RBEM Revista Brasileira de Educação Médica

ORIGINAL ARTICLE

DOI: https://doi.org/10.1590/1981-5271v47.4-2022-0373.ING

Approach to death in medical graduation: students' perceptions in light of Freudian contributions

Abordagem da morte na graduação médica: percepções de estudantes à luz de contribuições freudianas

Rafael Lourenço Donadeli[1] rldonadeli@gmail.com
Amanda Pais Ravasio[1] ravasioamanda@gmail.com
Larissa Ottoni Estevanin de Paula[1] lariottoniep@aluno.ufsj.edu.br
Nicolle Fraga Coelho[1] nicolle.fcoelho@hotmail.com
César Quadros Maia[1] cesar_quadros@hotmail.com
Elisa Maia Alkmim[1] elisalkmim@gmail.com
Vinícius Leite Melo[1] vileitemelo@hotmail.com
Denise Alves Guimarães[1] alvesguimaraesdenise@gmail.com

ABSTRACT

Introduction: In western contemporary society, attempts to prevent death and suffering promote a medical training focused on dealing mostly with the biological aspects of illness and death, to the detriment of the psychosocial aspects related to those issues.

Objective: The authors intended to identify medical students' perceptions about the approach to death and dying in the light of Freudian theory about death.

Method: This was a qualitative study with an exploratory approach, developed based on six focal groups consisting of 55 students from all the undergraduate medical school semesters from a federal university in the interior of the state Minas Gerais. The data produced was analyzed according to the thematic or category-based content analysis, from which the following categories emerged: 1- The death topic in undergraduate medical school; 2- The medical professional facing death.

Results: To discuss death and dying in the formative process is to talk about the anguish in the face of human finitude. The students identified the approach to death and dying in undergraduate school, but in a limited and insufficient way. They indicated the need to increase contact with the topic in the curriculum, and to include, in a mandatory way, the contents on Palliative Care. The medical role encompasses both the care focused on healing and the assistance in moments when healing is not possible. The preparation to deal with death throughout undergraduate training involves personal conceptions and experiences, undergraduate practice, access to theoretical contents, specificities and subjective aspects related to each situation. The mentioned resources to deal with death, in addition to the studies, were religiosity and psychotherapy.

Conclusion: To approach death in undergraduate medical curricula involves great complexity and challenges. From the viewpoint of psychological reality, human beings try to deny death and avoid suffering. Thus, the challenges in medical formation and practices consist in assuming the indissociable articulation between the biological, cultural and psychosocial aspects. To take care of life is also to take care of death and avoiding it may cause greater suffering to the patients, family members, students and medical professionals.

Keywords: Death; Education; Medical; Perception.

RESUMO

Introdução: *Na sociedade ocidental contemporânea, as tentativas de evitar a morte e o sofrimento impulsionam a formação de médicos voltados para lidar majoritariamente com aspectos biológicos do adoecimento e da morte, em detrimento dos aspectos psicossociais relacionados a essas questões.*

Objetivo: *Buscou-se identificar a percepção de estudantes de Medicina sobre a abordagem da morte e do morrer na graduação à luz de estudos atuais sobre a formação médica no país e algumas contribuições da teoria freudiana sobre a morte.*

Método: *Trata-se de pesquisa qualitativa de caráter exploratório, desenvolvida a partir de seis grupos focais compostos por 55 estudantes de todos os períodos do curso de Medicina de uma universidade federal do interior de Minas Gerais. O material produzido foi analisado a partir do referencial de análise de conteúdo temática ou categorial, e emergiram categorias: 1. a morte na formação médica; 2. o médico diante da morte.*

Resultado: *Discutir a morte e o morrer no processo formativo é falar da angústia diante da finitude. Os estudantes identificaram a abordagem da morte e do morrer na graduação, mas de forma limitada e insuficiente. Apontaram a necessidade de ampliar o contato com os temas no currículo, melhorar as metodologias utilizadas e inserir de forma obrigatória os conteúdos de cuidados paliativos. O papel do médico comporta tanto o cuidado com foco na cura quanto a assistência nas situações em que a cura não for possível. A preparação para lidar com a morte ao longo da graduação envolve concepções e experiências pessoais, experiências na graduação, acesso aos conteúdos teóricos, especificidades e aspectos subjetivos relacionados a cada situação. Os recursos mencionados para lidar com a morte, além dos estudos, foram a religiosidade e psicoterapias.*

Conclusão: *Abordar a morte nos currículos de graduação em Medicina envolve grande complexidade e desafios. Do ponto de vista da realidade psíquica, os seres humanos tentam negar a morte e evitar os sofrimentos. Dessa forma, os desafios da formação e da prática médica consistem em assumir a articulação indissociável entre aspectos biológicos, culturais e psicossociais. Cuidar da vida é também cuidar da morte, e evitá-la pode desencadear maior sofrimento aos pacientes, familiares, estudantes e médicos.*

Palavras-chave: *Morte; Educação Médica; Percepção.*

[1] Universidade Federal de São João del-Rei, Divinópolis, Minas Gerais, Brasil.

Chief Editor: Rosiane Viana Zuza Diniz. | Associate Editor: Mauricio Peixoto.

Received on 04/12/23; Accepted on 08/30/23. | Evaluated by double blind review process.

DOI: https://doi.org/10.1590/1981-5271v47.4-2022-0373.ING

INTRODUCTION

Although they are inherent to the human condition, death and dying, understood here in the dimension of the event and process, are considered taboos in several cultures and have raised questions since the beginning of humankind. Views on death have undergone changes and gained diverse interpretations according to different historical and social contexts, expressing cultural perspectives and psychosocial factors specific to different peoples. In contemporary Western society, issues related to death are relegated to a secondary level, in an attempt to avoid fear and anguish in the face of human finitude. This can also be observed in the history of medicine, in which death takes on the connotation of professional failure and increasingly, the processes linked to it are associated to hospitals and intensive care centers, aiming to remove them from human reality[1-5].

Modernity marks a radical separation between the living and the dead, placing the dead and dying increasingly distant from the context of cities and social life. Driven by the process of industrialization, intense urbanization and the Hygienist Revolution, in modernity the body takes on value as an instrument of production, meaning illness and death are reasons for failure, shame and unproductivity[6,7]. Especially for the working classes, health is seen as synonymous with a body fit for work and many scientific and technological advances are associated to attempts to prevent death, in an effort to deny it as part of existence itself[6,7].

Based on this context, health professionals are trained to deal primarily with the technical and biological aspects limited to the processes of illness and death. In addition to the commitment to alleviating suffering, the training and practice of health professionals focus on curing illnesses, minimizing the importance of psychosocial aspects that involve more intimate contact with the suffering of the person and their family, and the affections related to the contexts of illness and death and the affections this prompts in healthcare professionals[6]. Doctors are the main actors in the fight against death, which must be won by them at all costs[8,9]. Especially in situations that indicate the end of life, the current medical scenario brings a strong anchoring to life extension commitments, without, however, an adequate consideration regarding the limits of practices and interventions used for this purpose and which can often result in a painful process for the patient and their family members, leaving aside a set of possibilities for actions and decisions related to death and dying that involve the patient and their family[8,9].

The complexity of dealing with death and dying points to historical and social issues in their inseparable relationship with psychological issues and the meanings that are constructed for finitude and therefore, this study also resorted to some Freudian propositions about death and attitudes towards it[10-12]. As a physician, Freud developed a complex work that sought to analyze human suffering and its manifestations beyond the biological body function. His vast contributions forever marked the understanding of psychological reality and this study focused on a specific section linked to his discussions about death and suffering when faced with it.

For Freud, the civilizing process[12] required human beings to constantly renounce their desires, since individual needs and the demands of culture will always be in conflict with no possibility of conciliation. Regarding the search for the fulfillment of desires, there is a tension that Freud called 'malaise', a condition inherent to human existence. From these discussions on "Malaise in Civilization"[12], Freud pointed out that the suffering that constantly threatens human beings comes from three sources: the external world, more specifically the force of nature; the fragility of the body and relationships with other people, considering the precariousness in which bonds between people in the family, in the government and in society are regulated. The impossibility of dominating nature and the human body, as part of it, forces us to recognize both its transience and limits, as well as the inevitable nature of finitude. However, the knowledge that the human body is doomed to failure, instead of paralyzing, points out possible pathways. If it is not possible to abolish all suffering, it is possible to abolish part of it and attenuate another part[12]. And regarding how much death encourages human beings to construct meanings for life, Freud wrote: "If you want to endure life, prepare yourself for death." (p.229) [10].

Some discussions have addressed malaise in new contemporary settings and its importance for thinking about medical training and practices in the face of human suffering[13,14]. From this perspective, this suffering[13,14] can be situated: 1) in the encounter with human pain and suffering and with their impotence in the face of death; 2) in the competitiveness and culture of rigid training; 3) in breaking expectations of what Medicine is, taking into account the reality found in the training process, in professional performance and in the relationship with the field of medical knowledges.

In this sense, considering the importance of a training process that explores the medical student's encounter with death and the suffering resulting from it, this study aimed to identify students' perception about the approach to death and dying during undergraduate medical school.

METHOD

This was a qualitative research of an exploratory nature[15,16], developed through Focal Groups (FG) with medical students from the Federal University of São João del-Rei, Midwest Campus

DOI: https://doi.org/10.1590/1981-5271v47.4-2022-0373.ING

in Divinópolis, state of Minas Gerais, Brazil. From September to December 2019, six FGs were held, with an average of nine participants attending the 1st to the 12th semesters of undergraduate school. A total of 55 students participated, of which 27 were female and 28 male, and each FG consisted of students attending the same year of undergraduate school, initially selected by drawing lots and subsequently invited to participate in the study. The duration of the FG was between 90 and 110 minutes; the meetings were held in classrooms provided by the University, were recorded and later transcribed.

The FG technique, valuable in qualitative research, produces information from the process of communication and interaction between group participants, creating the conditions to expand their participation in the process of discursive exchanges. Furthermore, the FG allows the proximity, interaction and exchange of knowledges, experiences, perceptions and feelings about the discussed topics, going beyond the participants' individual analyses regarding the topic[17,18].

A roadmap for conducting the FG was prepared, addressing aspects related to the objectives of this study. The analysis of the produced material followed the framework of content analysis, according to Bardin[19], specifically thematic or categorical analysis, following the steps of 1) pre-exploration, which includes the organization of the material, transcription of recordings, floating readings and organization of reports ; 2) selection of units of analysis or units of meaning, comprising the classification of the material through exhaustive reading, identification and grouping of subjects that emerged from the participants' speeches, and, 3) final analysis, articulating the analyzed data to theoretical references, aiming to meet the established objectives. Two categories emerged from these processes: 1- The death topic in undergraduate medical school; 2- The medical professional facing death.

The statements offered to illustrate the results were identified using an alphanumeric coding system, with the FG code being used to identify the focal groups; the following number identifies the groups, by year of training, ranging from 1 to 6; and letter M or F designates Male or Female sex. All ethical procedures were respected, aiming to preserve the participants' confidentiality and all of them freely accepted to participate by signing the FIC form.

This study was approved by the Research Ethics Committee of the Federal University of São João del-Rei/ Midwest Campus (UFSJ/CCO) in 2019, under Opinion (CAAE) number 15627119.5.0000.5545.

RESULTS

The proposal to develop discussion groups to talk about death and dying discloses the complexity and difficulties surrounding these topics. In all groups, these were made clear both in silence and in the slower pace that characterized the beginning of each topic of discussion and also in the anguish demonstrated at several moments, especially those related to reports of loss of family members and close people, as well as questions about what would be the most appropriate ways to deal with death and the dying process during undergraduate school and in one's future professional practice. Despite the difficulties surrounding the topic, the students were very interested in participating. The intense discussions were gathered into categories, according to the proximity and similarity of the topics and summarized in Table 1, which depicts the categories and the cores of meaning that constitutes them.

Death in medical training

The students identified, at different moments during undergraduate school, contents related to the approach to death and dying, with mandatory curricular activities being mentioned, such as anatomy classes and communicating bad news; and extracurricular activities such as symposiums; internships promoted by Academic Leagues and, mainly, the Palliative Care approach in research and extension projects linked to an elective discipline.

Difficulties related to approaching these contents were highlighted in all groups, mainly related to limited contact with the subject in the curriculum, since most of the activities that addressed the topic were extracurricular ones, which required an individual search. In the initial semesters of the course, they reported the lack of introductory or preparatory classes regarding contact with cadavers during the learning process, causing great anguish.

> *"Most of the things we mentioned here are elective, the curricular (ones) are seminars, I don't know in which semester." (FG6F).*

> *"We didn't have a lesson on the respect for corpses, we were just thrown into the laboratory and (had to) deal with it, you know." (FG4F)*

Table 1. Categories and cores of meaning.

CATEGORIES	CORES OF MEANING
The concept of death in medical training	Curricular approach to the topic
	Suggestions to improve the approach to the topic
The medical professional facing death	The physician's role when facing death
	Preparation to deal with death
	Resources for coping with death and concerns related to future practice

Source: created by the authors.

 DOI: https://doi.org/10.1590/1981-5271v47.4-2022-0373.ING

Especially students attending the last years of medical school highlighted the deficiency in teaching how to communicate bad news, a topic considered complex as it involves the balance between personal involvement and respect for the individuality of the patient and their family. Although provided for in the curriculum, some groups considered the approach unsatisfactory or even absent.

> *"For us it was a big improvisation [the class on the communication of bad news], the students had practically to get the bibliography from scratch and the classes were just to talk about this topic during this period." (FG4M)*

Students from all years suggested ways to increase discussions about death and dying in undergraduate school, especially mandatory Palliative Care content; increasing the workload for the communication of bad news; more practical approaches and promotion of conversation circles to exchange experiences between teachers, health professionals and students.

> *"Everyone is trying to gain some knowledge, one chooses as an elective (discipline), the other chooses practice and ends up studying. So, everyone seems to feel this need and ends up looking for it on the sidelines. Maybe it would be essential to already have it in the curriculum, so we could have it as a basis, right." (GF6M)*

Some argued that there was a limit to what could be offered by the University and this preparation should not be restricted to the academic environment.

> *"Isn't the University already offering us what it can really offer?" (FG3F)*

> *"Even if this theoretical basis is a little deficient [...] there is no teaching method that will fully cover this." (FG4M)*

The physician facing death

The possibilities and limits for dealing with death and dying seem related to the physician's role. Both concepts, the one that defended that the objective of the profession would be to save lives and those that defended that the physician's role would be to provide technical support, care and comfort even when there was no possibility of a cure, were observed.

> *"I want to be a physician, I want to save lives, for now it is a primary instinct, to help people who are sick to have more years to live; for now, death is a more negative thing." (FG1F)*

> *"I think the physician's role, in addition to the healer's role, if healing is impossible, you have to be there to provide some support. Technical support, because sometimes it frequently constitutes a comfort for the relatives, you say "look, unfortunately, there was nothing else to do and so on" so you have a technical basis." (FG1M)*

In all FGs there were discussions about what would be the preparation to deal with death and dying and how this process depended on a group of interrelated factors, involving both access to theoretical contents and practical experiences during undergraduate school, as well as elements that constitutes each person's personal resources to deal with these issues. Students attending the last years discussed that there is a maturation process regarding how to deal with death during undergraduate school, since repeated experiences helped to learn how to deal with the anguish involved in the situation.

> *"So, I think we become more mature in relation to the way we deal with that. Not that we stop being distressed, sad, sensitive to the situation, but you learn to express yourself in the face of it in a less distressing way, I think." (FG5F)*

> *"No matter how much theoretical knowledge you have, practice is what will bring out all your feelings, all your subjectivities, you know?" (FG6F)*

Although they discussed that the doctor would never be completely prepared to deal with death, they observed greater preparation throughout the course.

> *"I think that saying that you are one hundred percent prepared is very arrogant, OK, because each situation is different, but I imagine that everyone here feels much more prepared than in the first simulations that we had here at the university, mainly because they have experienced it in internship." (FG6F)*

> *"The greater your theoretical background, the more confident you are and the more prepared you feel, until the first practical experience you have, because nothing teaches as well as practice." (FG6F)*

The use of health protocols and sources based on scientific evidence was highlighted as a way to guide preparation for dealing with death, but the professional should not be limited to them, taking into account each situation and subjective aspects of each patient. They also pointed out that the professional conduct would never be dissociated from personal conceptions, especially religious ones, regardless of the acquired medical knowledge.

> *"I think that we, as physicians, have to follow protocols, but at the same time we cannot hide behind them." (FG3M)*

> *"So, I think that regardless of what I learn here, when I have to deliver news like that, first I have to put my convictions forward, understand?" (FG3F)*

In all groups, the resources that students used to deal with death and concerns related to future practice were discussed. Religiosity, in its different perspectives, appeared in all FGs as a way to obtain better understanding and acceptance

 DOI: https://doi.org/10.1590/1981-5271v47.4-2022-0373.ING

of death, bringing comfort and acceptance, but also as a limitation, since loss and pain generated rebellion and led to questions about God's will and ones' own faith.

> *"I think that sometimes people see faith as a comfort, and sometimes as a sense of revolt, people revolt, sometimes they even lose a little faith." (FG5F)*

The use of psychotherapies was considered by some to be important for understanding the psychological aspects related to the death of a family member and their own death. They also mentioned that, upon entering the medical course, they sought to focus on the body's biological processes as a way to understand and justify death and being able to deal with it.

They discussed the best ways to deal with the patients, their families and end-of-life situations, as well as the implications arising from these situations in future practice. They pointed out that medical practice could make them accustomed to the experiences of death and dying, with some naming this situation as coldness, while others called it calmness, as it does not necessarily mean insensitivity towards these issues.

> *"Some people will call it coldness, but I think it's more calmness than coldness. It doesn't mean I'm insensitive to death." (FG3F)*

Some pointed out concerns about the frequency of contact with death in future practice and a possible implication on the ability to have contact with affective aspects, thus fearing a loss of humanity itself. They also questioned whether the profession could change their personal experiences around death and dying.

> *Because I don't know, after 20 years of work, how will we be dealing with this? Will it have become so, so commonplace for us? So I think it's a personal effort of mine to try to find that balance between distancing and feeling, it's difficult." (FG6F)*

> *"One question I keep asking myself is whether I will become a colder person and if when I lose someone in my family, for example, whether it will be a little less painful, based on my experience." (FG1F)*

They discussed the fact that the fear of losing patients changes future medical performance.

> *"It would be very difficult as a professional to feel responsible for someone's death, but by taking actions based on what was the best possible, on the best evidence, we will feel more relieved, at least, for thinking that we did the best we could. " (FG4F)*

> *"Maybe this explanation [related to protocols and guidelines on terminality] helps us deal with the dying process. If you put a little logic into what has no logic." (FG6M)*

Experiences with death during undergraduate school and the fear of having to deal with the death of patients in the future were mentioned as factors that could influence future professional choice, causing some to consider medical specialties in which they would not have to deal directly with this process.

> *"This is so, so decided in me [related to the fact of not wanting to deal with death in everyday medical practice] that I don't want to work in a hospital, I don't want to be on duty, I want to work in primary care and have the least contact with death." (FG4F)*

DISCUSSION

For this discussion, we sought to undertake a dialogue between some current analyses of medical training in Brazil and some of Freud's contributions, both in relation to the civilizing process, as well as the view on death and attitudes towards it.

When discussing death, considering the horrors of the First World War, in "Current considerations on war and death", Freud[10] stated that the attitude towards death as something natural, indisputable and inevitable is not a sincere one, confronting the idea that humankind would be prepared to pay this debt to Nature. In fact, Freud highlighted the tendency of human beings to eliminate death as part of life by trying to silence it, therefore making it unimaginable to think about one's death. The attitude towards death involves oppositions and conflicts, depending on the proximity or estrangement in relation to the dead: if, on the one hand, death is recognized as the annihilation of life, on the other, there is an attempt to deny it as being unreal. Freud demonstrated that these two ambivalent perspectives regarding death are present in the unconscious and just as the difficulty of admitting one's own death is present, desires for annihilation related to everything and everyone that stand in the way of achieving satisfaction are also present[10].

When it comes to the death of others, this issue is carefully avoided and supported in very specific situations, when addressed, for example, by doctors or other related professionals. Death evokes horror and the narrative about the dead person excludes any criticism about them. However, when death strikes someone close: "We bury with them all our hopes, ambitions, joys, we are inconsolable and refuse to replace the one we lost" (p.221) [10]. Thus, Freud analyzes attitudes of avoidance, denial, horror and desire towards death.

Freud highlighted the importance of these attitudes towards death, since this is what creates meaning for life, undertakings, relationships and makes us seek to avoid dangers. The death of another, stranger or close one, makes us think about our own finitude. The experience of death inaugurates

the production of different meanings for the annihilation of life throughout history, including the individual's dissociation into a body and a soul; the ideas of life after an apparent death and the different meanings constructed by religions, which also sought "everything with the purpose of robbing death of its meaning of abolishing life" (p.225) [10]. Freud analyzed that not only religion, but also art, psychoactive substances and other resources are used as ways of dealing with human anguish in the face of finitude[12].

Considering the historical, cultural and psychological perspectives in the face of death broadens the reflection on the difficulties and challenges related to the incorporation of discussions focused on this topic, when thinking about the organization of curricular structures of medical courses. In the scenario of Brazilian medical education, the insufficient approach to topics related to death and dying throughout training still appears as an overall reality[20,3], which causes students to resort to extension projects, academic leagues and optional subjects to obtain the knowledge they consider important and necessary on the topic[20,3]. This perception of deficiencies in medical training associated to aspects involving death and dying causes anguish in students who feel unprepared to deal with such situations in their daily medical practice, as with the communication of bad news[21-23].

Although the National Curricular Guidelines for the Undergraduate Medical Course includes the understanding of death as a competence required of undergraduate students, its approach is still treated with a focus on the biological and pathophysiological aspects, without taking into account the psychosocial components involved[3,24,25]. Given this scenario, several aspects were identified to improve the approach to these topics in the curricula of undergraduate courses, among them, the expansion of the construction of spaces for debate[26]; the increase in the mandatory workload; the use of active methodologies[27] and that would remove the impersonality of the topic[26,28]; the promotion of conversation circles between students, teachers and health professionals[26,3] and the responsibility of the Universities in adapting the curriculum and offering psycho-pedagogical support to students[26].

There are great challenges in incorporating topics related to death and dying into undergraduate medical curricula, as well as the methodologies and resources necessary for such an undertaking. The complexity of dealing with death can be glimpsed in the analyses undertaken by Freud[11] in the text "Mourning and Melancholia", in which he sought to assess pain in situations of loss. Mourning, considered a deep sadness in the presence of loss, can be due to the death or separation of a person or something such as a certain situation, an abstraction, an ideal. Contrary to what current psychiatry manuals recommend, Freud did not consider mourning a pathological process, nor did he define a period for its resolution. He highlighted that mourning is a process that has a very individualized connotation but has as a common trait the painful state of mind and loss of interest in activities that are not related to the memory of the person or what was lost; thus, mourning requires great expenditure of time and energy[11]. From the point of view of medical training and practice, it is about accepting the inevitable act of dealing with suffering; that suffering has individualized expressions and that the losses of others are related to our own.

Furthermore, to understand the challenges of approaching death and dying in medical training, it is worth revisiting Freud's discussions about Malaise, as an inherent condition of existence. When Freud discussed the civilizing process, he analyzed that it took place at the cost of intense and continuous oppression of desires, that is, considering a set of prohibitions that make social existence viable. In this sense, although it is possible to recognize the importance and need to talk about death, it is also necessary to admit how unbearable this topic is for each individual and how much they want to avoid it. Thus, Malaise in medical training can be perceived, both in the encounter between the student and the physician with the sources of human suffering, as discussed by Freud[12], as in the specificities of the training process,[13,14] which do little to help them build ways to deal with aspects of existence, which in themselves generate suffering. In this sense, a training process that embraces another view of the relationship between life and death can bring important contributions to future physicians, creating possibilities to broaden the perspective in relation to ways of approaching and dealing with the fear and anguish in the face of illness, suffering and death[12].

Freud had already drawn attention to the contributions that psychoanalysis could bring to medical training by demonstrating the relationships between physical and psychological life[29]. Throughout his clinical practice, Freud was able to attest to the presence of a body that did not correspond to the rules of anatomy and physiology, since the symptoms related to the suffering narrated by his patients could not be explained by an organic etiology[14]. Considering these Freudian discoveries, it is possible to infer the limitation of medical training and practice that does not consider the psychosocial aspects related to life and death, since medicine will always deal with the biological dimension of human existence, in its inseparable relationship with the psychosocial dimension.

In the current scenario, advances in science and technology have brought the possibility of treatment and cure for many diseases that previously represented the announcement of death. This fact can lead many doctors to exhaust all possible

DOI: https://doi.org/10.1590/1981-5271v47.4-2022-0373.ING

resources when faced with a disease, disregarding, in many situations, the need for comprehensive patient care. High-tech medicine does not necessarily mean a good death, which considers therapeutic principles associated with religious and moral principles and respects beliefs and values, guaranteeing care that respects the meaning of life and existence. Hence the importance of taking the patient's context into account when making medical decisions regarding terminality[2,30].

It is essential that the training process is organized around the duality that constitutes medical care: saving lives and providing support to patients and their families in the end-of-life process. This dual dimension of care provides an opportunity to break with the perspective of a practice focused exclusively on healing, and also expands the field of discussions aimed at analyzing the importance of time and quality of life[2,30]. In this sense, it is worth highlighting that both the teaching of Palliative Care, recently incorporated as mandatory in medical curricula in Brazil[31], and discussions about death and dying in undergraduate medical curricula have been gaining more space worldwide. These perspectives can help professionals and students to discuss the limits of medical interventions in the face of terminal illness and seek to expand the understanding of the importance of caring for terminally-ill patients[32-34].

Although death is a constant in medical practice, it is pointed out by several authors that medical training acts as training to exclude traces of emotion when caring for the patient, as feelings can be seen as an obstacle to good care[2,35-39]. The lack of approach during undergraduate medical school, therefore, may represent a way of preparing future professionals to deal with this issue through denial and distancing. Thus, the lack of training that incorporates the need to deal with situations that evoke different affections helps professionals maintain a position of impersonality, anchored in the positivist principles of "neutrality" and preserve their convictions of omnipotence in the face of terminality[2,39].

FINAL CONSIDERATIONS

As the study participants well expressed, talking about death is a great challenge, as it involves trying to put into words what causes anguish and how one tries to deal with it, whether through avoidance, denial, horror or desire. But it is certainly necessary to commit words to this process.

The transformations in medical training worldwide and in the country demonstrate the effort and challenge of a major paradigmatic change. Assuming a biopsychosocial dimension in medical training is a process of incorporating the complexity of several aspects that have been traditionally placed in an oppositional relationship. In this sense, caring for life is also caring for death, a proposition that needs to be constructed with and between students and professionals involved in the training processes.

The analyses undertaken by Freud in these specific excerpts from his vast theory already provide a glimpse of how much his propositions can help to understand the efforts to deny death and try to avoid suffering. The difficulties and challenges in dealing with death and human suffering are fundamental aspects of medical training and practice and the denial of these aspects can be perceived both in the exclusively biological and organic approaches to the processes of illness and death, as well as in attempts to exclude or avoid the subjective and corporeality dimension. The suffering of others refers to our own; and the death of another is a glimpse of the limit that is imposed on everyone. Trying to avoid dealing with these issues can often drive the search for comprehensive knowledge about diseases, practices and treatments that end up imposing greater suffering on patients, their families and even medical professionals.

Finally, we highlight a note made by Freud in relation to human attitudes towards death, here taken as a recommendation to think about the possibilities and challenges of medical training concerned with preparation to deal with terminality: "Wouldn't it be better to give death the place it deserves, in reality and in our thoughts, and to show a little more of our unconscious attitude towards death, which until now we have carefully repressed?" (p.229) [10].

AUTHORS' CONTRIBUTION

Rafael Lourenço Donadeli: Study concept, data curation, formal analysis, investigation, methodology, project administration and manuscript writing (original draft, review and editing) during all stages of article construction. Amanda Pais Ravasio: Study concept, data curation, formal analysis, investigation, methodology, project administration and manuscript writing (original draft, review and editing) during all stages of article construction. Larissa Ottoni Estevanin de Paula: Study concept, data curation, formal analysis, investigation, methodology, project administration and manuscript writing (original draft, review and editing) during all stages of article construction. Nicolle Fraga Coelho: Study concept, data curation, formal analysis, investigation, methodology, project administration and manuscript writing (original draft, review and editing) during all stages of article construction. César Quadros Maia: Study concept, data curation, formal analysis, investigation, methodology, project administration and manuscript writing (original draft, review and editing) during all stages of article construction. Elisa Maia Alkmim: Study concept, data curation, formal analysis, investigation, methodology, project administration and manuscript writing (original draft, review

and editing) during all stages of article construction. Vinícius Leite Melo: Study concept, data curation, formal analysis, investigation, methodology, project administration and manuscript writing (original draft, review and editing) during all stages of article construction. Denise Alves Guimarães: Study concept, data curation, formal analysis, investigation, methodology, project administration, supervision and manuscript writing (original draft, review and editing) during all stages of article construction.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

SOURCES OF FUNDING

The authors declare no sources of funding.

REFERENCES

1. Alves ÁTLS, Alves FV, Melo EV, Oliva-Costa EF. Evaluation of medical interns' attitudes towards relevant aspects of medical practice. Rev Assoc Med Bras. 2017;63(6):492-9.
2. Azeredo NSG, Rocha CF, Carvalho PRA. O enfrentamento da morte e do morrer na formação de acadêmicos de medicina. Rev Bras Educ Med. 2011;35(1):37-43.
3. Melo VL, Maia CQ, Alkmim EM, Ravasio AP, Donadeli RL, Paula LOE de, et al. Morte e morrer na formação médica brasileira: revisão integrativa. Rev Bioét. 2022;30(2):300-17.
4. Santos MRC, Lins L, Menezes MS. "As intermitências da morte" no ensino da ética e bioética. Rev Bioét. 2018;26(1):135-44.
5. Ariès P. História da morte no Ocidente: da Idade Média aos nossos dias. Rio de Janeiro: Ediouro; 2003. p. 15-25.
6. Combinato DS, Queiroz MS. Morte: uma visão psicossocial. Estud Psicol. 2006;11(2):209-16.
7. Hohendorff JV, Melo WV. Compreensão da morte e desenvolvimento humano: contribuições à psicologia hospitalar. Estud Pesqui Psicol. 2009;9(2):480-92.
8. Kovács MJ. Morte e desenvolvimento humano. São Paulo: Casa do Psicólogo; 1992.
9. Moritz RD. Os profissionais de saúde diante da morte e do morrer. Rev Bioét. 2005;13(2):51-63.
10. Freud S. Considerações atuais sobre a guerra e a morte (1915). In: Freud S. Introdução ao narcisismo, ensaios de metapsicologia e outros textos. São Paulo: Companhia das Letras; 2010. p. 120-41.
11. Freud S. Luto e melancolia (1917 [1915]). In: Freud S.Introdução ao narcisismo, ensaios de metapsicologia e outros textos. São Paulo: Companhia das Letras; 2010. p. 97-110.
12. Freud S, Souza PC. O mal-estar da civilização (1930). São Paulo: Penguin Classics, Companhia das Letras; 2011.
13. Gannam SSA. O mal-estar na formação médica: uma análise dos sintomas de ansiedade, depressão e esgotamento profissional e suas relações com resiliência e empatia [tese]. São Paulo: Universidade de São Paulo; 2018.
14. Fagundes Netto MVR, Kernkraut AM. Contribuições da psicanálise à medicina: grupo com residentes em um programa de cancerologia clínica. Rev SBPH. 2019; 22(esp.):133-56.
15. Minayo MCS, Deslandes SF, Cruz Neto OGR. Pesquisa social: teoria, método e criatividade. 34a ed. Petrópolis: Vozes; 2015.
16. Minayo MCS. O desafio do conhecimento. Pesquisa qualitativa em saúde. 14a ed. São Paulo: Hucitec; 2014.
17. Trad LAB. Grupos focais: conceitos, procedimentos e reflexões baseadas em experiências com o uso da técnica em pesquisas de saúde. Physis. 2009;19(3):777-96.
18. Gondim SMG. Grupos focais como técnica de investigação qualitativa: desafios metodológicos. Paidéia (Ribeirão Preto). 2002;12(24):149-61.
19. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
20. Sartori AV, Battistel ALHT. A abordagem da morte na formação de profissionais e acadêmicos da enfermagem, medicina e terapia ocupacional. Cad Bras Ter Ocup. 2017;25(3):497-508.
21. Sadala MLA, Silva MP. Cuidar de pacientes em fase terminal: a experiência de alunos de medicina. Interface Comun Saúde, Educ. 2008;12(24):7-21.
22. Storarri ACM, Castro GD de, Castiglioni L, Cury PM. Confidence in palliative care issues by medical students and internal medicine residents. BMJ Support Palliat Care. 2017;16;9(1):e1-1.
23. Correia DS, Bezerra MES, Lucena TS, Farias MSJA, Freitas DA, Riscado JLS. Cuidados paliativos: importância do tema para discentes de graduação em medicina. Rev Bras Educ Med. 2018;42(3):78-86.
24. Brasil. Resolução CNE/CES nº 3, de 20 de junho de 2014. Institui Diretrizes Curriculares Nacionais do Curso de Graduação em Medicina e dá outras providências. Diário Oficial da União. 23 jun 2014. Seção 1.
25. Bifulco VA, Iochida LC. A formação na graduação dos profissionais de saúde e a educação para o cuidado de pacientes fora de recursos terapêuticos de cura. Rev Bras Educ Med. 2009;33(1):92-100.
26. Silva GSN, Ayres JRCM. O encontro com a morte: à procura do mestre Quíron na formação médica. Rev Bras Educ Med. 2010;34(4):487-96.
27. Figueiredo MGMCA, Stano RDCMT. O estudo da morte e dos cuidados paliativos: uma experiência didática no currículo de medicina. Rev Bras Educ Med. 2013;37(2):298-306.
28. Tamada JKT, Dalaneze AS, Bonini LMM, Melo TRC. Relatos de médicos sobre a experiência do processo de morrer e a morte de seus pacientes. Rev Med (São Paulo). 2017;96(2):81-7.
29. Freud S. Deve-se ensinar psicanálise nas universidades? (1919). In: Freud S. História de uma neurose infantil ("O homem dos lobos"), além do princípio do prazer e outros textos. São Paulo: Companhia das Letras; 2010. p. 284-87.
30. Mello AAM, Silva LC. A estranheza do médico frente à morte: lidando com a angústia da condição humana. Rev Abordagem Gestalt. 2012;18(1):52-60.
31. Brasil. Resolução CNE/CES, nº 265, de 17 de março de 2022. Alteração da Resolução CNE/CES nº 3, de 20 de junho de 2014, que institui as Diretrizes Curriculares Nacionais do Curso de Graduação em Medicina e dá outras providências. Diário Oficial da União; 17 mar 2022.
32. Academia Nacional de Cuidados Paliativos. Manual de cuidados paliativos. 2a ed. Porto Alegre: Sulina; 2012. p. 23-31.
33. Sancho MG, Trota RA, Cantera JB, Casasnovas LC, Castillo ÁG del, Martínez JAH, et al. Atención médica al final de la vida: conceptos y definiciones. Gac Méd Bilbao. 2015;112(4):216-8.
34. Correia DS, Taveira MGMM, Marques AMVFA, Chagas RRS, Castro CF, Cavalcanti SL. Percepção e vivência da morte de estudante de Medicina durante a graduação. Rev Bras Educ Med. 2020;44(1). e013.
35. Kovács MJ. Profissionais de saúde diante da morte. In: Kovács MJ. Morte e desenvolvimento humano. São Paulo: Casa do Psicólogo; 1992. p. 226-43.
36. Concone MHV. O vestibular de anatomia. In: Martins JS. A morte e os mortos na sociedade brasileira. São Paulo: Hucitec; 1983. p. 25-37.
37. Perazzo S. O médico e a morte. Rev Psiquiatr Clín. 1985;12(3-4):96-100.
38. Romano BW. A prática da psicologia nos hospitais. São Paulo: Pioneira; 1994. p.137-47.
39. Quintana AM, Cecim PS, Henn CG. O preparo para lidar com a morte na formação do profissional de medicina. Rev Bras Educ Med. 2002;26(3):204-10.