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Original Article

The Impact of Bereavement on the Care Team in the Intensive Care Unit of a Public Hospital

Impacto do Luto na Equipe de Cuidado da Unidade de Terapia Intensiva de um Hospital Público

El Impacto del Aflición en el Equipo de Atención de la Unidad de Cuidados Intensivos de un Hospital Público

Abstract

Objective: To analyze the experiences of healthcare professionals in the face of a patient's death, investigating how they cope with grief, whether this process is institutionally recognized or not, and the emotional impact of the loss on the staff working in the Intensive Care Unit (ICU). **Method:** A qualitative, field study conducted with healthcare professionals in the adult ICU at Dr. Fernando Mauro Pires da Rocha Municipal Hospital, using semi-structured interviews. The data were analyzed using Discourse Analysis, strictly adhering to the ethical principles of research involving human subjects. **Results:** The findings show that the professionals' grief manifests as a complex emotional experience, often silent and culturally invisible, intensified by the bonds formed with patients. The narratives reveal psychological distress and individual coping strategies in the face of loss. **Conclusion:** We emphasize the need to recognize and legitimize the emotional distress of ICU healthcare professionals, strengthening institutional practices of support and mental health care.

Descriptors: Bereavement; Patient Care Team; Intensive Care Units; Adult; Psychology, Medical.

Resumo

Objetivo: Analisar as vivências dos profissionais de saúde diante da perda de um paciente, investigando como elaboram o luto, se esse processo é reconhecido ou não reconhecido institucionalmente, e o impacto emocional da perda na equipe que atua na Unidade de Terapia Intensiva (UTI). **Método:** Estudo qualitativo, de campo, realizado com profissionais de saúde da UTI adulto do Hospital Municipal Dr. Fernando Mauro Pires da Rocha, por meio de entrevistas semiestruturadas. Os dados foram analisados à luz da Análise de Discurso, respeitando rigorosamente os princípios éticos da pesquisa com seres humanos. **Resultados:** Os achados evidenciam que o luto dos profissionais se apresenta como experiência emocional complexa, frequentemente silenciosa e invisibilizada culturalmente, sendo intensificada pelos vínculos estabelecidos com os pacientes. As narrativas revelam sofrimento psíquico e estratégias individuais de enfrentamento diante da perda. **Conclusão:** Destaca-se a necessidade de reconhecer e legitimar o sofrimento emocional dos profissionais de saúde da UTI, fortalecendo práticas institucionais de acolhimento e cuidado com a saúde mental.

Descritores: Luto; Equipe de Assistência ao Paciente; Unidades de Terapia Intensiva; Adulto; Psicologia Hospitalar.

Resumen

Objetivos: Analizar las experiencias de los profesionales de la salud ante la pérdida de un paciente, investigando cómo elaboran el duelo, si este proceso es reconocido o no a nivel institucional, y el impacto emocional de la pérdida en el equipo que trabaja en la Unidad de Cuidados Intensivos (UCI). **Método:** Estudio cualitativo de campo, realizado con profesionales de la salud de la UCI para adultos del Hospital Municipal Dr. Fernando Mauro Pires da Rocha, mediante entrevistas semiestruturadas. Los datos se analizaron a la luz del Análisis del Discurso, respetando rigurosamente los principios éticos de la investigación con seres humanos. **Resultados:** Los hallazgos evidencian que el duelo de los profesionales se presenta como una experiencia emocional compleja, a menudo silenciosa e invisibilizada culturalmente, que se intensifica por los vínculos establecidos con los pacientes. Las narrativas revelan sufrimiento psíquico y estrategias individuales de afrontamiento ante la pérdida. **Conclusión:** Se destaca la necesidad de reconocer y legitimar el sufrimiento emocional de los profesionales de la salud de la UCI, fortaleciendo las prácticas institucionales de acogida y atención a la salud mental.

Descriptoros: Aflición; Grupo de Atención al Paciente; Unidades de Cuidados Intensivos; Adulto; Psicología Médica.

INTRODUCTION

The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being, and not merely the absence of disease, which implies the need for a broad and comprehensive approach to healthcare⁽¹⁾. This perspective reinforces that healthcare professionals must consider, in addition to biological aspects, the emotional, social, and symbolic dimensions that permeate the processes of illness, care, and death.

In contemporary society, the hospital has established itself as the primary setting for care, including for patients in the end-of-life phase, making death and terminal illness recurring experiences in institutional daily life⁽²⁾.

Studies indicate that palliative care in general hospitals reveals tensions between a technocratic approach and the need for comprehensive care that acknowledges human suffering and the social experience of death⁽²⁻³⁾. In this context, the process of dying takes on not only clinical relevance but also ethical, emotional, and relational significance.

Intensive Care Units (ICUs) are highly complex healthcare settings designed to care for critically ill patients who require continuous monitoring and advanced technological support⁽⁴⁾. Technological advances have broadened the definition of death and prolonged the end-of-life process, creating ethical dilemmas related to the limitation or intensification of therapeutic interventions^(3,5-6). The tension between life-sustaining measures and the inevitability of death poses significant challenges to the multidisciplinary teams working in these settings.

In this scenario, grief presents itself as an experience intrinsic to the ICU context, since professionals, patients, and family members live with loss on a daily basis⁽⁷⁾. Grief pertains to the rupture of meaningful bonds and constitutes a natural process of psychological coping in the face of loss, the intensity of which is directly related to the emotional investment established⁽⁸⁻⁹⁾. However, when experienced by healthcare professionals, this grief often lacks social or institutional recognition, characterizing it as unacknowledged grief⁽⁸⁾.

Studies show that continuous exposure to death can cause psychological distress, emotional exhaustion, and feelings of helplessness among healthcare workers⁽¹⁰⁻¹²⁾. Many professionals adopt defensive strategies, such as emotional detachment, due to the absence of institutional spaces that facilitate the expression and processing of grief^(8,10,13). This silencing tends to intensify psychological distress and compromise the quality of care provided.

Despite this, the bond established between professional and patient remains a central element of care practice. Grounded in relationships of trust, empathy, and shared responsibility, this bond transcends the technical dimension and takes on therapeutic value⁽¹⁴⁻¹⁷⁾. The literature indicates that the professional-patient relationship is influenced by attachment processes and that the rupture of this bond, in the face of death, can profoundly impact the professional⁽¹⁶⁾.

Traditional academic training, still centered on mechanistic and curative models, often fails to adequately prepare professionals to deal with the finitude of life, contributing to the perception of death as a therapeutic failure^(8,10,18). In light of this, authors highlight the importance of humanizing care and implementing institutional strategies for psychological support, supervision, and continuing education that foster an ethical and emotional approach to death and grief in the hospital setting^(6,10,15).

In this sense, understanding the experiences of healthcare professionals in the face of patient loss in the ICU is essential for analyzing how emotional bonds are formed, how grief is experienced and acknowledged—or silenced—in the institutional setting, as well as the emotional impacts of this experience on those who provide care.

The study aimed to analyze the experiences of healthcare professionals in the face of a patient's death in the ICU setting.

METHOD

Design, Period, and Setting

This is a qualitative study conducted within the scope of the Lato Sensu Graduate Program, in the form of a Multiprofessional Residency in Intensive Care, carried out from June to July 2025 at the Dr. Fernando Mauro Pires da Rocha Hospital.

The qualitative approach was adopted because it allows for the understanding of the meanings, values, beliefs, and interpretations attributed by participants to their lived experiences, recognizing the centrality of subjectivity in understanding social and institutional phenomena. This type of research requires analytical rigor, methodological coherence, and ethical commitment throughout the entire research process⁽¹⁹⁾.

Population and Inclusion and Exclusion Criteria

The study involved five participants in semi-structured interviews guided by leading questions. This technique allows for flexibility in interaction and facilitates in-depth expression by participants, while remaining aligned with the study's objectives.

The inclusion criteria applied to professionals with college degrees and technical training who work directly with patients, spend at least a 12-hour shift in the ICU, and have been practicing for at least two years, reflecting a period of experience and training as an intensive care specialist.

Exclusion criteria included professionals with higher education and technical training who do not work directly with patients or do not spend a minimum of 12 hours in the adult ICU, as well as residents in the unit.

Data Collection Procedure

Data collection took place in person at the adult ICU of the study site from June 17, 2025, to June 24, 2025, in a private, soundproofed room, ensuring privacy and confidentiality for the participants.

The interviews were conducted by the researcher herself, who was responsible for the study, ensuring the standardization of the data collection procedure and adherence to the ethical principles that guide qualitative research.

The interviews were conducted based on an ethical and non-directive approach, prioritizing sensitive listening to the participants' narratives and encouraging the free expression of their experiences, while respecting the pace, silences, and unique characteristics of the discourse produced during the interaction between the researcher and the interviewee.

The interviews took place individually, were recorded with the participants' prior consent, and followed a semi-structured interview guide, previously prepared and consistent with the research objectives. This format allowed for the exploration of the proposed central themes without restricting the emergence of new content or the deepening of aspects considered relevant throughout the interaction.

The choice of the semi-structured interview is based on perspectives that value the interpretation of meanings produced in discourse, the interactional dimension of language, and the complexity inherent in qualitative research⁽¹⁹⁻²⁰⁾. The professionals' participation was voluntary, upon acceptance of the invitation.

Data Analysis

The empirical material was analyzed according to the qualitative approach proposed by Minayo⁽¹⁹⁾, prioritizing the interpretation of the meanings attributed to the reported experiences, understood within the interplay between subjectivity, sociocultural context, and historical trajectory.

The analysis also engaged with the assumptions of Discourse Analysis, as per Orlandi⁽²⁰⁾, used as a theoretical-analytical framework for understanding language as a social and historical practice, in which meanings are produced under the conditions of enunciation.

The literature review was conducted in national and international databases, such as PubMed/Medline and the Virtual Health Library, as well as in institutional documents and books from the national literature, with the aim of supporting the theoretical foundation and data analysis.

Ethics and Integrity

The research project was submitted for evaluation to the Research Ethics Committee of the Dr. Fernando Mauro Pires da Rocha Municipal Hospital (Campo Limpo Municipal Hospital) via the Certificate of Submission for Ethical Review (CSER) 88395725.3.0000.5452, under opinion number 7.631.752.

Regarding data collection, the research objectives and ethical considerations were first presented. Participation in the study was voluntary and formalized through the signing of the Informed Consent Form (ICF), as required by Resolution 466 of December 12, 2012, issued by the National Health Council (NHC).

All empirical material, audio files, and interview transcripts were subsequently transcribed into digital format and stored on encrypted media to ensure the privacy and confidentiality of the information.

To maintain the anonymity of the participants, they were identified using names from African mythology, such as Yoruba.

RESULTS

The discourse analysis allowed for the identification of ten core themes that express the experiences of healthcare professionals regarding death and grief in the ICU context.

Although grief was not a direct theme of the guiding questions, it emerges transversally, revealing itself both in the expressed content and in the silences and discursive shifts.

Core 1 – The ICU as a space for building professional identity and career

The ICU is understood as an environment for technical training and professional consolidation, in which death presents itself as a constant source of meaning, permeating the discourses even when not explicitly named, shaping subjective positions regarding terminal illness.

Core 2 – Death as an Implicit Presence in the Daily Routine of Care Practice

Death appears as a structuring element of the work, manifesting itself in the silences and between the lines of discourse, revealing how professionals position themselves in the face of the limits of technique and care.

Theme 3 – Grief as an emotional experience that transcends technical logic

The accounts reveal grief as a complex experience, marked by sadness, helplessness, and emotional restraint, challenging the social expectation that healthcare professionals remain emotionally neutral.

Theme 4 – Spirituality as a symbolic resource for processing grief

Faith emerges as a subjective strategy for coping with loss, especially in situations involving young patients or violent deaths, serving as a support for attributing meaning to finitude.

Theme 5 – Loss as a catalyst for emotional bonds and psychological processing

The death of patients with whom a bond has been established calls on professionals to emotionally process the loss, revealing pain, frustration, and reflections on their own finitude.

Core 6 – Subjective identification with the patient and the intensification of suffering

The accounts indicate that identification with the patient's story amplifies the emotional impact of the loss, revealing emotional involvement, surprise, and helplessness in the face of unexpected outcomes.

Core 7 – The challenging coping with the emotional repercussions of death

The notification of death, the suffering carried outside the workplace, and the demand for emotional control highlight the difficulty of dealing with grief in the daily institutional routine.

Theme 8 – The absence of institutional spaces for collective mourning

The discourses point to the invisibility of professional suffering, marked by institutional silencing and the expectation of permanent resilience in the face of successive losses.

Theme 9 – Grief as a silent, singular, and symbolic process

Grief manifests itself in an intimate and largely unspoken way, evidenced by pauses, hesitations, and linguistic substitutions, reflecting the symbolic weight of naming the loss.

Core 10 – The bond as a structuring element of care and a legitimizer of grief

The construction of the professional-patient bond emerges as a central aspect of the quality of care, legitimizing grief as a constitutive part of care practice and reaffirming that caring implies being affected.

DISCUSSION

The analysis of the interviews, grounded in Discourse Analysis, enabled an understanding of how healthcare professionals construct meanings regarding death, mourning, and care in the ICU context. We start from the assumption that discourse is not restricted to the explicit content of utterances but is produced within the historical, social, and institutional conditions in which the subjects are embedded, being permeated by silences, contradictions, and discursive regularities⁽²⁰⁾.

It was observed that the ICU is discursively signified as a space of high technical complexity, marked by responsibility, constant vigilance, and pressure for results. Professionals associate the sector with the idea of challenge and competence, emphasizing technical mastery and the intensive use of technology in care⁽⁴⁾. However, even when the discourse is organized around protocols and procedures, death emerges transversally, revealing the permanent tension between therapeutic investment and the possibility of loss^(3,6).

In the accounts analyzed, death is frequently interpreted as therapeutic failure, especially when it occurs despite available technological resources. This interpretation reflects a professional training still guided by a curative logic, which prioritizes the preservation of life and hinders the symbolic elaboration of finitude^(8,18). As a discursive effect, one observes the silencing of emotions and the adoption of strategies of affective distancing as forms of defense against suffering⁽¹⁰⁻¹¹⁾.

Despite this context, the bond between professional and patient emerges as a structuring element of care. Even in a highly technical environment, the discourses reveal the construction of affective bonds sustained by daily interaction, listening, and continuous attention to the other's needs⁽¹⁵⁻¹⁷⁾. In light of attachment theory, such bonds can be understood as the result of sensitive and responsive interactions that foster trust and emotional security⁽¹⁴⁾. The rupture of these bonds, in the face of the patient's death, intensifies the emotional impact of the loss for the professional.

Grief, however, manifests indirectly and is often left unnamed. Although feelings such as sadness, helplessness, and emptiness are mentioned, these experiences are rarely recognized institutionally as legitimate grief⁽⁸⁾. This configuration characterizes unacknowledged grief, in which psychological suffering is experienced in isolation, without formal spaces for support and processing⁽⁷⁻⁸⁾.

This institutional silencing contributes to the emotional exhaustion and psychological distress of healthcare professionals. The literature indicates that the absence of support mechanisms contributes to the chronicity of suffering and reinforces defensive strategies that can compromise both the worker's health and the quality of care⁽¹⁰⁻¹²⁾. The analysis revealed that, even when the emotional impact is recognized by the subjects themselves, it tends to be minimized due to the need to maintain service operations.

Another core theme identified relates to the lack of preparation for dealing with death in the professional training process. The discourses indicate that health education prioritizes technical content, relegating discussions on terminal illness, grief, and human suffering to the background^(8,10). This gap in training contributes to the perception of death as a disturbing event and to the normalization of pain as an inherent part of the work, hindering its symbolic processing⁽⁸⁾.

Finally, the findings point to the need for a humanization policy that also includes healthcare professionals. The literature highlights that creating spaces for listening, supervision, and psychological support within the hospital setting can facilitate the grieving process and strengthen more ethical and sensitive practices in the face of mortality^(6,10,15). Recognizing the staff's suffering does not weaken care, but rather enhances it, by enabling more empathetic and responsible relationships until the end of life.

Thus, the analysis shows that the meanings attributed to death and grief in the ICU arise within a field of tensions between technique, ethics, and subjectivity. Understanding these discursive constructions brings to light the silenced suffering of professionals and reinforces the importance of institutional policies that recognize grief as a constitutive dimension of healthcare work.

Study Limitations

Noteworthy are the small number of participants (n=5) and the fact that the study was conducted in a single institutional context, which limits the generalizability of the findings.

Contributions of the Study

The study contributes by highlighting the need to incorporate the discussion of healthcare professionals' grief into institutional practices, expanding healthcare to include the worker's subjective dimension.

CONCLUSION

The present study highlighted the complexity of the grief experienced by healthcare professionals working in the ICU, a setting marked by the constant presence of death and intense emotional demands. Understanding these experiences proved fundamental to making the suffering of these professionals visible, valuing the bonds established with patients and family members, and recognizing coping strategies that combine technical skills and subjectivity, contributing to more humanized care practices.

The findings indicate that, although death is inherent to ICU work, professional grief often remains invisible and poorly legitimized in institutional contexts. The reported experiences reveal intense yet silent manifestations, marked by mechanisms of emotional containment, rationalization, and denial. Nevertheless, the bond with patients and family members emerges as a central element of emotional support, allowing the loss to be felt and, in some cases, reframed.

It was observed that resources such as empathetic communication, sensitive listening, spirituality, self-care, and therapeutic support are mobilized by professionals as ways to cope with suffering. However, such strategies occur predominantly on an individual basis, highlighting the absence of structured institutional mechanisms to support the grief of those who care for others.

The analysis also revealed that the institutional culture of the ICU imposes symbolic barriers to the expression of suffering, upholding the expectation of emotional neutrality as a professional ideal. However, the discourses demonstrate that recognizing, feeling, and processing loss does not weaken care, but rather humanizes it, enabling greater emotional and ethical sustainability in professional practice.

In summary, the study contributes to the assertion that professional grief is not limited to the experience of loss, but is linked to professional identity, emotional bonds, and the caregiver's subjectivity. This highlights the need for healthcare institutions to recognize and legitimize the emotional suffering of their teams, offering spaces for listening, acceptance, and psychological support. Understanding grief as an ethical, affective, and relational experience allows for a reframing of care practice, reaffirming care for life and finitude as inseparable dimensions of healthcare work.

AUTHORS' CONTRIBUTION

Transparency in authors' contributions according to the [CRediT Taxonomy](#).

Conceptualization	Daniela Neves da Silva
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Formal Analysis	Daniela Neves da Silva; Claudia Regina Graziano de Moraes e Abreu
Funding Acquisition	Not applicable
Investigation	Daniela Neves da Silva
Methodology	Daniela Neves da Silva; Claudia Regina Graziano de Moraes e Abreu; Lívia Kondrat Pinto Kanashiro
Project Administration	Daniela Neves da Silva; Claudia Regina Graziano de Moraes e Abreu; Lívia Kondrat Pinto Kanashiro
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