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Perception of the infant death and dying process by resident nurses in child health

Percepção do processo de morte e morrer infantil por enfermeiras residentes em saúde da criança

Percepción del proceso de muerte infantil por parte de las enfermeras residentes en salud infantil

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Abstract

Objective: to analyze the perception of resident nurses in Child Health regarding the process of infant death and dying in Pediatrics. **Method:** qualitative study, developed with four resident nurses from a University Hospital in Recife, Pernambuco, Brazil. The sample was selected by non-probabilistic sampling of the intentional type. The interviews were processed in IRAMUTEQ software and analyzed using the Descending Hierarchical Classification. **Results:** the following categories were observed: 1) coping with infant death; 2) process of pediatric death and dying; 3) expression of feelings before infant death; 4) formation and resilience of the multidisciplinary team before the end of life; 5) residency experiences. **Final considerations:** despite being part of the vital cycle of living beings, death is seen as a tragic event, especially in childhood, awakening different feelings, mostly negative.

Descriptors: Pediatric Nursing; Internship, Nonmedical; Death; Child; Attitude to Death.

Resumo

Objetivo: analisar a percepção de enfermeiras residentes em Saúde da Criança frente ao processo de morte e morrer infantil na Pediatria. **Método:** estudo qualitativo, desenvolvido com quatro enfermeiras residentes de um Hospital Universitário de Recife, Pernambuco, Brasil. A seleção da amostra ocorreu por amostragem não probabilística do tipo intencional. As entrevistas foram processadas no software IRAMUTEQ e analisadas mediante a Classificação Hierárquica Descendente. **Resultados:** observou-se as seguintes categorias: 1) enfrentamento do fenecimento infantil; 2) processo de morte e morrer pediátrico; 3) expressão de sentimentos diante da morte infantil; 4) formação e resiliência da equipe multidisciplinar ante o fim da vida; 5) vivências e experiências na residência. **Considerações Finais:** apesar de fazer parte do ciclo vital dos seres vivos, a morte é encarada como um acontecimento trágico, principalmente na infância, despertando diferentes sentimentos, majoritariamente negativos.

Descritores: Enfermagem Pediátrica; Internato não Médico; Morte; Criança; Atitude Frente a Morte.

Resumen

Objetivo: analizar la percepción de los enfermeros residentes en Salud Infantil sobre el proceso de la muerte y el fallecimiento de los niños en Pediatría. **Método:** estudio cualitativo, desarrollado con cuatro enfermeras residentes de un Hospital Universitario de Recife, Pernambuco, Brasil. La selección de la amostra ocurrió por amostragem no probabilística del tipo intencional. Las entrevistas se procesaron en el programa informático IRAMUTEQ y se analizaron mediante la Clasificación Jerárquica Descendente. **Resultados:** se observaron las siguientes categorías: 1) afrontamiento de la muerte del lactante; 2) proceso de la muerte y del moribundo pediátrico; 3) expresión de los sentimientos ante la muerte del lactante; 4) formación y resiliencia del equipo multidisciplinar ante el final de la vida; 5) experiencias y vivencias en la residencia. **Consideraciones finales:** a pesar de formar parte del ciclo vital de los seres vivos, la muerte se ve como un acontecimiento trágico, especialmente en la infancia, que despierta diferentes sentimientos, en su mayoría negativos.

Descriptores: Enfermería Pediátrica; Internado no Médico; Muerte; Niño; Actitud Frente a la Muerte

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INTRODUCTION

Infant mortality represents an important marker to indicate the health conditions of a country. In Brazil, the occurrence of deaths in the first years of life is associated with the sociodemographic context, access to public policies and coverage of actions and services available in the Health Care Network, in addition to the humanization and quality of care in addressing vulnerabilities that increase the risk of death from preventable causes[1-2].

Given this scenario, despite the advances within the Unified Health System (SUS) for the development of lines of care for maternal and child health, mortality remains unequal in the regions of the country due to the vulnerable contexts that interfere in the professional and personal scope of health professionals[3], especially for nurses who provide direct health care to children at all levels of health care.

The death of a child can provoke in professionals a feeling of profound loss associated with the rupture of the conception of childhood, since the interruption of the life cycle should happen only in old age[4]. The bond that this professional establishes is sometimes abruptly interrupted, and he is forced to deal with his own finitude and that of the people with whom he lives. However, these feelings fade away as a form of self-protection and continuity to their work[4-5].

Because it is incompatible with the childhood age group, early death makes the situation uncomfortable for the professional who is not prepared to adequately manage the process of infant death and dying[6]. Thus, despite being part of the nursing routine, the situation becomes even more painful in the face of the professional caregiver-patient relationship established between the nurse and the child[7]. It should be noted that the word “death” carries great socio-cultural weight, being avoided due to the taboos established in Western culture [7].

The residency is a specialization in service, so it is expected that the teaching-learning process occurs during the exercise of the profession, and dealing with the process of infant finitude should be an essential approach in the training of residents in Child Health, considering that, when faced with the hospital reality, they need to deal with death even if they are not prepared by their initial training, which surrounds aspects of health promotion and prevention and does not foster the discussion of the process of death and dying[8].

It is in this context of professional training that residents face aspects that stress the epidemiological and medicalizing constructions to which they were intensely exposed throughout their professional training. Moreover, it is observed the scarcity of scientific production on the theme in question, as well as the absence of discussion and reflection on the finitude of children. Given this situation, the study was guided by the following research question: what is the perception of resident nurses in Child Health regarding the process of infant death and dying in Pediatrics? Therefore, the objective of this study was to analyze the perception of resident nurses in Child Health regarding the process of infant death and dying in Pediatrics.

METHOD

This is a qualitative study, conducted and structured based on the Consolidated Criteria for Reporting Qualitative Research (COREQ)[9]. It was carried out at a University Hospital in the city of Recife, Pernambuco, Brazil. The site was chosen because it met the necessary requirements for the development of the research, the Nursing Residency in Child Health, the population of interest of this study.

Four resident nurses in Child Health, selected by non-probabilistic purposive sampling, participated in the study. The saturation of data was used to reach the total sample, a moment in which the field collections do not bring new data to clarify the object studied[10]. Inclusion criteria were: to be a graduate in Nursing and a resident in Child Health Nursing at the hospital chosen for the study. And as exclusion criteria: participants with health limitations that prevented the researcher from collecting data, such as uncorrected hearing impairment.

Prior contact was made with the residents to present the research, its purpose and objective, and to clarify the procedure for data collection. For those who agreed to participate, a day, time, and place were scheduled according to their availability, thus avoiding losses both in their weekly workload and in data collection.

The data collection process occurred between September and October 2018, through the delivery of a semi-structured form of characterization of the participants addressing sociodemographic issues and academic training; soon after there was an interview that followed a semi-structured script composed of the following guiding questions: a) have you ever witnessed the death of a child during your training or work? If yes, tell me about; b) what are your feelings about the death of a child in your daily life? c) how do you mourn the death of your patients? d) how did

your undergraduate education prepare you to deal with the death of patients?

The interviews lasted an average of 33 minutes, and two voice recorders (MP3) were used as an auxiliary resource, aiming not to lose any relevant information during the course of the interviews. In order to guarantee the anonymity of the participants, the excerpts from the interviews were identified by the word "resident", followed by an Arabic number according to the order in which the interviews were conducted.

The characterization forms of the participants were typed and stored in a Microsoft Excel spreadsheet, while the collected audios were duly named and filed in a specific notebook, protected by password, with access restricted to the researchers involved in this research. The audios were transcribed, and the reliability-validity of the material was checked after the participants read the reports.

The research corpus was submitted to analysis and processed using the lexical analysis technique, with the aid of the software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRAMUTEQ) version 0.7 alpha 2. The textual analysis of the data was obtained by means of the Descending Hierarchical Classification (DHA), and graphical and descriptive resources were used to present the data. It is noteworthy that it is considered a good use of the corpus the index of 75% or more(11), and this research had a utilization rate of 90.31%. It was considered as statistically significant values ($p < 0.0001$) along with the chi-square ($\chi 2$), when considering the value of association the class (≥ 15.31).

This study met the standards established by Resolution No. 466 of December 12, 2012, of the National Health Council of the Ministry of Health. The project was submitted, via Plataforma Brasil, to the Ethics Committee on Research Involving Human Beings of the Federal University of Pernambuco and was approved under opinion no. 2.776.558. To participate in this research, the residents had to sign the Informed Consent Form (ICF) in two copies, with one copy belonging to the resident and the other to the researcher.

RESULTS

The results were portrayed in a descriptive and illustrative format, composing the "universe" of the perception of the process of death and dying in children, based on the oral arguments raised in this study. The participants were characterized according to table 1.

The population was composed mostly of recently graduated nurses (75%), with one to two years of training, only one of them had graduated for over five years (25%), and all of them (100%) came from public institutions of Higher Education in the State of Pernambuco. Residency is the first professional contact after graduating in Nursing for three participants (75%), on the other hand, the resident with the longest time of training has care experience of 3 years and 2 months in Primary Care (25%). None of the residents is a mother, but during the interview it was found that Resident 4 was pregnant.

The interview corpus was submitted to analysis aiming to reach the CHD, which was fractioned in 392 text segments (ST), relating 1,629 words with an occurrence of 13,778 times. We obtained 90.31% of the total ST, corresponding to 354 analyzable words, which generated a dendrogram (figure 1) with 5 classes. After analyzing the dendrogram and reading the TS that make up each class, it was possible to name them.

Class 2, Coping with Childhood Death, features the coping strategies used by residents to deal with their patients' death and dying process.

> *I try when I get home from duty to relax as much as I can, rest, watch a movie, do something I like, that reminds me of good things, good energies.* (Resident 1)

> *I try to sleep and not think about it [...] when you get home, you take a shower, stop, reflect, breathe. Then you can talk to someone, you can digest better.* (Resident 4)

> *I like to write, if I am very desperate I start to write. It is a way of saying goodbye, that that child is marked, but not recorded.* (Resident 1)

The mutual support among the residents themselves in the face of pediatric death is noticeable.

> *We were talking and one was supporting the other. That it didn't stay like this, that we are still going to experience this a lot. And that we have to be strong, to try to solve the problem, to solve the situation.* (Resident 2)

> *Since we are residents, we have a lot of support from each other. So, we end up sitting down,*

Table 1. Characterization of the resident nurses in child health participating in the study. Recife, PE, Brazil, 2018.

Interviewee	Gender	Age	Civil Status	Religion	Year of Residence
Resident 1	Female	22	Single	Evangelical	1st Year
Resident 2	Female	29	Married	Catholic	1st Year
Resident 3	Female	24	Single	Catholic	2nd Year
Resident 4	Female	24	Single	Catholic	2nd Year

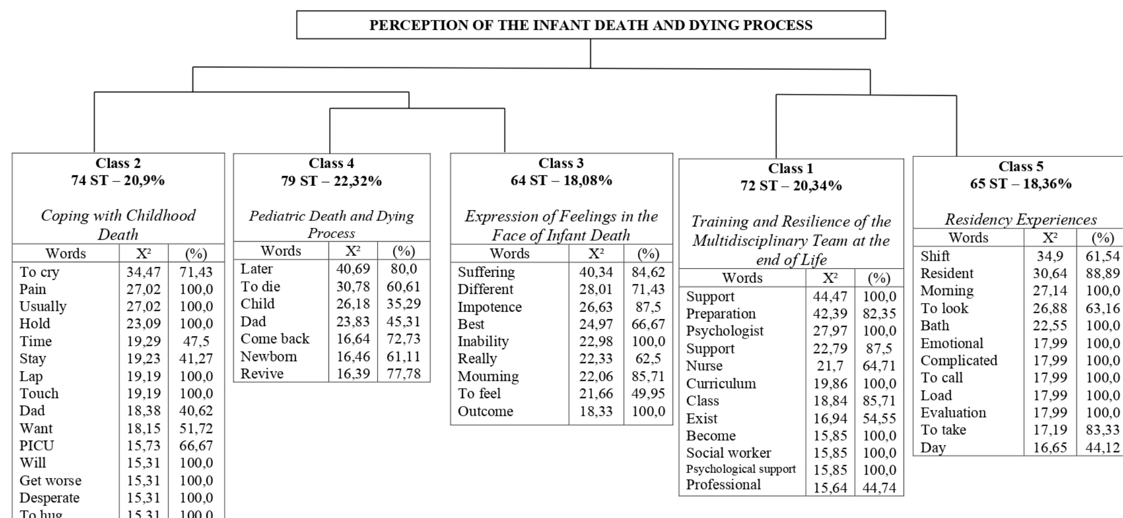

Figure 1. Descending Hierarchical Classification Dendrogram of the corpus on the perception of the infant death and dying process. Recife, PE, Brazil, 2018.

Source: Corpus analysis processed in IRAMUTEQ 0.7 alpha 2 software.

> *talking, discussing about what each one thinks could have been done to change that reality, we end up supporting each other always.* (Resident 4)

When children die, the professional attitude is expected to be maintained, regardless of the circumstances, because there is an "invisible and non-verbal" contract between professional-institution-team-patient-family.

> *In general, I isolate myself a little, if I feel like crying I cry, but I isolate myself. I don't show to others what I am going through. And so, not only for the other professionals, but also for the family.* (Resident 3)

> *The professional is expected to have emotional control, his world may be falling apart but he has to have emotional control.* (Resident 1)

Residents also look to religiosity/spirituality for resources to cope with infant death.

> *I try to pray.* (Resident 4)

> *The fact that I am catholic and have this belief in the resurrection comforts me a lot, that she (child) is not suffering. That the best was done for her.* (Resident 2)

> *When you believe that there is something greater than this, that regardless of what is happening now, tomorrow will get better thanks to, I don't know, the cosmos, God, the spirits, the saints. There will be a solution, let's say, in the future it will pass, your pain, your anguish, so I think it helps, if you believe.* (Resident 3)

Class 4, called Pediatric Death and Dying Process, explains the nuances inherent to the aforementioned process, which is part of the professional's routine, depending on the sector where they work and on the oscillation of the patients' clinical picture.

> *The girl started getting worse, worse, worse, and the day she died was a Saturday. We kept*

> *looking at each other's faces, without even being able to act.* (Resident 2)

> *The child was stable, the parents went to talk to the baby, he was apparently fine. In the course of the shift, this child evolved to death.* (Resident 1)

The process of death and dying is faced according to the peculiarities of each case and by the conducts adopted.

> *There are some children that, due to their pathology and prognosis, we think that death is the relief of their suffering. Many times I am asking for the child's moment of departure. We invest a lot in the child and end up prolonging her suffering.* (Resident 4)

> *I always think that we have to talk to the child, say goodbye, prepare, say, take a deep breath and see that sometimes it was better, that that child really rested.* (Resident 1)

Class 3, Expression of Feelings in the Face of Infant Death, highlights the tangle of feelings that are brought up in the face of death.

> *Impotence, I felt helpless, I didn't know how to do anything.* (Resident 2)

> *You get sad because it's a patient you've become attached to, you've spent a lot of time with, you believed in that patient's cure, and then you end up being surprised because the patient is heading towards death.* (Resident 4)

> *We are left with sadness and a feeling of longing.* (Resident 1)

> *I feel pain, I feel sadness and anguish, but it's not only for the child itself, it's for the context, you know? For the family.* (Resident 3)

It is apparent that the bonds created with the patients directly interfere with the feelings that are generated and expressed.

> *She already arrived in death, I didn't witness this death, this death came to me, I didn't follow this evolution, she already arrived stopped, she had nothing to do and that was too shocking. I was not sad, because there was no time, I think I am sadder when I know the story of that child, of the family.* (Resident 4)

The quality of the care work developed by the multiprofessional team interferes with the feelings generated individually by each professional, which can be similar or not.

> *Many times Nursing goes as far as it can, if Nursing can go there, I see that Nursing does its best, but we are not a profession that works alone, no profession works alone. And then you need a support, a support, when this line of care, when this care network has a blockage and that blockage leads to death, I believe that this loss is more difficult to deal with.* (Resident 1)

> *There are those children that you see, that if a certain professional had done differently, that outcome would have been different, this ends up generating indignation.* (Resident 4)

Class 1, Training and Resilience of the Multidisciplinary Team at the end of Life, stresses the importance of preparing professionals to deal with death, as well as highlighting their ability to remain "firm and strong".

> *In the graduation course we are prepared to cure, to care, to do everything for that patient to survive and have quality of life, but for death I never had a class.* (Resident 4)

> *It has been a while since I graduated, but I don't remember any classes talking specifically about death, only the class on preparing the body after death.* (Resident 2)

> *There could be a course or module within one of the undergraduate courses that works with this part of communicating bad news and preparing for death.* (Resident 3)

One notices professionals unprepared to deal with death and with the situations/conflicts arising from death.

> *I think that there is a lack of preparation, a lack of professionals present, because if I am not the*

> *one that gives the news, then I don't need to be there. And most of them break the news, turn their backs and leave. Sometimes not, but the majority that I saw, give the news and leave. The mother gets desperate, this is not good for anyone.* (Resident 4)

> *The exposure that we have to emotional stressors is very high and what I see is that hospitals don't make the slightest effort to mitigate this, there is no debate, there is no listening to the professionals.* (Resident 1)

Class 5, Residency Experiences, recalls moments experienced during the specialization.

> *When you are an academic you are part of supervised care, when you become a professional the burden of that is much greater on you, the thought that you could or may intervene is much greater as a resident.* (Resident 1)

> *In the residency I have taken more than ten deaths and none is the same as the other, it is always different, but what is the same is my feeling towards the family, with all of them I feel that I could do something for the family or that I should do something.* (Resident 4)

> *So, as it was my first rotation, I had never had hospital experience outside undergraduate studies. And for me it was difficult because I didn't know how to react, there were the girls, R2, on the day rotating with us and they already had more practice than us [...]. I had never experienced a situation like that.* (Resident 2)

Death is permeated by "negative" feelings that can be intensified by the circumstances in which this death occurs.

> *During the residency, there was a death of a child that was totally avoidable, she went through a process of evolution and there were some negligences, let's say, in the care of this child and she died [...]. The team's feeling was of incapacity, because it's one thing to see a child die when you do everything possible, but when you have a child that dies because of incapacity, or a mistake or something, it's not the mourning that remains, it's the feeling of incapacity in the face of that.* (Resident 2)

> *It was as if she was no longer a person, you know? They didn't treat it as a human being, they didn't even see the mother's situation. Soon after the child died, the team that was with her asked the doctor to learn how to intubate her, to take advantage of the fact that she was already dead.* (Resident 3)

> *There are situations where you see a person climbing up a ladder and jumping on top of the child during resuscitation and the child dies, and you see that he or she had a rib fracture, you take out a probe and bleed, even if the cause of death was not this, this could have been avoided, it would have been less suffering, it is a very heavy situation.* (Resident 4)

DISCUSSION

Death is one of the stages of the vital cycle, however, it is observed that this subject is sometimes neglected in the training of nurses. In contrast, the Nursing team spends a long period next to the patient and participates/follows the different moments that permeate the life of the human being, from birth to death. It was found that, despite the lack of preparation during their training, nurses need to deal with and manage the process of infant death and dying during their work. In this scenario, they seek different ways to deal with and process grief as a result of the child's death, among them the search for support from colleagues and family members and the comfort of spirituality. It should be noted that dealing with each death is unique and the impact it has is related to the context in which it occurred.

Society seeks to exclude the process of death and dying from its daily life, and this attitude is reflected negatively in nursing care to patients who are at the end of life. Such behavior can be attributed to the technical-educational unpreparedness resulting from the existing deficit in training curricula, since nurses are not trained to deal with death and the dying process, as well as there are few undergraduate nursing courses in Brazil that have subjects that discuss human death.

Nursing care must be applied/planned not only at the current moment of the disease, but it must foresee the possible variables that involve the patient[12-13].

Care is essential to Nursing and enables the development of a relationship of help and trust during the process, promoting comfort and dignity, both for patients and for the professionals themselves[14]. The death of a child can arouse countless feelings such as: suffering, fear, frustration, sadness, anguish, and pain. These feelings can be intensified or softened depending on the conditions that led the child to death or on the family's acceptance. Talking to friends, family and colleagues and seeking spiritual comfort are coping strategies used by health professionals[15].

The absence of debates on the subject can lead nurses to a posture full of prejudices that are intrinsic to Western society, which can overburden and cause suffering, favoring the development of psychosomatic illnesses such as depression and Burnout Syndrome due to the imbalance between body, mind and spirit and the absence of expression of feelings[16].

According to the participants of this study, the lack of preparation to deal with death is evident. The pediatric nurse is expected to meet all the needs of their patients, however, subsidies for a holistic and comprehensive care are not offered. During the experience of infant death, they do not find help in their training or in the institution in which they are inserted, resorting to colleagues, friends, and relatives[17].

Once pediatric nurses have the theoretical foundation and support during the experience of a child death, over time they will be prepared to provide a good death to their patients, enabling the construction of memories that ease the process of death and dying, which will continue to be painful, but less painful[18].

Coping is a set of strategies developed by the subject to face situations of pain and suffering. The escape from experiencing grief/loss associated with a significant disarticulation corroborates to pathological grief, and therefore, it is necessary that the professional seeks to recognize positive aspects of life, so that he/she can elaborate and face the grieving process[19]. Pathological mourning leads the individual to a condition of inertia, which develops a sense of inferiority, favoring that grief traits such as disaffection and disinterest in the world are prolonged and, in some cases, interminable[20].

Coping allows the individual to overcome the conflict and make adaptations according to the current scenario in which he is inserted. Facing grief does not mean forgetting what happened, but it is about the bereaved person's ability to move on with his or her life. The coping/elaboration of grief is related to different variables, among them are the gender of the bereaved person, since there is a difference in the way men and women deal with death; the age of the deceased, since children's death evidence the feeling of natural disorder; if the individual has psychological problems, he/she becomes vulnerable to losses; cases of homicide, suicide, unexpected and/or violent deaths, as well as multiple losses influence the assimilation of the loss[19].

It is evident that the coping strategies are developed by the nurses themselves, without the help of a professional specialized in grief counseling. These experiences enable the development of a belief system, instilling faith and hope, with emphasis on the spirituality of the cared for and the caretaker[21]. Religion and spirituality are essential elements in coping with grief, since "religious/spiritual traditions create theories about suffering and death, and for this reason they generate meanings and strategies to deal with it". [19]. Spirituality revives hope, which helps to end the anguish brought on by death[19].

The bond between professionals and children is weakened due to the fragmentation of care. The patient requires qualified listening from nurses, so that they can meet the patient's demands and offer holistic and integral care and not merely technical interventions[22]. Care needs to be permeated by care, by touch, by listening to the other, not allowing technologies to override the individual and their needs.

In a similar study, it is noted that the perception about the process of death and dying is directly influenced by the aspects that encompass death, such as the involvement of the family with the professional and the presence or absence of those at the time of death. This experience may be permeated by feelings both favorable and unfavorable, since this experience is particular to each social agent involved in it[23].

It is noteworthy that the death of children is seen as a failure in both the personal and family spheres, generating stress and psychological suffering. This feeling is intensified in Nursing professionals due to the longer time they spend providing health care to the ill. It is essential that such discussion and reflection be raised in hospital complexes in order to help professionals to go through mourning in a more balanced way, giving them the necessary support to care for both patients and their families. However, such attitudes do not annul the need to seek psychological support, aiming at a less painful acceptance of death and dying and minimizing their own suffering[24].

Depending on the sector in which the professional is inserted, death can be expected due to the severity of the clinical conditions of children, however, this fact does not make the process easier, because during graduation, professional training aims at the promotion and prevention of health, healing, aspects related to life/survival and not the death of the patient. Thus, it is necessary to create an environment that promotes well-being and encourages the patient to actively participate in decisions that concern his clinical condition, respecting his understanding and age group.

The care offered during the process of death and dying are not widely discussed during graduation or in health facilities; despite the literature available, it does not mean that there is practical understanding and that this is applied in the daily lives of professionals. What sets up a difficulty for nursing in caring for the patient in a comprehensive way in his finitude, since the care is directed only to the lifeless body and not the human being who died[25].

Preparing the multiprofessional health team makes it possible to offer a quality service, and the patient's death starts to be seen in a more natural way, as a stage of the life cycle. In this way, the care provided during the assistance is supported by ethical principles, professionalism, and meets the principles of humanization in health[26].

Grief and loss need to be dealt with so that they do not negatively affect the provision of services to patients who are without therapeutic possibility. For the professional to lead a healthy life, it is necessary that the suffering and stress resulting from the work environment be mitigated. To this end, it is recommended that coping/overcoming strategies be provided by both the academy and health institutions, serving the professionals exposed to the stress of the work environment[27-28].

Resilience refers to the individual's ability to recover, to continue life, despite traumatic situations, "it implies that the traumatized individual overcomes and reconstitutes himself" [29]. However, it is necessary that the service provides the conditions and the adequate tools for the professional to be resilient in the face of the child's death.

It is perceived the lack of training for nurses to deal with death, especially that of the child. The nurse is trained to fight death and not to accept it as a stage of life. This posture contributes for the professional to suffer at the expense of the death of his patients, besides adopting strategies, not always adequate, to face mourning. In addition, it is necessary that the service offers support to its professionals so that they can express, without judgment, the feelings that are aroused, in addition to providing a professional follow-up when appropriate.

There is an urgent need to rethink and reflect on the practices of nursing care through the process of infant death and dying. Nurses need to be prepared to assist children and their families in this moment of grief, making it possible for this moment to be peaceful and as less traumatic as possible. However, it is noted that in order to care for the other, it is of paramount importance that Nursing also takes care of itself.

The initial discomfort of the participants in talking about the process of infant death and dying stands out as a limitation of the study, being circumvented during the interviews through a supportive researcher-participant relationship, without causing damage to the construction of data. In addition, the field of study, the Child Health Nursing Residency, is limited, reducing the number of participants. However, it did not interfere with the quality of the data and the representation of the process of infant death and dying in the Hospital/Residency Program studied.

IMPLICATIONS FOR HEALTH AND NURSING PRACTICE

It is evident the need to discuss the process of death and dying in the training of nurses, as well as in the services. It is essential that workplaces encourage and provide the necessary resources for professionals to strengthen their self-care practices during the process of infant death and dying. In addition, it is necessary to put this issue in evidence, aiming to reduce the illness of the category. To this end, it requires the construction of a safe space for expressing feelings and sharing experiences and effective coping mechanisms. The service needs to ensure the referral to specialized care in cases where the suffering caused by the loss of the patient interferes with the quality of life of the professional.

FINAL CONSIDERATIONS

In conclusion, it is observed that the resident nurses in child health have developed their own mechanisms to deal with infant death and dying in view of the deficiency in their training. One notices an initial reluctance to accept death as natural to the life cycle. In addition, nurses do not seek professional help to elaborate and experience grief, despite considering the therapeutic process important. The death of a patient is permeated by different feelings, usually with negative connotations. This scenario reinforces the

need for the redefinition and deconstruction of the concept of death present in the West. The resident nurses in child health perceive infant death as a tragic event or for "rest from suffering" depending on the patient's clinical condition. However, regardless of the context, it is still painful, and it is necessary to resignify death and dying during the provision of Nursing care.

AUTHORS' CONTRIBUTION

Data Collection, Conceptualization, Project Management, Research, Methodology, Writing - Preparation of the original, Writing - Revision and Editing: Jefferson Wildes da Silva Moura

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Research, Methodology, Writing - Preparation of the original, Writing - Revision and Editing: Kaili da Silva Medeiros, Filipe Souza Lemos, Maria Gabrielle Moreira Santos Silva

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