in the sector. Difficulties in following an internal flow in the emergency sector hinder the reception of patients and their families. The nurses brought situations from an emergency sector in which patients should stay for a short time, as it is a place where immediate care conducts and clinical observations are conducted, but patients end up staying for a long time in inadequate accommodations, in the corridors, without any comfort, and many end up dying in these conditions.

"(...) In the medication room, we see patients literally on stretchers and on the floor. In the wards, no, in the wards we still have the minimum of comfort, it's one bed per patient" (Subject 2).

"There are patients on stretchers, a few on beds, which is a very small amount. And time, that you can't get time to pay attention to that patient, to be able to make a quality visit" (Subject 11).

"So I believe that this lack of beds, this lack of convenience for patients, ends up limiting us also to provide better care at the end of life" (Subject 6).

Discussion

Assisting terminality is a challenging process, because, most of the time, caring for a patient on the verge of death and his family is an experience that arouses discomfort for the professional. Thus, anchoring death and end-of-life care in representations that alleviate the suffering of patients and their families is a way that many nurses use to deal with this painful process, as verified in this research. Anchoring in SR enables professionals to associate something strange and disturbing, such as care in terminality, with objects and notions already represented, making something unfamiliar familiar, which helps in attitudes and behaviors related to the object of representation [9,10].

SR are created from a network of relationships that seeks, in a way, to interpret some reality to create a collective position on a certain subject, task or object. This occurs, for example, through anchoring, when the individual seeks the "familiarization of the stranger". In the case of death, it is common for people's behaviors to be influenced by their culture and previous experiences to anchor their actions and feelings in the face of death, which makes the process less threatening [14].

In this sense, some nurses, in view of the inability to work at the end of life, anchor their actions in representations of personal experiences of loss, which, in a way, represents additional suffering for them, which can result in illness. This lack of preparation to take care of the family and the patient who is approaching death reflects a precarious approach and reflection on the theme in the academic training of these professionals. Thus, the clinical practice of nurses, especially in hospital institutions, is permeated by many terminal situations, making it a challenge to find the appropriate way to behave, assist, and, above all, care for patients and their families [9].

Daily, nurses experience, in their care practice, situations of intense suffering, often caused by irreversible circumstances, such as pain not relieved by the action of medications, terminality and death, which generates feelings of fragility, vulnerability, impotence and fear associated with insecurity in caring for terminality. This causes death within hospital units to be represented by negative feelings such as failure and frustration [15].

However, it was found that having greater experience in the profession makes nursing professionals develop defense mechanisms against the negative emotions that end-of-life patient care can generate. Many prioritize bureaucratic actions so as not to have to come into direct contact with the process of death and dying. These are escape strategies that nurses, due to lack of reflection, often unconsciously adopt in situations of death [16].

This can be seen mainly in units where death is part of the professionals' daily lives, such as in emergencies, where many develop strategies to better deal with these situations to reduce their own suffering [17]. In a study and in the statements of the nurses in this research, forms of coping were verified, ranging from distancing, to avoid the bond with the patient and his family, to the naturalization of the end of life, which can culminate in the trivialization of death [18].

Thus, to resolve these care inadequacies and promote the quality of life of patients and their families in the face of a threatening and terminal disease, the National Palliative Care Policy (PNCP) was instituted within the scope of the Unified Health System (SUS). Palliative care consists of a set of approaches aimed at preventing and relieving suffering, by the early identification, assessment, and treatment of pain and other physical, social, psychological, and spiritual symptoms. This must be conducted by all health professionals and be available at all points in the network, including urgent and emergency services [19,20].

However, note that there is still a long way to go to achieve truly humane and ethical care in the face of the end of life, especially in the context of urgency and emergency. In these places, the number of patients in palliative care is increasing; Therefore, it is urgent that teams create individualized and flexible care plans that preserve human dignity [21,22].

There are many difficulties reported by nurses in providing end-of-life care in the emergency room, with emphasis on the lack of ability to communicate bad news, information loaded with emotions and with great potential to change people's lives. For health professionals, it is about informing diagnoses of life-threatening diseases, amputation of limbs and, the most feared, the communication of death/end of life [21].

In this sense, communication without empathy was evidenced in the statements of the participants of this study, especially on the part of the medical team, passing on the information almost always in a technical way, with scientific terms, making it impossible to understand effectively, which is also corroborated by the literature [21]. For the communication of bad news to occur in a therapeutic way and not generate additional damage to this process of terminality, there must be a good interaction between the patient-family-team tripod [21,22].

However, the dynamics of many emergency services are not favorable for offering end-of-life care due to the difficulty of establishing a bond between the patient and the professional and the absence of a protocol that guides the practice [23]. There is also a discouragement in promoting training for professionals who work in this sector, since there is a concept that the emergency is not intended to provide this type of care [22].

Because of this lack of understanding of end-of-life care, many health professionals obstinately seek to prolong life via increasingly modern treatments, which goes against the principles of palliative care. These actions, in the practice of the professional, are anchored in culturally constructed traditions that one should celebrate life and wait for it. Death, nevertheless, in addition to making the professional think about his own finitude, is synonymous with failure, and thus must be avoided, removed, and institutionalized at any cost [24,25].

However, in the hospital environment, when an older adult dies, the acceptance of this death becomes easier, since it is understood that he has already fulfilled all the cycles of life. However, when death is unexpected, such as in younger patients, even when coping strategies are used, there is greater pain, a feeling of frustration and helplessness in nurses. This is because, socially, death is strongly anchored in old age, and for it to be better accepted, the patient must have fulfilled all his life cycles. In this way, it is understood that the behaviors and feelings caused by death depend on some variables, such as age, the bond established, and how the death occurred [14,15].

Another point that generates a lot of anguish in the nurses in this study is related to the structure of the emergency room to assist patients at the end of life. These units are environments that usually do not have a physical structure that welcomes a person who experiences terminality, as patients spend long periods in the corridors, on stretchers, without the slightest comfort or privacy. This whole scenario also causes suffering to the professionals involved for not being able to offer the care they want [5].

Note, then, that the feelings linked to death in these places are also related to the precarious conditions offered to terminally ill patients. This is because, socially, the end-of-life process is anchored in the conception that every individual should have a dignified death, with comfort, pain relief and privacy, and not offering this generates additional feelings of frustration, failure and sadness in nurses. Nevertheless, in spaces with conditions to provide privacy and a minimum of dignity for the patient's end of life, it is possible to perceive better coping in dealing with situations of professional conflicts [26].

The accelerated routine in the face of numerous consultations is another factor that disfavors the emergency sector in relation to end-of-life care, as most nurses who work in emergencies cannot provide adequate care. According to the literature, because it is a sector with a high turnover, many professionals cannot offer adequate care to those terminally ill patients due to work overload and linked to the lack of technical and emotional preparation to act in situations that cause them suffering [5].

Thus, it is understood that promoting humanized end-of-life care in urgent and emergency services goes beyond the awareness of the nursing team, covering several factors, such as hospital infrastructure, human and

material resources, and the work overload of professionals [26].

The limitations of this study regarding the small sample size and the local reality of a single public hospital make it impossible to generalize the results. However, it has the potential to contribute to the studies of death and dying in the emergency room, since, even with the growing discussion on the subject, there is a large gap in the practice of nurses in the emergency room, as most do not feel prepared to provide care adequately in the face of the end of life and death.

Final considerations

Death within the emergency sector is regular and generates suffering for nurses. Note that the main social representations of death are reflections of personal experiences and experiences. Many anchor death in old age, which makes the process more acceptable when it is understood that the individual has completed his entire life cycle and then dies; otherwise, there is a feeling of failure in care. Some nurses do not feel prepared to deal with the family and the patient about to die, and when death occurs, they use mechanisms such as escape because they do not know how to behave in front of the family member.

The results of this study show the need for a more reflective emphasis on the theme in the various curricular components in the academic education of nursing professionals. Moreover, offering structural conditions and human resources prepared and adequate for the high demand of work has a direct influence on the promotion of humanized care for patients at the end of life. Thus, more studies are suggested that seek to identify the feelings and attitudes not only of nurses, but of the entire multidisciplinary health team about the end of life and death in the emergency sector, to understand the consequences generated in care, contributing to a more sensitive and welcoming care for patients and their families who experience this moment.

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Contribution of the authors (CRediT)
Daiane Brito Ribeiro and Juliana Xavier Pinheiro da Cunha participated in the study design, data collection, analysis, and interpretation; discussion of the results. Chrisne Santana Biondo and Emanuelle Caires Dias Araújo Nunes participated in the analysis and reading of the results. Ana Clara Cunha Soares Silva and Jéssica Nayara da Silva Prado participed in data reading. All authors contributed equally to the writing the manuscript, critical review of the content, approval of the final version, and take responsibility for the integrity and accuracy of the work.

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