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ORIGINAL ARTICLE

Perception of support in professional's and technician's grief of pediatric intensive care units in public hospitals

Percepción de apoyo en duelo por profesionales y técnicos de cuidados intensivos pediátricos de hospitales públicos

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Abstract

Introduction: Death in childhood is a reality faced by health professionals, especially in highly complex units such as intensive care ones. This leads to feelings of helplessness and frustration in health professionals, compromising their physical, emotional, and mental health, which is worsened by the feeling of low social support and poor preparation for coping with death and support for the patient's family. **Objective:** To expose the perception of sorrow support of professionals and technicians in pediatric intensive care units of public hospitals, after the death of the patients. **Subjects and Method:** Qualitative study with a phenomenological approach. 16 in-depth interviews were conducted with pediatric intensive care professionals and technicians from five public hospitals in Santiago, Chile. Inclusion criteria considered working for more than a year in the Unit, having experienced the death of patients, and recognizing that they have gone through a professional sorrow. The interview focused on the following question: How have you experienced the sorrow support received after the death of patients in your unit? Once the narratives were transcribed, the phenomenological analysis and subsequent data triangulation were carried out, achieving saturation. **Results:** It was observed that the participants feel little supported in their sorrows after the death of the patients, where there are obstacles to face the situation. Although facing death is something complex for the participants, they recognize that they can generate protection strategies and also feel supported by the people around them. Despite the complexity of this experience, the participants consider that there are lessons learned in facing death which leads them to give meaning to their professional work. **Conclusion:** Professionals need the recognition of deaths in the workplace and, therefore, formal and continuous support from their work team and institution.

Keywords:
Sorrow;
Social Support;
Health professionals;
Intensive care;
Child

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Introduction

Although modern medicine in recent decades has focused on prolonging life and curing diseases, death is a reality that has to be faced daily, especially in high complexity units[1,2]. For pediatric unit teams, the death of a child has become difficult to address, understand and accept[3,4]. Therefore, this type of situations can generate in professionals impotence and frustration, which can compromise their physical, mental, emotional, and even spiritual state, leading them with the time to professional wear[5,6]. This can be worsened if the professional feels isolated and with low social support facing the death of the patients, added to the deficient undergraduate education in coping with death and support to relatives[7]. Several investigations have demonstrated that social support can be a mediator to face the patients' death, helping to alleviate stress and allowing to improve the coping style before these situations and thus favor the work environment in high complexity services[7,8]. However, this social support is focused on the recognition of the links between peers, rather than considering the death of a patient as a professional and personal loss, therefore there is a difference between the expected support and the received one from their environment as well as from the hospital[7,9]. Thus, the objective of this research is to unveil the perception of bereavement support in professionals of pediatric intensive care units (PICU) of five hospitals in Santiago de Chile, after the death of patients.

Subjects and Method

This study was carried out through qualitative design, with phenomenological approach according to Husserl[9,10], which allows revealing the true meaning of the human experience regarding a phenomenon, in the most original possible way[10,11], through a reflective and subjective method, which is developed through a rigorous, critical, and systematic methodology.

The sampling was intentional, inviting to participate in university and technical professionals who work in pediatric intensive care units of five public hospitals in Santiago de Chile, between May and September 2017.

Among the considered inclusion criteria were working for more than a year in the unit, having experienced the death of patients, acknowledging that he/she has gone through professional bereavement, and that voluntarily would like to participate. Staff members with recent personal bereavement were excluded, on the recommendation of experts. Professionals were invited by email, and those who agreed to participate were contacted by the researchers to arrange the interview and give consent.

The data generation and analysis technique were carried out according to the stages postulated by Streubert[11], starting with the bracketing writing by each of the project researchers. The data were collected through recorded in-depth audio interviews, which were conducted by five of the trained researchers (EA, PC, XG, ML, and PV), using a unified script. Each interviewer met with one of the participants in a private setting outside the hospital. After reading and signing the informed consent, the interview was conducted, guided by the following question: How have you experienced the bereavement support received after the death of patients in your unit? The audios were literally transcribed, and then one of the researchers (PV) normalized the accounts. These, once transcribed, were submitted to a comprehensive analysis by the seven researchers separately, who later carried out the triangulation of their findings, reaching consensus to unveil the units of meaning, grouping them into larger units and thus structuring the phenomenon once the data were saturated. The findings were returned to the participants, who expressed a sense of being represented. During the process, compliance with the methodological rigor proposed by Guba & Lincoln[10] was ensured. In addition, this study was approved by the Scientific Ethics Committee, MEDUC (N° 16-329), and financed by the National Fund for Health Research (FONIS-SA16I0189).

Results

In this study, 16 health professionals participated who shared their experiences through their accounts. Table 1 shows the Socio-demographic characteristics of the participants.

Findings

After the death of patients, professionals and technicians face complex situations that lead them to feel emotionally involved, experiencing a professional bereavement. However, there is a perception of low support for this situation, generating the need to visualize this issue and be able to express their grief in protected instances. In spite of the above, these experiences bring with them learnings that allow them to give meaning to their professional work (Figure 1).

Next, each of the revealed units of meaning will be analyzed.

Low perception of bereavement support

The professionals who work at PICU perceive low

support in bereavement after the death of their patients, due to *the lack of formal support from the institution, a low recognition of the link with the patient, and lack of bereavement interventions towards the teams.*

"It's not really a big deal, no! I have never heard, for example, from the nursing directorate or sub-directorate that this is within some goal or some strategy or as a mental health objective of the staff, related to the loss of patients... Considering that we are also a pediatric hospital! But no, not really, I don't see it that it's relevant to them. It's never been touched on, either."

Nurse, 38 years old

"The problem is that I don't know if people become hard over time. Of course!.. it affects suddenly. You shed a tear, but it's like saying, "It's one more". So when you say, "Oh, what a pity he died, I loved him so much, I felt so sorry for him, I feel sorry for his mom..." My workmates say to me: "Hey! Don't you worry, girl! With the years you'll get it over."

Nurse technician, 52 years old

"Yeah, the environment where I work isn't bad. We have a good treatment among nurses, doctors and ourselves, but in that aspect, that intervention is lacking. Because the patient dies, it's sad and pity, but you have to go ahead and clean the unit and that's it, another patient arrives and you forget what happened."

Nurse technician, 45 years old

Obstacles to coping with professional bereavement

The participants feel that there are obstacles within their professional work that do not allow them to adequately express or experience their grief, among which are *not being able to speak freely of losses, work overload, and feel death as failure.*

"But also, is like well restricted. Because not everyone is really willing to listen to you about what the process was like... how you feel about the loss. Not all of them are linked to the subject matter. So, it also becomes a little complex and there I had to regulate to say some things."

Social worker, 36 years old

"... since it's an ICU, you have to help the other child. "Now, then, let's care another one." And it's like a process... everything is like a quick process that doesn't give room to experience the moment of the child's death."

Pharmaceutical chemist, 40 years old

Table 1. Sociodemographic characteristics of the participants

Characteristics	Total number: 16
Gender	
Female	15
Male	1
Age	
43 years on average	
Range between 29 to 59 years	
Maritial status	
Married or cohabiting	9
Single or separated	7
Educational level	
Nursing Technician	4
Nursing	6
Physician	4
Social work	1
Pharmaceutical Chemistry	1
Psychology	0
Professional performance time	
Less than 5 years	2
6 to 15 years	4
More than 15 years	10
Suffering from professional losses	
Yes	16
No	0
Suffering from personal losses	
Yes	9
No	7
Participation in grief seminars	
Yes	10
No	6

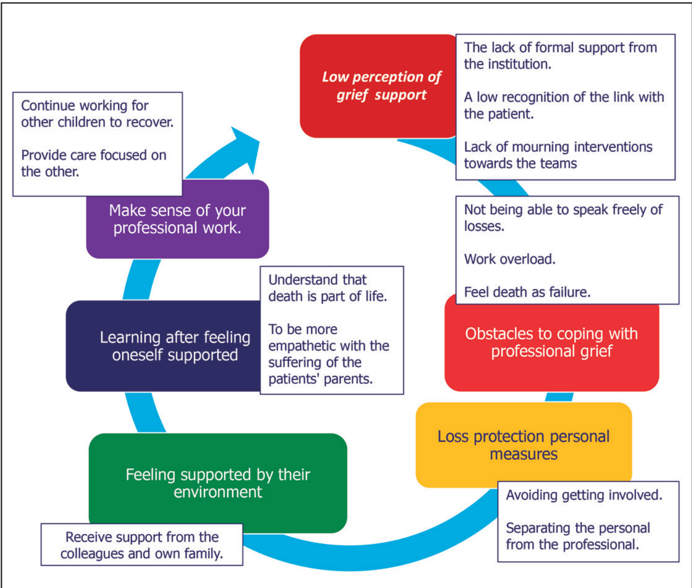

Figure 1. Perception of grief support in PICU professionals.

"Now, obviously people when... when they put a lot of effort into a patient... living and not dying, and finally the patient dies, they feel defeated, a failure, a tremendous failure. "

Physician, 40 years old

Loss protection personal measures

The death of patients in PICU and the low support perceived by professionals forces them to develop strategies to protect themselves, such as *avoiding getting involved and separating the personal from the professional.* According to the reports, these measures allow them to continue working in a unit of high complexity, with a high emotional load.

"I think the nurses, especially the older nurses in the hospital, it's like they have "more distance". I mean, the relationship with the patients... "No! That's it for us, is a patient. You take care of him, you do well your job and everything you can do. But that's all!" You don't form a further bond."

Nurse, 29 years old

"You don't have to take your work home with you! I try not to mix. Because everyone has their own process. I mean, how are you going to overload more with what happens to you and the rest of the family! So... it's hard work, it's not an easy job."

Physician, 33 years old

Feeling supported by their environment

Despite the experiences of poor support facing their professional losses, the participants point out that there is informal and spontaneous support from the people around them, such as their workmates and their own family. In the latter case, support is mostly provided by their partners.

"At work, I receive support from my workmates, who in one way or another had to handle the same patient and from the boss. And at home, from my husband. In fact, sometimes I feel half guilty because I often pass on to him much of the anguish I can handle on a shift. But in certain situations, I end up stressing him too, because I'm talking and telling things, and the poor man ends up stressed too. However, when my husband listens to me and hugs me... For me, physical contact is super important from an affective point of view!"

Physician, 35 years old

"On the part of workmates, I do feel support. Above all, from those who have already suffered the loss of patients. From those who are newer... on the contrary. It is you, who has been working longer, who has to go and support the new one. Because it's also very difficult for them to have a patient die in your shift... That's why, to rely on a team more than anything... and on the team of nurses or technicians, or on the physicians closest to you... That helps! "

Nurse, 32 years old

Learning after feeling oneself supported

Being supported in facing the losses inside the teams has allowed them to acquire learnings that lead them *to understand that death is part of life and to be more empathetic with the suffering of the patients' parents.*

"It hurts the same... what they say you get used to. Lies! I think you do put up barriers, or things, that some say "you learn how to handle it and everything". Maybe in the sense that I now know that a sick patient is not always going to go home... That a patient who arrived polytraumatized, a burned one, is not always going to return home. In that yes... that I believe that I grew... Because before I thought that they arrived here and that all the small children were going to go to their house, that the death was like far away, I did not feel it near... but it is not like that! But I've already learned that."

Nurse technician, 38 years old

"Here the parents had visits for two hours. Then there has been a change [extending the schedule], which I believe has made us understand this look that body and mind are not separated. That we have to accompany the parents throughout this painful process because it is not just grieving. I mean, admission on an intensive care unit is for the parents, imagine! that they have never separated and on top of that I say to them: "you can't stay". Because I have nowhere they can stay..."

Physician, 56 years old

"...to be able to help, to be able to give something to that suffering family. And that's like what still, at least to me, motivates me to stay in this. In fact, that's why I went to nursing school. I mean, my aim was to be able to help from a more humanized way than maybe what a doctor can do. The power to give support. In the end, it is good, we can do many things, there are many procedures, there are many things and we can learn a

lot. Yes, but the support provided by the nurse is fundamental in these crisis processes... and with the children even more so."

Nurse, 29 years old

Make sense of your professional work.

The learning that the loss has brought and the possibility of feeling support from their environment, has allowed them to make sense of their professional work, *which has led them to continue working for other children to recover and provide care focused on the other*.

"...they are critically ill and then you see them that they moved forward and got, they got better and they are alive! Seeing the patients who have improved and are at home, then they come to see us here. And... That kinda comforts you. Yeah!"

Nurse technician, 59 years old

"Notice that I am motivated more by a job well done than by recognition. It's happened to me that the parents come over and thank you… I remember that I go by and the patient had been moved down to die in the intermediate care unit... He was in the last room with a screen. The mother cried alone..... Then at that moment like no one had stopped to see what was going on with her. I just passed by and saw her... More than seeing her, I felt like she was sobbing and I walked in. I brought her a chair, I made her sit down, I asked her if she wanted to hold her son in her arms, who was a little boy who had something hepatic. Then she says to me, "And can I hold him?"... "But of course - I tell her- it's your son." "Did they talk to you? Are you aware of everything...?" "Yes, miss," she said. Then I sat her down, took the boy, and passed him to her in my arms... It was what I could do. Then I say to her, "Are you able to hold him?" "Yes, miss," she said, "I want to hold him," I passed him to her, and I left. Then I did a couple of rounds and then the little one had already died..."

Nurse, 35 years old

Discussion

After this study, it was revealed that professionals working in pediatric intensive care units experience mourning, experiencing feelings of grieving and loss after the death of a patient. For them, it is inevitable to generate certain bonds with the patients and/or their family, so this directly impacts and affects the pre and post mortem care and attention that they provide [12]. Likewise, this experience requires certain skills of accompaniment and support to family members, for which many times they do not feel prepared[12,13]. In some cases, professionals consider that post-mortem preparation actions should be carried out without care for the professional's own emotional needs, with incongruence between not feeling ready for grieving and acting[14].

Regarding the above, participants report that the perceived support for their grieves in the professional environment is deficient, determined by limitations in terms of lack of institutional support, low training, work overload, the scarce time to be able to close cycles, and see death as a failure, which is described in a series of investigations conducted in highly complex units[12-14]. For Kapoor et al. this situation is described as the need for a "sacred pause" among ICU workers, whose absence generates in them a "cumulus" of suffering, affecting both their working and personal lives[15]. According to Peterson et al., this would be worsened by the lack of instances to talk within the teams in a protected environment, such as the implementation of coping programs within units[13]. As for seeing death as failure, both the participants and the accounts of professionals in other investigations reveal that they feel responsible for the deaths, where they perceived themselves as the direct or indirect causes of the death of the child, generated in them emotions such as anger, impotence, sadness, desperation, denial, feelings of emptiness and vulnerability[15,16].

On the other hand, they account that over time they generate individual and group strategies to overcome the loss of patients, such as accepting the support given by peers and their own relatives[12,14]. As for the peers, this support is materialized in the possibility of sharing the experiences of loss through informal conversations between a small group of workers and/or the possibility of freely expressing their emotions in a protected environment[15,17,18]. In the case of their family, Gálvez et al. point out that it is within this family that professionals feel most contained, finding understanding and emotional support[14].

However, several professionals over the years are developing protective measures against deaths, by staying away from patients in order not to generate significant relationships[13]. Experts point out that this strategy constitutes an attempt to move away from the experienced pain and suffering, avoiding thinking about it, and generating an emotional distancing, so as not to fall into the risk of being inefficient at work because of their emotions[12,19]. The participants in this study also share this.

Notwithstanding the above, in several studies the professionals who work in this type of unit point out that, despite being a complex situation, facing the death of children and being able to accompany fami-

lies, has allowed them to see death as a natural and daily process in the work context and with it, to develop empathy facing the pain of parents[9,14,16,20]. These experiences have allowed them to realize that, even though the patients die, the team did the best they could have done at that time[14,18,20,21]. This perception is also shared by the participants, who see it as a learning of the grieving process, which allows them to give meaning to their work and continue working in the unit.

After the development of this study, the low participation of men is considered a limiting factor, despite the fact that the sample was intended to favor the equitable and voluntary participation of all workers, regardless of their gender. This difference in participation between men and women has been observed in other studies in health professionals, where male participation does not exceed 20%[5,8,22,23]. It should be noted that, in a study conducted in the same population as the present study, of the 210 participants, only 11% were men[23]. In turn, the results showed that men are perceived as less recognized in their griefs than women (p value = 0.039), which opens the question as to the interest and need of male health professionals to address issues related to death. Therefore, it is suggested to consider this population in future researches that approach this phenomenon from a qualitative perspective.

Conclusion

The PICU professionals require that the deaths of their patients be recognized as professional losses, for which it is considered essential to receive the support of their peers, family members, and the institution itself where they work. Although there are obstacles that do not allow them to say goodbye and close the relationship with patients[15,16], they consider that rites could be developed that favor the elaboration of closing processes through a short pause of time within their work routine, considering them as "sacred pauses"[17]. That is in addition to the creation of instances to be able to talk about their grief and their own experiences [13], improving the instances of communication within the team, and favoring the cohesion among workmates, a key element in this type of processes[24].

According to Kapoor et al.[17], developing closing rituals fosters teamwork, appreciation of efforts, and also provides a moment to make sense of what is given, recognizing the gratitude and pleasure of caring for patients in the ICU.

In addition, as presented in other researches[7,12,13,14], the findings of this study reveal the concrete need that professionals in intensive units have to receive formal support from institutions, through accompaniment interventions or training on the subject of death[14,15]. This allow them to reflect on their apprehensions and fear of this situation, and promote the search for meaning of experiences[20,21,25].

After what has been analyzed, it becomes relevant to work grieves within the teams and in a personal way, since it allows giving meaning to the professional work, facilitating the generation and delivery of a humanized care to the patient and their families, which can become a self-care strategy of the professional[26].

Like any qualitative study, this research allows the approximation to reality among professionals who share the experience of the same phenomenon and its possible transference of the revealed data without generalizing them.

This presents the great challenge of continuing research into the grieving processes of professionals, addressing the different factors that influence the complex phenomenon of coping with the death of patients, especially the pediatric ones.

Ethical Responsibilities

Human Beings and animals protection: Disclosure the authors state that the procedures were followed according to the Declaration of Helsinki and the World Medical Association regarding human experimentation developed for the medical community.

Data confidentiality: The authors state that they have followed the protocols of their Center and Local regulations on the publication of patient data.

Rights to privacy and informed consent: The authors have obtained the informed consent of the patients and/or subjects referred to in the article. This document is in the possession of the correspondence author.

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Conflicts of Interest

Authors declare no conflict of interest regarding the present study.

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