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PROCESS WORK IN URGENCY AND EMERGENCY IN INTERFACE WITH THE DEATH

O PROCESSO DE TRABALHO EM URGÊNCIA E EMERGÊNCIA EM INTERFACE COM A MORTE

EL PROCESO DE TRABAJO EN URGENCIA Y EMERGENCIA EN INTERFACES CON LA MUERTE

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This qualitative study aimed to understand the experience of nursing professionals in the working process with adult patients and their families who experience the death event in emergency rooms. One analyzed narratives of 12 professionals, from an emergency room in a university hospital of high complexity, in Botucatu, São Paulo. Data collection occurred from December 2008 to April 2009, through semi-structured interviews. Using content analysis, the central theme emerged: The organization of work in urgency and emergency rooms, with four subcategories: Death as a working routine, Teamwork, Motivation at Work, and Death at a teaching hospital. One concluded that the possibilities of personal and professional growth, the need, and the desire to intervene were identified as motivators for working in emergency rooms, even when it is permeated by death.
Descriptors: Nursing Process; Death; Emergency Nursing; Qualitative Research.

Estudo qualitativo que objetivou compreender a experiência dos profissionais de enfermagem no processo de trabalho junto a paciente adulto e sua família que vivenciam o evento morte em sala de emergência. Analisadas narrativas de 12 profissionais, de pronto-socorro em um hospital universitário de alta complexidade, em Botucatu-São Paulo. A coleta de dados ocorreu de dezembro de 2008 a abril de 2009, por entrevistas semiestruturadas. Utilizando análise de conteúdo, emergiu o tema central: A organização do trabalho em urgência e emergência, com quatro subcategorias: Morte como rotina de trabalho; Trabalho em equipe; Motivação no trabalho e Morte no hospital-escola. Concluí-se que as possibilidades de crescimento pessoal e profissional, a necessidade e desejo de intervir foram apontadas como motivadores para o trabalho em urgência e emergência, mesmo quando permeado pela morte.
Descritores: Processos de Enfermagem; Morte; Enfermagem em Emergência; Pesquisa Qualitativa.

Estudio cualitativo cuyo objetivo fue comprender la experiencia de profesionales de enfermería en el proceso de trabajo con paciente adulto y su familia que experimentan el evento de la muerte en la sala de emergencia. Analizadas narrativas de 12 profesionales de primeros auxilios de hospital universitario de alta complejidad, en Botucatu, São Paulo, Brasil. La recolección de datos ocurrió de diciembre de 2008 a abril de 2009, por medio de entrevistas semiestructuradas. Utilizando el análisis de contenido, el tema central emergió: La organización del trabajo en urgencia y emergencia, con cuatro subcategorías: Muerte como rutina de trabajo; Trabajo en equipo; Motivación en el Trabajo; y Muerte en hospital universitario. Las posibilidades de crecimiento personal y profesional, la necesidad y el deseo de intervenir fueron identificados como factores de motivación para el trabajo en urgencia y emergencia, incluso cuando permeada por la muerte.
Descriptores: Procesos de Enfermería; Muerte; Enfermería de Urgencia; Investigación Cualitativa.

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INTRODUCTION

One can define working process as the transformation of a given object in a given product, through the intervention of a human being, who uses instruments to do it. Working is something that humans do intentionally and consciously, with the goal of producing a product or service that has value for himself and for other human beings[1].

In the peculiar dynamics of working organization in urgency and emergency services, with great service demand, limited physical infrastructure, overburdened professional and demanding population that reflects the aspirations of modern society is when care is presented, where time gains a different dimension, which may be a limiter for thinking and feeling, and where the complex issues pertaining to death are included[2-3].

Contemporary society reaches a historical phase where man believes to have the power to control life and death. Death starts to be denied with intensity, understood as science's and men's failure in healing. This concept of "forbidden death" is opposed to the concept of "tamed death" that used to happen in homes, shared and experienced by the family and the community. Death remains institutionalized in hospitals by seeking the advent of modern medicine, rejecting any possibility of the end of its existence. The hospital is the place where dying is hidden from the eyes of those who continue alive, as witnessing death becomes an unbearable event[4].

With the tendency of capitalist production, the hospital also brings in its working organization the hierarchy of relationships according to the power logic, historically based on a scientific rationality that values techniques. Thus, by abandoning the institutional tradition of charity and by centralizing knowledge, research and medical education, between the late eighteenth and early nineteenth century, a journey of recovery and prestige of the medical professional starts, and patients' hygiene care, feeding and comfort go to a secondary position of importance in this context[4].

In a study conducted in Porto Alegre-RS, seeking to describe the discourses of nurses on the theme of death, the authors report death's historical trajectory highlighting the following categories: silenced and hidden death; waging a struggle against death, death in scene with multiple facets, and most recently, death and palliative care as a paradigm shift. This study allowed a better understanding of the topic and highlighted how publications about death and dying make reference to the nurses' subjectivity[5].

In this perspective, there is still a medical-hegemonic and focused on technique structure, there is a multiplicity of feelings and conceptual dimensions related to the process of death, giving sometimes health working process, different purposes than it would be meeting the person and his family in their human dimensions, with care provided in a broader way[5-6].

In the present conformation of health production, the dimension centered on technical and disciplinary knowledge and on a certain way professional, may counteract the caring dimension, as a gathering of subjectivities for the development of a treatment plan, and this starts also in the undergraduate course. One verifies gaps in proposing the reflective elements that could contribute to the seizure and drafting of competences, which should be developed as necessary attributes for the future professional[7].

With this, one emphasizes the malformed experience lived by nursing professionals, which may have implications in the workplace. When considering the culture that prioritizes the technical skill and care of the biological body, one can have a complicating factor during the process of caring for the person and his family in such an important moment[8]. This justifies the need for studies like this, in this area of professional practice, where reflective processes can provide the approach and proposal of care required by the person and his family. So one wonders: how do professionals who work in urgency and emergency care experience

caring for adult patients and their families in this working process?

Therefore, this study proposes the following goal: To understand the experience of nursing professionals in the working process with adult patients and their families who experience the death event in the emergency room.

Highlighting the theme may provide professional with scenarios to explain, treat and consequently strengthen the interactional processes. It is expected as a result that there is the possibility of a working process with better understanding and less pain.

METHOD

This is a study of qualitative nature that enables understanding and reflection on the issues approached and that was conducted in the emergency room's technical service of the Hospital of Botucatu. It is a tertiary and referral service, integrated to the Regional Health Department VI (DRS-VI) comprising 68 municipalities in São Paulo State.

Data were collected from December 2008 to April 2009. Twelve nursing professionals participated in the study, being four assistants, four technicians and four nurses, in order to represent the members of the nursing staff who work at the Urgency and Emergency Adult Emergency Room. This sample size and its distribution were not intentional, nor pre-established, it was achieved by theoretical data saturation. To represent the experience of all the members of the nursing team, as they processed the collection and analysis, one used the criterion of saturation in qualitative research, ie, when there is a repetition of the data, the invariant, the common, the essential.

The proposed research question was: "Tell me your experience regarding death and the care to the family in this process".

After transcribing the interviews, one used a superficial reading, performed several times to establish greater familiarity with the material seized. According to the Content Analysis proposal, one cut the reporting units that allowed the discovery of the meaning nucleuses for the chosen analytical objective. One made the steps proposed by the method: pre-analysis, material exploration, processing of results, inferences and interpretation, which allowed the thematic analysis[9]. The analysis and interpretation of data were conducted in the light of a theoretical framework, composed by concepts and ideas developed by researchers and scholars on the issues of working process, emergency care, death and family.

The project was approved by the Ethics and Research Committee of the Medicine College of Botucatu, Universidade Estadual Paulista, under number 537/8.

RESULTS

The interviews resulted in reports of rich meanings, and out of their analysis one could get the central theme: The organization of work in urgency and emergency, with four subcategories: Death as working routine; Teamwork; Motivation at Work and Death in the teaching hospital, as shown in the description below.

Death as working routine

There are interactive care processes in the agents' perceptions, concerning life and death and the product reflected in their own and family members' feelings, defining it as part of their routines. *There are too many deaths. It's something that we get used to, for being a working routine. But well, I see death because it is part of the routine* (E3). *Because we handle a cardiac arrest. But then we see another soon after. There are days when there are four, at night, on the day shift...* (E4).

Coping with situations involving death and dying, for nurses, makes daily work more mechanical, becoming automatic. *Especially when it comes to an emergency room, it is more mechanical. One does not have so much emotion... because I got used to the idea of living with death day-to-day* (E6). *One is in an emergency room, the patient is dying or the patient gets there already dead… The patient's death happen there... It becomes an automatic thing. So, it is something very mechanical. It doesn't get*

cold, but it gets mechanical ... the funeral company comes and takes the body away (E12).

The perception of care as mechanic causes mixed feelings, which can become a source of great anxiety. *We, for being like that and seeing a lot of people dying, usually at the moment of caring, I think that is even something good. We manage to be, therefore, slightly colder* (E1).

The emotional detachment and the predominance of the technical aspect over the relational characteristics are often associated with nursing work, understood as essential for an effective practice. *I've become colder ... I've become used to seeing all this. We see it every day. For us it is normal for someone to die. We go there and take things away... (E2).* But at the same time, the emotional involvement is identified as a potentially sickening source, even creating, for self-protection, a distance of the object of work. *It's hard to deal with it, death. So if we don't know how to handle it, it gets worse at work. It's worse for us because, otherwise, we don't live either, if we get depressed because of all patients who die. There is no way* (E2).

Teamwork

Health work has as its principle the complementation by skills, and this is due to the creation of a multidisciplinary team, which should occur in an integrative way and not only by the grouping of professionals. Producing health actions within a community requires a daily contact exercise, but there are conflicts, which can also be understood as exhausting and demotivating. *Because you will always be in a team. No one will respond the same way as you. Most of the times, it is done as a joke, sometimes not. It is very difficult* (E6).

One highlights the nursing staff as more present in the direct care actions, suggesting that there is therefore greater psychological distress for these professionals. *We give attention to the patient, but the doctor does not. The doctor only cures that disease and doesn't see a human being there. He doesn't see that there is a heart there, there is a family who needs to know the news, the evolution. Knowing how to give support, saying good words to the person. Nursing gives emotional support, because we spend more time with them and we see all the aspects, helping in this process* (E4).

In the context of urgent and emergency care, where there is valuing of life versus death denial, professionals express the need for team unity. *I think we lack unity, talk more, try to be like everyone else, speak one language only. We lack compassion for people* (E4).

Living in a team with situations of death and dying requires from its members patience with others. *To work here, you have to have patience too, know how to listen to people, respect everyone. If you don't have respect, no one works, it would be a war! Here you have to go slowly, otherwise it doesn't work* (E7).

The staff recognizes that it is a difficult job and, due to emotional self-defense, professionals may differ in care actions, demonstrating deviation of focus on the dimension of the working object, which are the patients and their families.

Motivation at work

Teamwork, in a suffering situation, is recognized as difficult, creates pain, but this pain does not paralyze but motivates one to do good things to others. *I like it. I think I'm doing something, acting... So sometimes I'm in the ER, because I can do a lot for the patient, the patient's family* (E11).

From suffering one also learns and generates personal satisfaction. *It is rewarding for us. I think it has to be part of our lives. The feeling of helplessness remains... I think that when I get used to it, when I stop thinking that way, I have to stop. Then there is no way I could work with it. You have to change places... You stopped giving a hand, giving value to life. I think it's time to stop* (E7).

It is a compassion exercise, doing good to others and feeling fulfilled, satisfied, feeling useful to someone. *Even feeling tired, I like it. I always want to do the best I can, so that I can learn, do better. And attend all the cases* (E4). *I find it so important to work in the ER! Because I think that, here, I learned a lot. It is like a school for me. I learned a lot of things. Even respect, doing things faster, more organization, more everything here... I'm proud to work here in the ER* (E7).

It mobilizes in professionals internal resources that make them produce care within their possibilities, and in the midst of suffering, they can feel pride and pleasure in their work. *It's good to do something for someone. So, it's a team. It's beautiful! Especially when the team works, all together... Even with a lot of suffering there. But it becomes beautiful when it gets nurses and doctors together... Even when we lose someone* (E5).

The desire to care, the reason to do good to someone prevails. *I love it!... If I could stay here, I think I would,*

because that's what I like. Even crying! I think it's part of it. Working here, I think it is very good for the team because we work as a team and we are very united. It is a friendship. One cares about the other... I think this is what helps us a lot to put up with it (E9).

Death in the teaching hospital

It is evident in the professionals' speeches the presence of the hierarchy that imposes the power in the health institution. *Bringing them here, they come after twenty minutes of cardiac arrest, and trying to reanimate them. I consider it as inhumane. It's as if there was no will. I help, by obligation. But it is a situation I wouldn't like to help* (E6). *But the elderly patient, I feel sorry for them when they are intubated... Like a course to another, for example, the doctor learns. But it's part... I'm not against doing it. We do it... We must know what we do... No wonder we start learning doing, start doing. I think there should be a moment to do it... Sometimes the family doesn't even want them to do it.... I get really angry!* (E7).

There is evidence that in a teaching hospital the hierarchy that establishes power is linked to the specialty's knowledge. The medical expertise can create hegemony in command, devaluing shared decisions among the team members. *People coming in and out, and outside the family doesn't know anything. Nobody stops to talk to them, not even a word. Because those who are outside don't know what's going on inside. They see people coming in, coming in increasingly. That opens a question. They don't know if they're investing too much, if there is something very curious, that everybody wants to see as that is a teaching hospital. That is very difficult. I think, mainly for the family* (E6).

The procedure of cardiopulmonary resuscitation is pointed by the nursing staff as an example of denial of death at any cost, for both the family of the deceased as well as for the multidisciplinary team.

DISCUSSION

The Nursing working process is complex and multifaceted, and the professional needs to operate consciously and intentionally in the various sub-dimensions that compose it, such as managing, assisting, teaching, doing research and participating politically[1,10].

This interaction of components occurs, in this study, in an urgency and emergency unit, with the peculiar characteristics of the investigated scenario, and the subjects of the study narrated the representations, under intense and frequent contact with death in their work environment.

The denial of death is a feature of western society, not exclusive of hospital environments, because its forbidden character toughens the discussion of the subject[4]. One emphasizes the influence of the media in this process by promoting daily exposure, without reflection, banishing it to the shallowness and detachment. In places where people in the end of life are treated, there are many decisions that need to be reflected in a team[6,8].

In the hospital context, the daily contact with death and dying, permeated by the patient's and his family's suffering, result in very painful experiences for health professionals. These situations that generate strong anxiety can lead to coping mechanisms that result in the trivialization of death, making it impossible to give this phenomenon its true importance in human existence[11].

This phenomenon can result in the fragmentation, the depersonalization and in the lack of commitment to care that involves the entire process experienced by patients and their families[11]. In this sense, the subjects exposed in their speech the perception of care as being mechanical and automatic.

The terms mechanical and automatic, cited by the subjects, imply a working organization with functionalist characteristics. In this logic of care production predominate techniques, technological resources and the division of tasks, circumscribed in tightly established routines and standards, where the goal is to optimize the time and the workforce[11].

Therefore, beyond the coping strategies adopted by the subjects, the way the care production is organized hinders the manifestation of these professionals' caring dimension. Thus, the phenomenon of trivialization of death can be reinforced by the lack of

reflection on the meaning of work, very common in systems which value the production done piecemeal.

The patient and his family when facing death, can therefore become fragmented objects and devoid of their singularities[10]. However, health professionals have as object of work subjectivity, unlike industrial activities. This constitutive element of human beings is not often ignored and the contact with others bring to these professionals identifications that lead them to tense relations between the professional-specific dimension and the care dimension[11].

The professional's perception of subjectivity can lead to demotivation at work from the moment the logic of production in health prioritizes functionalist, fragmented and depersonalized production[10]. But even recognizing these conflicts in the workplace, subjects reinforce the focus on technical practice, referring to the emotional involvement as a potentially sickening source. When the team understands that in certain collective environments there are elements of risk to the integrity of workers, they discuss how the coping mechanisms operate in these places. To defend themselves from exposure to illnesses, professionals act in ways understood as effective to the objective of work and, at the same time, protective of the aggressors[12].

In short, when considering the intense contact with death, subjects tend to trivialize it, but live the conflict generated by the elements of subjectivity involved in the situations reported. They seek ways of protection and distancing is placed as a clinical practice that provides the performance of a well done job, without large impact on their emotional balance. However, due to characteristics inherent to working with health, illnesses can be enhanced when measures for treating anxieties are relegated to secondary importance.

When one thinks about care that involves death and dying, teamwork can become an empty speech, where what prevails is the depersonalization of professionals and the devaluation of the subjectivity involved[12]. In this situation, blaming and delegating responsibilities mask the relationship difficulties, which result from differing perceptions about the intended care[13].

The contact that the nursing professional has with the patient and the family allows an opening to the other person's subjectivity, however, it does not always happen. The feeling of guilt for not attending the patient's needs can lead to a blaming process. In this case, the medical team can become the focus of nursing professionals' negative feelings[12].

When there is the transference of feelings for this team member, abetted by the medical defense posture and arrogance, there is the inhibition of nursing professionals to perform welcoming.

The fear of death, inherent in every human being, is also present in doctors. However, the focus on actions and heroic measures to control and dominate the illness and death are actually coping mechanisms due to the anxiety generated by these events, reflecting the narcissistic fragility[13]. When death is realized and becomes common in the workplace, physicians may develop other strategies to protect themselves, as staying far from patients and their families and delegating part of care, except practices exclusive of these professionals, to other members of their team.

In Brazil there are advances, but in the United States and other countries there is consensus about what they call shared decision, when someone is at the end of life, and the medical decision considers the patient's desire, when it exists, what the family thinks and if necessary they resort to the ethics committee. This provides peace of mind for the whole team to see that this is not isolated behavior, with possible ethical violations[11].

Within the context of urgency and emergency care, when they prioritize to save lives at all costs, doctors and nursing professionals may perceive their work as frustrating, demotivating and meaningless. And this understanding, in general, can be enhanced when

there is no space to discuss the treatment plan, and to exchange experiences about death[13]. On the speeches of the subjects in the present study, this need is perceived and expressed.

Interdisciplinary work in urgency and emergency units presents itself in a fragmented manner, to act in their specific niches, on a permanent exercise of knowledge articulation and pursuit of reciprocity and respect from professionals to get the best results, or simply to wear out less. What is observed, however, is the juxtaposition of knowledge acquired in the training process, when what is implicit is the need for a new attitude towards knowledge, a change of attitude in search of a relative unity of thought and action. In this scenario, care dimensions are articulated between human and technical skills[14].

When considering teamwork, where there are different realities and thoughts, subjects try to avoid debates, looking for a less aggressive environment. To do so, they develop coping mechanisms centered on the expulsion of the working object and on the escape of emotions[12].

Teamwork emerged from the subjects' speech, which gave the sense of limit for care: there are divergent views about the desired care, leading to conflict between professionals, especially among doctors and the nursing staff. These clashes were considered as a way to restrict the dimension of care, from the moment that there is not an exchange of knowledge and perceptions about death and dying, resulting in fragmented care. These data also allowed the inference that professionals do not know clearly their working object, which are the patients and their families.

For the organization of work to be able to produce a transformation of nature with the specificity that characterizes particular spheres of professional activity and social contribution, it is essential to recognize the working object, the person being cared for and his family[10].

The organization of work in urgency and emergency, associated with the constant contact with death, creates an extremely anxiogenic environment. This perception can lead to coping mechanisms that allow a less painful experience by the nursing staff.

A study on the significance of the care relations in urgency and emergency, makes reference to the dimensions that mobilize and articulate the multiple human and technical skills, including rethinking the practice itself, and to the conditions of the environment as a space of care to meet the needs of patients and their families[15].

However, organizational difficulties, such as pressures on the working process have impact on the result of work and in meeting the needs of the patient and his family[16].

The perception of subjectivity of the patient and his family enables the professional to give meaning to work, even when he is inserted in fragmented and depersonalized logic. It also reveals, in the end of life situation, the family's need to be welcomed and receive care in order to overcome the challenges in this painful process[17].

The feeling of helplessness due to the situations that involve death can mobilize health professionals to search for various forms of providing care. The care dimension, when it is achieved, enables the recognition by the one who is cared, and generates feelings of pride and pleasure[8,14].

In search of that desired care, nursing professionals understood the learning process as a motivator for personal and professional growth. Therefore, the teaching hospital, which may impose limits in the individuals' actions, also offers to them the opportunity to add new experiences and knowledge, in order to build the care dimension. When asked about the execution of a job involving all the dimensions of health care, the subjects made several references to teamwork as an important motivating factor.

Working in urgency and emergency situations, due to their peculiarities, enables the manifestation and the interaction of all the professionals, as the goals of care are clear and need fast execution. Moreover, the power of nursing professional, often considered peripheral, is valued in these scenarios because they have expertise in other aspects of care, besides medical actions, such as the bureaucratic intricacies and the availability of instruments. The ability to mediate the activities of the various subjects in that scenario also reinforces the importance of these professionals within the team[6].

In environments where suffering is very present, team unity is characterized as a coping strategy, where all anxieties can be shared and welcomed. In this sense, relationships are strengthened and understood as an attitude of concern and appreciation for the common welfare[18]. Faced with the speeches analyzed, it was observed that, even in a potentially sickening work environment, the desire to take care prevails.

A study on the same subject showed that the possibilities for personal and professional growth, the need to intervene on the other and the team interactions act as great motivators for work in urgency and emergency, even when death is present[19].

Heroic measures may be one of the common features in the actions of professionals who work in teaching hospitals, although this is not uncommon in other services. In this context, the doctor, as a central subject in urgency and emergency situations, decides countless times, without questioning the real meaning of his actions, not putting intentionality and consciousness[1]. This can be explained by a training focused on procedures and on a biologist vision of life and death and by the denial before an unconscious process, death[6,8].

In this work environment, where suffering is part of the other dimensions, power is a prominent element contained in these relationships.

The working process in a health institution, developed by different professionals is always guided by different skills. In the specific case of doctors and nurses, when they share the care actions, this composition keeps an interface of different powers. In a recent study about professional knowledge and political power, the author quotes about the distinction between professional knowledge and institutional power and in the perspective analysis, considers that they are historical forms of relationship between classes and social forces and of relationship between the government and society[20].

There are similar results in our study, because according to the ones who were interviewed, the medical approach founded on expertise generates behaviors in teaching hospitals that prioritizes, for example, resuscitation as a routine measure, which causes great anxiety among nursing professionals for being closer to the patient's and his family's needs.

It is configured in this scenario, the conflict between what was prescribed and the care dimension of such workers, where the feelings of powerlessness and limitation are amplified before the medical hegemony, which can be minimized though shared decision making[11,14].

When one insinuates the problem of medical training, speeches punctuate the expenditure of energy in sustaining life at any cost, to the extent that future professionals learn how to prolong life, but receive little training or clarification about what life is. In this context, one emphasizes the possibilities of discussion on the topic of death and the importance of communication with family members and with the patient, in the pursuit of the human care dimension, because, that way, the doctor may prolong life, but he will also take into consideration the patient's needs, discussing them frankly with him[5].

Another characteristic element of the teaching hospital is the interest mobilized by the procedures of cardiopulmonary resuscitation. The attention focused on the service trivializes the importance that the moment of

death has for the family, causing an unnecessary feeling of distress because of a team that does not welcome their anxieties[13,20]. In the nursing professional, who participates in this logic of care, the feelings of guilt and limitation may be expressed by blaming attitudes from the medical education system[13,19].

The attitudes focused on cardiopulmonary resuscitation procedures lead subjects to experience impotence, due to the doctor-hegemonic logic in the teaching hospital environment. Furthermore, the data have highlighted in some way, the anxiety created in the subjects because of the doctors' behavior, suggesting that in the education of these professionals one does not consider death as an important event in the family's experience.

FINAL CONSIDERATIONS

The present study aimed to understand the experience of nursing professionals in the working process together with adult patients and their families who experience the death event in the emergency room. Additionally, there was the purpose of increasing knowledge about the topic of death, from the viewpoint of nursing professionals in this specific area. It enabled the construction of the analytical theme, entitled the organization of work in emergency care, with four subcategories: death as a working routine, teamwork, motivation at work and death in a teaching hospital.

Death is a routine is translated by intense contact with this event, which can enable the subject to feel trivialization, by not exempting them from the conflicts generated by the subjectivity involved in the situations reported. The detachment is mentioned as protection in the professional practice, which can apparently generate the conditions for the execution of work and lower emotional impact. This does not ensure workers' mental health and the sickening process can be enhanced. As a practical application one stimulates therapeutic areas, in groups, which may allow measures for the welcoming of anxiety.

Teamwork has dimensions which require an exercise of daily contact. The blaming process, in particular due to the physicians' actions, and the delegation of responsibilities, mask the relationship difficulties. There are differing views about the intended care, the data also allow the inference that professionals do not know clearly their working object, which is the patient and his family.

Teamwork in a potentially sickening environment reveals contradictions of support and conflicts and the desire to care, overlapping these issues. The possibilities of personal and professional growth, the need to intervene, and the team interactions were also identified as motivators for working in urgency and emergency care.

The teaching hospital has as its characteristics, greater freedom of action, without disregarding the routines, but relying primarily on science and on the teaching learning process. Attitudes centered on procedures, such as cardiopulmonary resuscitation in situations with seemingly little chance of recovery of life, leads the subjects to the experience of powerlessness due to the hegemonic medical logic in the teaching hospital's environment. Furthermore, the data demonstrate the anxiety generated by the medical education that may not consider death as an important event in a family's experience. As a strategy applied to reality, one focuses on experiences that stimulate the culture in which decisions regarding the end of life can be shared.

The study does not allow generalizations, but it was possible to understand some principles applied in this complex working process, where death and life are interwoven and often determine painful outcomes also for the subjects of the research. The acceptance of limits and of the powerlessness concerning death enable the construction of ways to conduct the caring dimension, proposing reflection with an essential element for the implementation of the intentional and conscious work.

COLLABORATIONS

Dell'Acqua MCQ contributed since the conception, participated in the analysis, data interpretation, formatting, corrections proposed until the end of the version to be published. Tome LY developed the study design, performed the data collection, analysis, interpretation of data and monitoring for the article's formatting until the final version to be published. Popim RC contributed as a co-advisor of the study, participated in the analysis and data interpretation, in particular in the theoretical framework about death, article's correction until the final version to be published.

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