

Nurses' coping: dying process in palliative oncology

Conflicto del enfermero: proceso de muerte en oncología paliativa

Enfrentamento do enfermeiro: processo do morrer em oncologia paliativista

ABSTRACT

It is necessary to check if the nurses as health professionals present in all stages of the human life cycle, are you really ready – from theory to practice – to deal with and face with the finitude of cancer patients no prospect of healing and their families. To this end, the topics were analyzed: how the context of socio-cultural evolution influences the ideology, the possible coping strategies, and the burden of the nurse as a team coordinator. Elaborated from the analysis of chapters of the Medical-Surgical Nursing Treaty of 2014, reference literature in the field of international nursing articulating a parity through the review of integrative literature, through the Virtual Health Library. Selected articles in full online in Portuguese in the period from 2013 to 2018. Making up 10 articles matching the topics. It should be extended by the dimension of care associated with science the biopsychosocial means of obtaining health and need to care for those who care.

DESCRIPTORS: Nursing; Palliative Care; Medical Oncology; Death.

RESUMEN

Es necesario verificar si el enfermero como profesional de la salud presente en todas las etapas del ciclo vital humano, está realmente preparado – de la teoría a la práctica – para lidiar y encarar con la finitud de pacientes oncológicos sin perspectivas de cura y de sus familiares. Para ello, se analizaron los temas: cómo el contexto de la evolución sociocultural influye en la ideología, las posibles estrategias de enfrentamiento y la sobrecarga del enfermero como ordenador de equipo. Elaborados a partir del análisis de capítulos del Tratado de Enfermería Médico-quirúrgica de 2014, literatura referencia en el campo de la enfermería internacional articulando a una paridad a través de la revisión de literatura integrativa, a través de la Biblioteca Virtual de Salud. Seleccionados artículos completos online en portugués en el período de 2013 a 2018. Haciendo coincidir 10 artículos que correspondiera a los temas. Aunque, se debe extender por la dimensión del cuidado asociado a ciencia los medios biopsicosociales de obtención de salud y de necesidad al cuidar de quien cuida.

DESCRIPTORES: Enfermería; Cuidados Paliativos; Oncología Médica; Muerte.

RESUMO

É necessário verificar se o enfermeiro como profissional da saúde presente em todas as etapas do ciclo vital humano, está realmente preparado – da teoria à prática – para lidar e encarar a finitude de pacientes oncológicos sem perspectivas de cura e auxiliar seus familiares. Para tal, foram analisados os tópicos: como o contexto da evolução sociocultural influencia na ideologia, as possíveis estratégias de enfrentamento e a sobrecarga do enfermeiro como ordenador de equipe. Elaborados a partir de análise de capítulos do Tratado de Enfermagem Médico-Cirúrgica de 2014, literatura referência no campo da enfermagem internacional articulando a uma paridade através da revisão de literatura integrativa, por meio da Biblioteca Virtual em Saúde. Seleccionados artigos na íntegra online em português no período de 2013 a 2018. Fazendo-se condizente 10 artigos que correspondesse aos tópicos. Contudo, deve-se estender pela dimensão do cuidar associado a ciência os meios biopsicosociais de obtenção de saúde e de necessidade ao cuidar de quem cuida.

DESCRITORES: Enfermagem; Cuidados Paliativos; Oncologia; Morte.

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Sociocultural influence in palliative oncology

Considering that the professional nurse is responsible for providing continuous care to patients affected by some neoplasia, being the professional who is most present due to the demand of the care process in its holistic form, the need to understand which possible coping mechanisms used by him in his work routine when dealing with subjects that bring in his intimate sociocultural stigma to, thus, outline the promotion of new reflections, in order to improve care and make him more humanized with mutual benefits to patient-nurse-family triad, adding the possibilities of beneficial extension to society⁽¹⁾. In the daily routine, the nursing professional who deals with the patient without curative therapeutic possibilities usually "carries" feelings of frustration, helplessness, sadness, anger, among others; that hinder the process of forming their professional bond with the patient and family⁽²⁾.

The search for the understanding of the experiences of the nursing professional strengthens the dialogue about the terminality of life, which is rarely addressed since graduation and highlights the importance of how these situations that interfere in the quality of care for these patients who need assistance a lot peculiar, both in clinical and psychological aspects and also affect this professional who will offer care directly or indirectly, and who will once again interfere in patient care⁽³⁾.

This demand has a great influence on the current model of deficient academic education, where nurses since graduation, even in their training as specialists, are trained with the limited intention of only curing. In the case of palliative care, the focus is not the cure, but caring, which is the solidity of the art of nursing. Current technological advances have contributed to ceaseless healing and brings up

the other stigmatized aspect, which is the process of dying, but we must keep in mind that we do not govern science and technology in their total efficiency when dealing with the health dimension and the subjectivity of death in the individuality of each being.

The exposure of nurses to various feelings and situations involving nursing care for cancer patients raises questions about how this professional experiences such emotions, and involves critical and subjective aspects of the professional-client relationship and how this binomial influences the health process, both this patient as well as this professional. When dealing with an individual with oncological pathology itself, the taboo built over the centuries is carried over as overwhelming pathology, sometimes avoiding referring to the subject that ends up causing a greater impact on the construction of care links, if the professional nurses do not have a foundation of subjective and critical quality in their being to deconstruct the generalist and overwhelming hypothesis that perhaps reigns, unfortunately there are great possibilities for reflecting traumatically in the care of this care⁽³⁾.

Linked to these aspects, it is highlighted that the nurse in the care of cancer patients with no prospect of cure, faces daily and stands out with the proximity of the death of these patients and admits that this reality involves more than a technical issue, instead that the word death awakens a set of reactions and emotions in this professional, as a natural instinct of the human being's inner survival and socio-cultural aspect over decades. However, the term cancer is avoided by health professionals and is carried by the stigma of imminent death⁽³⁾. However, in addition to death being a frequent episode in the lives of health professionals, especially when treating cancer patients without the prospect of a cure, it is a true episode in the life

of any human being in his vital qualities⁽⁴⁾, which highlights the need to understand, understand and outline ways of dealing with the subject in a more positive and resilient way, seen as a natural part of the life cycle, and accepting that when healing is not possible it is necessary and, whenever possible, caring.

Possible coping mechanisms

Dealing with critically ill, terminal patients and those affected by diseases that often lead to great suffering due to their aggressiveness and treatment, as in some situations of oncological diseases that carry the idea of finitude directly or indirectly, proves to be a complicated task and delicate⁽¹⁾. Professionals working in oncology sectors routinely and to a great extent experience the physical and psychological instability of the patient and family of which he is a part, first because the treatment often causes adverse effects that are difficult to control, others due to the cultural stigma that carries and, supposedly, due to the morphophysiological aggressiveness of some cancers⁽³⁾. They also deal, in a palliative care environment, with the increased and expected possibilities that stand out from the life cycle of death routinely in these patients, where, however, these professionals need greater psychological support, preferably offered by the work environment, in order to minimize or eradicate diseases. susceptible to compassion fatigue, Burnout Syndrome, and others that can be characterized as defense mechanisms of this professional correlated to their mental health⁽⁴⁾.

When dealing with subjects that carry in their context a fine line and that has been gaining space in our country, a certain subtlety is needed when addressing the themes involved in these bioethical issues, which can assist in this process in health and academic institutions are the Commissions and

Ethics Committees, making it necessary to create and qualify its members. In addition, the continuing education department must propagate the role of disseminating knowledge always in the aspect of bioethical neutrality to prepare professionals in context.

The first step within the possible departments that turns to nurses' coping strategies is expressed in the cultural understanding of what it means to "have cancer", what it means to "die" and what this process entails, and the management of health institutions for the nurse to work with satisfaction. In-service education is a major factor in the development of ethical competence and the factor of developing positive attitudes towards these actions, in order to prepare the professional⁽⁵⁾. When dealing with issues such as being born, living and dying, we must also encompass and learn about the science that will help us mediate issues in an empathic, fair, autonomous and non-maleficent way, which is bioethics⁽⁶⁾, thus, it tends to positively benefit everyone involved in the scenario to be treated. There must be occupational support for the oncology professional by the institution, for example, one of the pillars of palliative care, which is the strengthening of multidisciplinary work in order to share experiences in group meetings and minimize emotional suffering, participation of specialization courses and knowledge improvement, since there is constant technological updating of therapeutic modalities in oncology and to link these growing current demands with the link to palliative care in emphasizing quality of life in situations without curative perspectives⁽³⁾.

From the moment that the nurse understands the importance of caring on all uncomfortable occasions, re-signifying the unilateral focus of prevalence of academic training that is based closely on healing, he ends up assisting the patient and family in

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a humanized way, providing the social cycle the participation of the patient's terminality process, which, although painful in several dimensions, is necessary for those involved, in return for the transition ritualization of the process of mourning death and dying. The nurse ends up feeling rewarded for providing comfort to the patient and family, generating positive feelings in this professional of recognition and usefulness⁽³⁾. This confirms that the possibility of assisting the family and the client provides pleasure to the nurse when performed in an understood and reasoned manner, acting with attitudes related to this understanding and reasoning that not all cure is available, but all care is taken. Brand as its essence, which highlights the importance of impartial reasoning, even with its subjective values that can be worked on by continuing education, ethics commissions and the restructuring of the academic model⁽¹⁾.

It appears that even the nursing professionals who claim to be in the palliative area, and in general the category alone, lack exact knowledge of palliative philosophy, and that they end up manifesting difficulties in working in the face of terminality and are mobilized for the sadness, grief and impotence for the exposure of the patient's death and dying process. Professionals who know the palliative philosophy within their objectives and coherent philosophies, maintain personal satisfaction, especially when they manage to provide adequate care and recognize that if the entire team was aware of this philosophy, continuity of care for these patients with greater quality and completeness, respecting their autonomy⁽⁷⁾.

Overload in the nurse's leadership

In addition to direct care for the patient and family, the nurse must interact with the work team with technical knowledge, emotional sta-

bility, and ethical posture, further involving the team for this care. And the team seeks and charges the nursing competencies several times, which in addition to planning and, sometimes, carrying out assistance actions, leads the team in relation to the responsibility and expectation that they create when they see him as a leader. However, it is not a simple task and divergences can be constant, favoring an increase in the level of stress and overburdening this professional, only because of the role of leader and manager who naturally engages in his profession, linking to the subjective tenuous points of oncology and palliative care, it ends up strengthening this overload⁽³⁾. In view of the situation, the importance of interdisciplinary teamwork is evident, which results in the provision of comprehensive care and decentralizes work overload, and it is also necessary for these professionals to perform forms of relaxation for themselves. The spiritual search has been presenting itself as an important coping tool strategy, which highlights some of the ways and strategies to minimize the suffering and psycho-emotional upheavals caused in the daily care and assistance of people with cancer, in addition to the connection with the numinous in its transcendence. Spirituality, whether or not it includes religiosity, has beneficial effects from the release of neurotransmitters in the body to the feeling of resilience, and it proves to be one of the possible tools in which, outside the work environment, professionals can present their real ideologies without having to maintain themselves. in the care of impartiality.

The provision of comprehensive and quality care is essential in the daily care of cancer patients without curative perspectives, in which each professional does what is best within what is within their power to mitiga-

te the effects of the manifestation of the neoplasia and its treatment, which proves that to be able to perform this role with excellence, this professional must already enter the work environment with well-being in balance with himself, so that he can act⁽¹⁾.

It is noticeable that nurses express different feelings according to the patient's age range, but the reason that leads them to awaken them is only the finitude of life. In any age group, the interruption of projects and affective relationships confront the human being to the state of being alive and leads to innumerable reflections and, even, changes, part of the finite nature despite all the cognitive, economic and social development that distances him so much from the others⁽³⁾. It is evident that each professional adopts a behavior to face the daily work in the face of cancer without a curative perspective, although most seek spirituality, hobbies and leisure activities, in addition to therapy, their way of proceeding in these situations, however, will depend on also from the baggage of each one's experiences, from his professional trajectory, his solid educational backgrounds and the connection with the current phase in his life, which he faces⁽¹⁾.

During this time of coexistence and practice of care for cancer patients and terminal situations, the nurse can react and develop behaviors and strategies as a shield in order to avoid emotional involvement with the cancer patient and, with this, hoping to reduce the possible suffering in the face of the terminality of life, however, these attitudes can only cause harm to both instead of the supposed positive effect expected⁽³⁾. In view of the peculiarities of each professional and the different coping strategies adopted, it is essential to listen and give a voice to nurses in their workplace, so that they can better deal with the demands of their occupational trajectory according to

the profile and values of each professional, team and institution⁽¹⁾.

As it is seen that the nurse's experience is then marked by conflicting situations, exposing the nursing professional to an atmosphere of feelings, mainly negative and internalized conflicts that may reflect directly or not abroad, which can cause damages that are considered in both emotional relationships as well as in the professional aspects of this individual, which may lead the nurse to withdraw from direct assistance to the patient or even to abandon the professional duties in this area, which can generate pathologies in this professional resulting from his work⁽³⁾. Some nurses may use it as a false SHIELD to face the challenges through distance or approximation, in an attempt to avoid feeling, making it possible for the patient to distance himself to the point that he and his pathology do not influence the psycho-emotional state of the professional. Another way of leaving, but which can be beneficial is the daily end of the workday, which represents the way of dealing with the daily care of critical patients. Therefore, this type of leave is seen as a way of not allowing assistance to the individual to influence their lives outside the hospital unit⁽¹⁾.

Thus, it is attempted that some nursing professionals are not emotionally and psychologically prepared to deal with the patient in finitude, and that such unpreparedness reflects in the assistance provided, so that this professional, in most cases, assumes the patient's withdrawal posture and family within the work environment⁽²⁾. Thus, it is evident that most of the strategies used by the nursing team to deal with the situation is denial and resignation in care, the search for support in the health team and the plurality and multiplicity of views on care, including the patient and family and the search for personal and professional improvement⁽⁵⁾.

Each professional, as well as each person, has their own peculiar way of facing situations of suffering and the prospect of death and that, although each has its own way of dealing with the demands of care for cancer patients, everyone feels and knows that in some moment this care experience can affect them psychologically and emotionally⁽¹⁾. When knowing the perceptions and feelings of nurses in oncology, one realizes how difficult it is not to be affected psychologically and emotionally in the face of the demands that go through technical-assistance care⁽⁸⁾, hence the importance of looking and listening in all dimensions and proposing improvements for this professional, which is so necessary in the life of all human beings.

It is pointed out that some nursing collaborators do not allow themselves to express and experience mourning in the workplace and, for some professionals, death is accepted in a calm way, as it is part of the life cycle⁽²⁾. It is complemented that it is necessary to create bonds with all patients to establish professional humanization and empathic communication, what must be balanced is the degree of this bond, but there is a need to create some degree of involvement with the being that demands your care and that this assistance is provided with quality and in an integral way⁽⁸⁾. The essence must be in the care that provides comfort for the body and the soul, as the actions must be focused on quality and humanized care, during and after the death of the patient and that family that surrounds him⁽²⁾, remembering that when the patient gets sick, sometimes it affects the structuring of family members and close ones around him in several aspects. And the same extends when the patient dies, everyone who loves, surrounds and accompanies him in this battle will feel, to some degree, those same possible anxieties, uncertainties, fears and hopes.

As recommendations for the cure or prevention of various pathologies in palliative cancer care, it was found that for these nursing professionals, using healthy personal habits, including diet, exercise, stress reduction activities, such as dance, yoga, tai chi, meditation etc, and quality sleep, help this to protect itself against the harmful effects of stress in coping with death and in the process of dying⁽⁹⁾. They also help to alleviate stressors and aggravating factors: participatory management action; permanent and/or continuing education; shared rest environments; team meetings, as already mentioned, to answer the doubts and difficulties of the professionals and give them more security the training⁽¹⁰⁾. Since institutional support is necessary with educational and therapeutic measures, which help in strengthening and effectiveness of actions and targeting such management and monitoring tools for nurses in these environments, which may contribute to reducing absenteeism and work overload rates.

CONCLUSION

Space is gaining in the moment of transition of care centered on the patient's experience and, with this, one faces the barriers of the socio-cultural historical deconstruction that has prevailed for years. However, it appears that in this phase of transition and deconstruction it is worthwhile and necessary to pay greater attention to strategies for reformulating this new context that the health area has to face, which goes hand in hand with community morality.

The fact is, we must take care of those who do. Caring for care centered on the patient's experience, holistically addressing him in his individuality, especially in palliative care in cancer patients, is paramount and of great relevance to provide quality of life to them, however, it does not remove the

real need to perform assistance also focused on caring for the professional - standing out from the one who most practices the art of caring -, the patient and his / her stakeholders will only have quality assistance if that professional presents the veracity of quality of life and, mainly, of their mental health.

The order of the factors in the real situation alters the order of the products, since, without detracting from the importance of reformulating care centered on the patient's experience, giving voice, autonomy, quality of life and minimizing their sufferings, they are absolute and extreme necessity, however, the new era should begin with attention to the professionals who will possibly play in the scenarios for this health model.

The rhetoric of history is no longer able to change it, but the time has come to propose discussions to restructure and give insight to the health model based on the health of its performers. Reformulate the teaching model based on competencies, including the palliative philosophy at all educational levels of health education, making this professional feel satisfaction, appreciation and recognition, in addition to welcoming their work environment with continuous performance of functions cross-sectional teams, positively interferes in the assistance, scientific and cultural-historical performance of palliative care and oncology.

The need for a minimum wage, looking at the amount of weekly hours performed, the quality and educational support of their training preparing them for practice in the job market are some legal means to think that provide the quality of life for the professional. In this way, they are more likely to be able to carry out coping strategies after dealing with their professional routine to seek their quality of life and, consequently, the release of occupational overload.

The same occurs when coupled with palliative care and oncology, we

will only be able to demystify the stigmas they bring that there is nothing more to be done, that all cancer leads to death, and to treat death as distant from our life cycle, if you do not start holding discussions based on the restructuring of the educational level and working environments.

Palliative care has increasingly highlighted its need for a dignified death arrangement for critically ill patients with incurable pathologies, since the profile of pathologies of the current century has been going through a transition phase, where it has been minimizing the infectious diseases that prevailed until the last century and significantly increasing chronic non-communicable pathologies, which bring high rates of morbidity and mortality. Therefore, care does not refer to and is not limited to saving lives, it is a fact that the necessary and the necessary must be done according to the aspects of legality, but it must be in the context

of each nurse and health professional who takes care it goes further... caring is saving lives, but preserving human dignity, caring is healing; but when incurable is treating symptoms and minimizing the multiple strands of suffering that refer to total pain, pain is feeling and suffering is perception, caring is informing and giving autonomy, it is giving quality of life, respect and empathy, caring is having compassion, for you and the other. Nurses who are unable to have this basis of care in their consciousness and that death is part of life and does not refer only to their professional failure, will not be able to be fully dedicated and giving themselves in the art of caring for their patients and those involved in terminality in an authentic way, which may reflect on the feelings of potentiation of anguish, stress, impotence, and negatively interfere in the construction of necessary bonds for the care of terminal cancer patients.

In addition, the need to re-signify the values of life, to think about the appropriate use of available technologies and therapies, and as a professional team leader nurse, you will be able to manage better ways of coping, education and sharing of the team in the face of these issues as an aspect for the inclusion of action plans to care for those who care. But the nurse himself, above all, needs to be cared for and be active in the fight process in the recognition of strategies beneficial to his mental health and that of his team, in addition to his patients, when dealing with palliative care in oncology.

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