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FEELINGS AND ATTITUDES OF NURSING PROFESSIONALS TOWARDS THE DEATH PROCESS OF PATIENTS IN PALLIATIVE CARE

Sentimentos e atitudes dos profissionais de enfermagem diante do processo de morte dos pacientes em cuidados paliativos

Sentimientos y actitudes de los profesionales de enfermería ante el proceso de muerte de pacientes en cuidados paliativos

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RESUMO

Objetivo: identificar os sentimentos e atitudes dos profissionais de enfermagem diante do processo de morte dos pacientes em Cuidados Paliativos. **Método:** estudo qualitativo, cuja coleta de dados foi realizada por meio de entrevistas semiestruturadas. Foi realizada análise de conteúdo para a análise dos dados. **Resultados:** foram entrevistados 14 profissionais de enfermagem, emergindo de suas falas cinco categorias: Empatia como principal atitude frente ao processo ativo de morte de pacientes em cuidados paliativos; Visão da morte como um alívio para o sofrimento do paciente em cuidados paliativos; Promoção do conforto do paciente como principal atitude dos profissionais de enfermagem; Estratégias de manejo dos sentimentos dos profissionais de enfermagem; Desconhecimento e incertezas dos familiares acerca dos cuidados paliativos, como elemento desafiador na assistência a esses pacientes. **Considerações finais:** A equipe experimenta intensamente os sentimentos e reconhece os desafios diários dos cuidados paliativos, ainda que varie nas estratégias de manejo emocional.

DESCRITORES: Cuidados paliativos; Processo ativo de morte; Cuidados de enfermagem; Equipe de enfermagem.

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ABSTRACT

Objective: to identify the feelings and attitudes of nursing professionals toward the death process of patients in palliative care. **Method: a** qualitative study was conducted, and data was collected through semi-structured interviews. Content analysis was performed to analyze the data. **Results:** 14 nursing professionals were interviewed, and five categories emerged from their statements: 1) empathy as the main attitude toward the active death process of patients in palliative care, 2) death as a relief from suffering for patients in palliative care, 3) promoting patient comfort as the main attitude of nursing professionals, 4) strategies for managing nursing professionals' feelings, and 5) family members' lack of knowledge and uncertainty about palliative care as a challenging element in assisting these patients. **Final considerations:** The team experiences intense emotions and recognizes the daily challenges of palliative care, although emotional management strategies vary.

DESCRIPTORS: Palliative care; Active dying process; Nursing care; Nursing team.

RESUMEN

Objetivo: identificar los sentimientos y actitudes de los profesionales de enfermería hacia el proceso de muerte de pacientes en Cuidados Paliativos. **Método:** estudio cualitativo, cuya recolección de datos se realizó mediante entrevistas semiestructuradas. Se realizó un análisis de contenido para analizar los datos. **Resultados:** Fueron entrevistados 14 profesionales de enfermería, surgiendo de sus afirmaciones cinco categorías: Empatía como actitud principal ante el proceso activo de muerte de los pacientes en cuidados paliativos; Ver la muerte como un alivio al sufrimiento del paciente en cuidados paliativos; Promoción del confort del paciente como principal actitud de los profesionales de enfermería; Estrategias para la gestión de los sentimientos de los profesionales de enfermería; El desconocimiento y la incertidumbre de los familiares sobre los cuidados paliativos, como elemento desafiante en la asistencia a estos pacientes. **Consideraciones finales:** El equipo vive intensamente los sentimientos y reconoce los desafíos diarios de los cuidados paliativos, aunque las estrategias de manejo emocional varían.

DESCRIPTORES: Cuidados paliativos; Proceso activo de muerte; Cuidados de enfermería; Equipo de enfermería.

INTRODUCTION

Palliative care is the active and holistic care offered to individuals of all ages facing intense, health-related distress due to serious illnesses, particularly those approaching the end of life. The goal is to improve the quality of life for patients, family members, and caregivers.[1]

This type of care involves the prevention, early identification, and comprehensive evaluation and management of physical problems, including pain and other distressing symptoms, as well as psychological, spiritual, and social issues.[1]

Even though death is an inevitable, universal, and natural process inherent to life, it is still faced with great difficulty by the general population. Death can evoke feelings of anxiety in family members and even in the professionals responsible for care.[2]

Attitudes toward death have changed over time, primarily due to the advent of hospitals and intensive care units. In this sense, the concept of "terminality" was institutionalized and began to be experienced by health professionals, who were emotionally impacted by their experience of care and by their recurrent contact with finitude.[3]

Although death is a common occurrence in the daily lives of healthcare professionals, many have difficulty dealing with this reality because they were not prepared for it in their training. Many consider it to be a failure. This can generate a harmful emotional burden in all areas of these individuals' lives.[4]

Witnessing the death of a patient in palliative care can evoke intense emotions in the healthcare team due to their proximity to the patient and their family.[3]

Health professionals report a lack of preparation and skills during training to support patients in palliative care through the death process. This process can impact their mental health, often leading them to seek psychological support. Death can also influence day-to-day work, such as communication with the team, interpersonal relationships, and performance of activities provided to users. It is a delicate time for professionals to deal with the final stages of the disease and death.[3]

Understanding the feelings and attitudes of health professionals when facing the death of patients in palliative care will help them cope with the difficulties they experience at this time and encourage them to seek support in critical situations.

In view of the above, the following question was defined: What are the feelings and attitudes of health professionals when facing the death of patients in palliative care?

METHOD

This qualitative research has a descriptive and exploratory character. The article's report followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.

Data collection took place between April and July of 2024. The study participants were nursing professionals from a secondary-level hospital in the interior of São Paulo state. The hospital has 50 beds, 10 of which are exclusively for palliative care patients. The following inclusion criteria were adopted to delimit the sample: working in the aforementioned service's nursing team for at least one year and providing direct care to palliative patients. The exclusion criterion was being away from work (due to vacation or leave) during the data collection period.

The study was approved by the Research Ethics Committee of the University of São Paulo's College of Nursing in Ribeirão Preto, under protocol No. 6,018,090. After approval, participants were invited to take part in the study, at which time the study's objective and their role in it were explained. Two copies of the Informed Consent Form (ICF) were delivered, and after the participant read it, doubts were clarified, and the participant signed both copies. The researcher also signed both copies of the ICF, keeping one copy and delivering the other to the participant.

Individual interviews were conducted with the participants in a private place at the same institution where the study was conducted. Data collection was carried out at a time defined by the participant so as not to interfere with their work schedule.

The nursing team professionals were invited to participate in the research through direct contact with the researcher during their work hours. This approach was used to create a convenience sample.

Semi-structured interviews were conducted, guided by the following questions: "What is it like to care for a palliative care patient who is dying?" and "Do you experience any feelings while caring for a palliative care patient who is dying?" What are your attitudes toward the death process of the palliative patient under your care?"

Also, to characterize the participants, the following information was collected: training, time working in the service, and time working in palliative care.

With the participants' permission, the interviews were recorded on a digital device. Later, the material was transcribed in full.

The total number of participants was defined by the convergences and divergences observed in the elements used to understand the phenomenon. Saturation was obtained by showing repetition of statements and descriptions of the phenomenon.[19] To ensure anonymity, the interviews were organized by data collection date and identified by Arabic numerals. Interviewees were identified by the initial of their profession, e.g., Nurse 1 (N1).

In the present study, content analysis was carried out from Bardin's perspective. This approach involves a set of communication analysis techniques that aim to obtain indicators (quantitative or qualitative) through systematic and objective procedures for describing the content of messages. These indicators allow for the inference of knowledge related to the conditions of production/reception (inferred variables) of these messages.[5]

The content analysis will follow these organizational criteria: pre-analysis, exploration of the materials, and treatment of the results (inference and interpretation).

The pre-analysis involves systematizing the materials used in data collection to guide the analyst's understanding of the phenomenon studied. For this purpose, a "floating" reading approach is typically adopted, which refers to the initial engagement with these documents. This contributes to defining the research corpus and formulating hypotheses, objectives, and indicators, which help interpret the material.[5]

The second phase comprises exploring the material, summarized by structuring coding through choosing registration units. This process involves cutting and enumerating the material (paragraphs, notes, etc.) after identifying words and phrases related to the objective theme, thus creating the initial categorization. Then, the initial categories are grouped by theme, resulting in intermediate categories. When these intermediate categories are grouped by theme again, the final categories are formed.[6]

The third phase follows, referring to the treatment of the results (inference and interpretation). The evaluator must attribute meanings to the raw results according to the proposed theoretical framework. To do so, a deep interpretation is necessary to understand not only the expressed content of the material but also the latent content contained within.[5]

RESULTS

A total of 14 professionals participated in the study: five nurses and nine nursing technicians. Of these participants, four were men and ten were women. The mean age of the participants was 35 years. On average, the professionals had been trained for ten years and had worked in palliative care for five years.

The interviews were conducted at various times of the morning, afternoon, and evening, when the professionals were available, without affecting patient care needs or institutional demands. The interviews lasted approximately 25 minutes, and all participants authorized recording, enabling full transcription for analysis.

Based on the participants' statements, five thematic categories emerged from the data obtained in the research: 1) Empathy as the main attitude towards the active process of death of patients in palliative care, 2) Vision of death as relief from patients' suffering in palliative care, 3) Promotion of patient comfort as the main attitude of nursing professionals, 4) Strategies for managing nursing professionals' feelings, and 5) Lack of knowledge and uncertainties of family members about palliative care as a challenging element in caring for these patients.

Empathy as the main attitude towards the active process of death of patients in palliative care

Upon full evaluation of the interviews, it became evident that the primary attitude of professionals in the face of patients' active dying process in palliative care was empathy, reflecting the human connection between professionals and patients.

> *[...] Behind death, there is a person who is a father, a son, there are feelings behind it. And you realize that you are preparing a body, and that tomorrow it could be you. And the one in palliative care could be you [...].* (NT6)
>
> *[...] Ah, I think it's empathy. Because we must think about the other, so I believe it's a lot of empathy. Also care—having care for the other, thinking that the person there is someone's loved one, right? So, they are someone's father, someone's son, someone's brother, someone's mother, someone from that family [...].* (NT9)
>
> *[...] It's putting yourself in their shoes. We always must put ourselves close to both the family and the patient because one day it could be us. My attitude is always to put myself in the place of the person we are taking care of [...].* (NT14)

According to some participants, empathy was more pronounced when facing the active death process of younger patients. According to the interviewees, a life-threatening disease diagnosis in these cases represents a break in the natural life cycle, abruptly interrupting the patient's potential experiences. Additionally, the closer the age difference between the patient in palliative care and the nursing professionals providing care, the greater the identification and, consequently, the more intense the sensitization.

> *[...] Our human side comes out more when the patient is younger, as in her case, because there's no way to separate your own life and the lives of those around you. You see that example and you think, wow, it could be me, it could be my sister, it could be… and so young, with so much still to live. Our humanity comes out; our empathy comes out [...].* (N1)
>
> *[...] There are younger patients too, of course. We feel more with the younger ones, but still, most have already lived their lives, already done what they had to do, followed the natural cycle of life and came here to die. [...] We once lost a patient here who was the same age as my son, you know? So that really hits you harder [...].* (NT10)
>
> *[...] When the patient is younger, it's a little more complicated because of their life history, the expectations that patient had, right? We've been seeing quite a few cases of people who are 27, 30, early 30s, coming into palliative care [...].* (NT12)
>
> *[...] When it's an older person, you still feel it, but it's easier to handle. But like I said, when it's someone young, then it really hurts, because they had a whole life ahead of them, right? [...].* (NT13)

For other participants, empathy was more related to family members and companions during the active process of death and loss.

> *[...] It's a feeling of deep empathy that I experience, especially toward the family members, so I try to offer a lot of support [...].* (N2)
>
> *[...] But from the moment you see how much the patient is suffering, it's something I would think about by putting myself in their place: 'What would my attitude be if a family member of mine were in this situation?' [...]* (N4)
>
> *[...] So it's a mix of feelings—often powerlessness, and also real sadness—of putting yourself even in the place of the family member [...]* (NT11)
>
> *[...] In fact, it's often more compassion for the family, for those who are left behind, because of the loss. Because for the patient, it almost feels like a relief from suffering [...].* (NT13)

The vision of death as relief from the suffering of patients in palliative care

Some participants expressed that, from the patient's perspective, death represents relief from prolonged suffering. Adopting this perspective allows one to perceive a new meaning of death that differs from the common societal view. In everyday situations, the idea of death is usually avoided and rejected; however, in these cases, death becomes a more favorable alternative.

> *[...] The patient, if they are going… We do feel sad, yes, but… like I said, it's also a relief, because they won't be suffering*

> *anymore there in the bed. Because sometimes I think, gosh, why does the patient have to suffer so much? Why doesn't God take them? Why so much suffering? Because they're so hurt and still lying there, and it feels like the person takes a long time to let go. I'm not selfish to say they must stay. I feel like they must go, for their relief [...].* (NT5)

> *[...] So yes, some patients make us sadder, while others bring relief because they are being freed from suffering that we know has no way back, that is progressive. So, you say, 'Jesus, take them.' Many times you say, 'God, have mercy on this patient,' because there's nowhere else to run to [...].* (N1)

> *[...] But the feeling, I think the relief of the patient no longer suffering is much greater than the sadness [...].* (N4)

> *[...] So… But you know, I think my view of death has changed a little? I used to be much more afraid. I used to see it as something much more negative. And now, not anymore, you know? Because I see that most of them die very peacefully [...].* (N8)

Empathy is the main attitude toward the active process of death for patients in palliative care. Death is envisioned as a relief from patients' suffering in palliative care. Patient comfort is the main attitude of nursing care. Strategies are needed to manage nursing professionals' feelings. Family members' lack of knowledge and uncertainty about palliative care is a challenging element in the care of these patients.

Promotion of patient comfort as the main attitude of nursing professionals

The study participants recognize that ensuring patient comfort is the most important aspect of palliative care.

> *[...] We try to keep the patient as comfortable as possible. We prioritize measures of comfort and human dignity—the dignity of the patient. Respecting that person's humanity, their story, their family's story [...].* (N1)

> *[...] So I try to learn what the patient has lived through up to that point, as soon as I take over the shift, to see what I can do to help the patient have the greatest comfort possible. Because what we really don't want is to leave the patient uncomfortable, in suffering. We want them to be calm, we want them to be comfortable so that when the time comes to go, they can go peacefully [...].* (N4)

> *[...] Many times we discuss with the multidisciplinary team, we discuss with the doctor to adjust pain medication, to adjust some other type of medication. Sometimes, just by letting a family member in, the patient already feels more comfortable, already feels better. So, often we allow 4 or 5 people to visit. 'Oh, and the child?' That's fine, the only condition we set is whether the child is okay to see it. Otherwise, we allow it, no problem. So, I think it's not about something we do automatically; we look at what the family needs at that moment and try to help them, try to meet that need they have [...].* (NT9)

It was observed that, in the context of palliative care, comfort refers to the patient's holistic well-being, transcending analgesia as the only form of comfort.

> *[...] Whether it's comfort, if the patient asks for different food, we contact the nutrition service and request it. Today a patient asked for yogurt, we provided yogurt for him. And every birthday we make a cake. There was a patient who came in really at the end of life. We allowed more family members to come into the institution. Normally, we allow up to four visitors at a time, so the family can say goodbye to their loved one. Many people only value life at the very end, right? And we also allow children to come in, depending on the time and the age. The other day there was an elderly gentleman here, over 80, who wanted to see his 5-year-old granddaughter. We allowed her to come in, and it gave him a real lift. He was discharged in better condition. [...].* (N3)

> *[...] And comfort would be… he feels less pain and more pleasure at the end of his life. What would that pleasure be? Eating what he wants, seeing a relative he hasn't seen, making peace with the past, making a video call, something like that, which will bring him well-being. That's what it's about. [...].* (NT6)

> *[...] One very interesting thing that happens here is that sometimes a palliative patient wants ice cream, here, there's ice cream. Or a Coke—they'll find a way. Palliative care is about improving life in that moment. It's about relieving pain, if they're in pain; it's about offering the food they want to eat. (...) Having family support. Any patient. That's why here you can see that companions are allowed to stay. They provide full support so that the companion can remain, meals, everything. [...].* (NT7)

> *[...] I really value spirituality. I never do anything without knowing the patient's religion. But I always try, in general, to offer a word of comfort, to ask for a safe passing. Sometimes patients are still in suffering, so I go, talk, tell them to stay calm. I say a general prayer that isn't from any specific religion, you know? And I think that's mostly what I try to do, besides the technical aspects that we provide for comfort, right? For pain, for breathing… For me, caring at that time… I like to focus more on the spiritual side, so that they can have a peaceful passing. [...].* (N8)

Strategies for managing the feelings of nursing professionals

Multiple strategies for managing feelings were identified among the study participants, most of which were out-of-hospital practices. The analysis of the participants' statements revealed the paramount importance of these practices to the mental health and well-being of nursing professionals who are in constant contact with the active process of death in palliative care (PC).

> *[...] I take really good care of myself. I pay close attention to the spiritual side, including my own. I go to therapy and reflect on what it means to be someone who cares for patients with this profile. It's not just the patient, it's the family too. I'm Catholic, and my religion helps me a lot, but it's also important to say that I have complete respect for all other religions. [...].* (N2)
>
> *[...] I walk. I walk and think. I think, 'Did I do well? Did I do well? Did everything turn out okay? Yes, it did'. [...].* (N3)
>
> *I practice Umbanda, so I ask my guides to protect me and give me discernment and wisdom. I also ask for comfort, because we end up… it's very overwhelming. Working in an environment with three or four deaths a day is very draining, both psychologically and energetically. Human beings aren't naturally equipped to deal with death. It's a difficult process, even though we know it's going to happen. [...].* (N8)
>
> *[...] I actually started therapy a month ago. I had already been seeing a psychiatrist before, because of what happened after the pandemic… [...].* (NT11)
>
> *[...] Oh, and I read a lot. I watch YouTube videos on psychology and psychiatry because, as I said, my father passed away too. But I've been preparing myself, because I know everyone will die one day. So we have to be prepared… [...].* (NT13)

However, some participants argue that it is necessary to separate personal and professional matters to ensure that neither patient care nor the professional's mental health is harmed. Others say that they do not feel emotionally affected by their daily work routine and its respective complications due to the structured routine they have experienced for years. Nevertheless, some also adopt extra-hospital practices and recognize their importance.

> *[...] Like I told you, you can't let the emotional side become bigger than the professional side. Because if you do, you won't be able to give support. I think that's where the key lies. [...].* (NT6)
>
> *[...] But in general, I think that over time, being there every day, you end up developing a shell. [...].* (NT10)
>
> *[...] So, I deal with palliative patients both here and at my other job, I work in the ICU. So there too, things are very serious and critical, and I don't spend too much time thinking about it. I think I don't reflect much also because of the fatigue. When I get home, I'm tired. But I do have my activities—I go to the gym, I really enjoy cycling, I practice martial arts. That takes me away from the hospital a bit. And that's important: stepping out a little from the hospital routine. If possible, walking out the door and leaving the hospital behind. Because if we keep carrying too much of it with us… it really messes with your head. [...].* (NT14)

Lack of knowledge and uncertainties of family members about palliative care, as a challenging element in the care of these patients

The analysis of the interviews revealed that a lack of knowledge about palliative care directly influences family members' understanding of what can be done for their loved ones during this delicate time. Several participants pointed out that the lack of knowledge among family members, coupled with the emotional stress of dealing with this situation, can pose a challenge to the nursing care provided during the active dying process of patients in palliative care (PC).

> *[...] I think maybe it's when a family has more difficulty understanding palliative care, that's when it ends up being a little harder. But we always try, at least I always try, to put myself in the family's position. Because sometimes families can even be rude to us, right? They get upset, argue, answer back… [...].* (NT9)
>
> *[...] What really makes it difficult… I don't know if it's a lack of empathy on our part… It's that the families aren't prepared for that moment. So sometimes you want to provide the appropriate care the patient needs at that time, but the family doesn't allow it, you know? They think there's still a chance of recovery. Sometimes the family interfering with our care is what complicates things, what makes it harder [...].* (NT10)
>
> *[...] I think many times it depends again on the family member, on whether or not they accept it. They agreed back when the meeting was held, but when they actually see the patient's condition progressing, it's like: 'But you're not going to feed my father, my mother? You're not going to do this? My father is just lying here…' Yeah, that's it, in my view. I think the worst part is that there's always one or another family member who doesn't accept it. I know it's difficult, but I think that's really what makes it harder [...].* (NT11)
>
> *[...] I think the element that makes care the most difficult is the family. The family complicates things a bit, because we already have the foundation, we already understand*

> *the care. What makes it harder is the family, who don't understand the care and want to interfere with it. That's the difficulty. [...].* (NT14)

DISCUSSION

Empathy is a fundamental element in providing quality nursing care, especially in the context of palliative care and the dying process. Considering the empathic movement, a deeper, more human interaction is established between the nursing professional and the patient. This allows the professional to more broadly understand the biopsychosocial needs of each patient under their care, thus favoring holistic, effective care tailored to each patient's needs.

The present study corroborates this aspect, which is supported by literature. For example, a Korean study investigating factors affecting nurses' performance in caring for patients in the final phase of life concluded that empathy is a determining factor in this type of nursing care. The study observed that empathy is a necessary dimension for health professionals to better understand others.[7]

Another study reflected on how empathy can help with issues related to death. Since nursing professionals who work with patients in their final days have not experienced death, the study used Cicely Saunders's words to summarize empathy in this context: "I care about the fact that you are you. I care until the last moment of your life. We will do everything in our power to help you die in peace and to help you live until the day you die".[8]

In the above-cited study, the author concludes that these elements consider a humanistic view of both professionals and patients, ensuring that their principles are respected and their autonomy is strengthened, allowing them to participate in a more sensitive and welcoming care structure.[8]

According to the present study, it was evident from the participants' statements that professionals were open to discussing socially subjugated topics such as death. Additionally, a significant redefinition of death was observed; it was considered an alternative capable of alleviating the prolonged suffering of patients in PC.

A Brazilian study corroborates this fact, stating that, although death persists in individuals' everyday utopian imagination as a terrible event to be avoided or postponed as much as possible, it is notable that, in the face of the sick's suffering, some caregivers understand death as something that provides peace and relief, both for themselves and for the patient. Thus, some caregivers were able to redefine the meaning of death, which is no longer a feared situation, but rather an inevitable event that alleviates anguish and pain.[9]

Comfort was also observed as a priority for the nursing team in palliative care. According to the literature, patient comfort practices are essential for holistic and effective palliative care. Several uncomfortable symptoms affect hospitalized patients with advanced, incurable diseases, and these symptoms often worsen as death approaches. Meticulous management of bothersome symptoms is important at any stage of the disease but becomes the primary focus near the end of life.[10]

Additionally, another study emphasized the importance of a multidisciplinary approach encompassing physical, emotional, social, and spiritual aspects in providing this care. Despite numerous advances, it is evident that palliative care is in a constant state of evolution due to the need to adapt to demographic changes, emerging cultural nuances, and new scientific discoveries. Therefore, it is imperative to conduct research and refine practices. Every patient and family facing a life-threatening illness deserves care that alleviates suffering and celebrates life in all its complexities.[11]

In most cases, the management of nursing professionals' feelings was necessary, and extra-hospital activities showed a clear benefit. However, some participants stated that they were no longer sentimentally affected after contact with death became routine. Literature indicates that daily contact with death can lead professionals to replace sadness with coldness and indifference as a defense mechanism to reduce the associated pain.[12]

On the other hand, the author points out that some professionals still feel sadness or other emotions when interacting with patients facing imminent death, regardless of how long they have worked in the field. He also emphasizes that sadness is an inherent human emotion that everyone experiences at some point in life.[12]

However, health professionals become particularly vulnerable to these feelings because they experience them daily. With constant contact with this process, many end up becoming unprotected and denying death, exhibiting stigmatizing characteristics within the teams.[12]

Finally, the participants in the present study revealed a lack of popular knowledge about palliative care. The challenging influence of this on nursing care during the active dying process of patients in PC was observed.

According to the literature, there is an explicit need to create mechanisms to expand popular knowledge about palliative care and its peculiarities. A research revealed that most existing technologies aimed at disseminating knowledge focus on daily care and conceptual guidance. Guidance focused on caregivers and information aimed at self-care has also been considered.[13]

Therefore, it can be concluded that new educational products must be developed for specific audiences within their sociocultural contexts. Given the exponential growth of the elderly population and the resulting increase in chronic diseases requiring palliative care, there are still information gaps for this audience. It is crucial to develop new technologies aimed at this age group. Moreover, ethnic peculiarities must be considered, as what is developed in other countries may not serve the Brazilian population. Brazil is a country with continental dimensions and significant cultural differences.[13]

FINAL CONSIDERATIONS

The nursing team perceives the manifestation of feelings during the care of palliative care patients in the active process of death as a prevalent aspect of their daily lives, in which empathy stands out.

There was an agreement on the attitudes adopted in caring for palliative care patients in the active process of death, as well as different perceptions about strategies for managing the feelings that emerge among professionals. Additionally, the challenges the nursing team faces in providing end-of-life care to these patients were identified and represented by consensus among the professionals.

In summary, the feelings and attitudes of the nursing team when facing the death process of palliative care patients highlight the human dimension inherent to care, based on empathy, understanding, and commitment to patients' well-being.

This study's limitations are its restriction to a specific sociogeographic context and its small sample size, which prevent the extrapolation of the findings to other contexts and populations. Further studies in this area are encouraged to contribute to understanding the personal, emotional, and attitudinal perspectives of nursing professionals caring for palliative care patients, considering regional and ethnic differences.

This study has the potential to advance knowledge in this area by encouraging professionals to reflect on the emotional impact of their attitudes in their daily professional context. It opens the door to exploring the human side of nursing professionals and viewing them beyond their profession. This adds a broader and deeper perspective to palliative care research by analyzing not only patients and family members experiencing the situation but also nursing care providers.

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