

# Taking care of terminal patients: nursing students' perspective

CUIDANDO DE PACIENTES EM FASE TERMINAL: A PERSPECTIVA DE ALUNOS DE ENFERMAGEM

EL CUIDANDO DE PACIENTES EN FASE TERMINAL: LA PERSPECTIVA DE LOS ALUMNOS DE ENFERMERÍA

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## ABSTRACT

The aim of this study is to understand how nursing undergraduates perceive themselves while care delivery to terminal patients and expose the meaning of the experience they have. Fourteen students were interviewed, and answered the following question: *What is the image you have about caring for a terminal patient?* Students always consider this to be a painful experience, one that puts them face to face with their weaknesses and insecurities. They attribute their difficulties to their personal incapacity to accept death and to their lack of preparation and their inexperience. They report a lack of support from professionals with whom they share this care. In terms of professional development, for some, the experience was positive, despite the difficulties; others evaluate it as negative, resulting in a rejection of similar situations. Further studies on this subject are needed with a view to a deeper and broader reflection on nursing education in Brazil.

## KEY WORDS

Nursing care.  
Terminally ill.  
Attitude to death.  
Students, nursing.

## RESUMO

Este estudo busca compreender como alunos de graduação em Enfermagem percebem a si mesmos ao cuidar de pacientes em fase terminal e expor os significados da experiência vivida. Foram entrevistados 14 alunos, respondendo à questão: *Como se mostra a você o cuidar do paciente na fase terminal?* Para os alunos, é sempre uma experiência dolorosa, que os coloca face a face com suas fragilidades e inseguranças. Eles atribuem suas dificuldades à própria incapacidade de aceitar a morte e ao despreparo e inexperiência. Relatam que falta apoio dos profissionais com quem compartilham esse cuidado. No que se refere à formação profissional, para alguns a experiência foi positiva, apesar das dificuldades; outros a avaliam negativamente, resultando em rejeição a situações semelhantes. Novas investigações sobre o tema são necessárias para aprofundar e ampliar a reflexão para o âmbito da formação dos enfermeiros em nível nacional.

## DESCRIPTORIOS

Cuidados de enfermagem.  
Doente terminal.  
Atitude frente à morte.  
Estudantes de enfermagem.

## RESUMEN

Este estudio busca comprender como los alumnos del curso de Enfermería perciben el cuidar de pacientes en fase terminal y exponer los significados de la experiencia vivida. Fueron entrevistados 14 alumnos, respondiendo a la pregunta: *¿Qué le parece a usted cuidar de un paciente en fase terminal?* Para los alumnos, siempre es una experiencia dolorosa, que los coloca frente a frente con sus fragilidades e inseguridades. Atribuyen sus dificultades a la propia incapacidad de aceptar la muerte y a la falta de preparación e inexperiencia. Relatan que les falta apoyo de los profesionales con quien comparten ese cuidado. En lo que se refiere a la formación profesional, para algunos la experiencia fue positiva, a pesar de las dificultades; otros la evalúan negativamente, resultando en rechazo a situaciones semejantes. Nuevas investigaciones sobre el tema son necesarias, en el sentido de profundizar y ampliar la reflexión dentro del ámbito de formación de los enfermeros a nivel nacional.

## DESCRIPTORIOS

Atención de enfermería.  
Enfermo terminal.  
Actitud frente a la muerte.  
Estudiantes de enfermería.

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## INTRODUCTION

Nursing care goes much beyond technical care. Taking care is to look after someone, which implies caring about the person, getting involved with him or her. Peplau defined nursing as a human relationship of help, proposing a theory based on the development of nurses' interpersonal communication skills. In this conception, nurses' perception of themselves, when looking after their own difficulties and the possibilities of helping the patient, is the basis to develop a therapeutic relationship with that patient<sup>(1)</sup>.

The purpose of palliative care is to improve the quality of life of patients who are in the terminal phase of the disease. This care focuses on preventing and relieving their suffering through the treatment of pain and other physical, psychosocial and spiritual symptoms, within the conception of reaffirming life and considering death as a natural process<sup>(2-3)</sup>. Physical suffering, death and anguish are common for patients who face an imminent death. The communication with the health team receives greater importance: the patient is vulnerable and has limited time. A stronger attachment is established between the practitioner and the patient, there is a need for more availability and intimacy between them<sup>(3)</sup>. Palliative care, as described above, is based on the *humanitarian and solidary care* paradigm, which uses the benefits of technical-scientific evolution but privileges ethical principles, promoting a humane and honorable death, whenever it should occur<sup>(4)</sup>. On the other hand, the current *technical-scientific model* in health care privileges the use of state-of-the-art technological resources to prolong life at any cost, even if it means increasing the patient's suffering and not offering any perspectives of quality of life or survival<sup>(4)</sup>.

The literature on this issue describes nurses' reactions towards terminal patients: dealing with death on an everyday basis is extremely anguishing and wearisome, causing feelings of helplessness, frustration, and a lack of confidence in view of the patient's suffering and the failure of professional actions<sup>(3-5)</sup>. National and international studies involving nursing students have revealed that the participants report their suffering and lack of confidence when looking after terminal patients, as well as their family. Their difficulties are related with their own lack of preparation to deal with death, as well as with the lack of theoretical and practical instruction to work with the patient's death process. Other studies indicate that most undergraduate schools dedicate a small part of their curriculum to studying the psychosocial aspects of care, and even less to issues concerning the patient's death<sup>(6-11)</sup>. These results suggest that the following contents should be included in the curriculum: themes concerning human finitude; the most appropriate forms of care in this stage of life; philosophical, ethical, and moral aspects about death; accepting the limits of science in view of a terminal disease<sup>(5,7-11)</sup>.

Some authors<sup>(7)</sup> have proposed models of how to take care of people in the terminal phase of a disease, as a resource for teaching and instructing students and nurses. The structure of this model considers the tension between two positions of the caregiver: the first regarding the *personal ideal of care* (how should the best care to terminal patients be, their rights, *the good death*); the second refers to *the personal reality experienced* at the moment of care (what happens with the patient: what is real, what is unknown and what is unique and specific in the perception of that situation). The conflict between the two positions generates tension, causing negative feelings like rage, frustration, guilt and uncertainty. Aware of these feelings, the professionals try to solve their own conflicts through support from friends, by exchanging thoughts with the team and controlling their involvement with the patient. This model refers to the use of the therapeutic relationship: nurses, while taking care, accomplish themselves as persons, realizes their own feeling and limitations, and seek external help to overcome the difficulties and become therapeutically involved with the patient, with the purpose of helping that patient<sup>(1)</sup>.

Dealing with death on an everyday basis is extremely anguishing and wearisome, causing feelings of helplessness, frustration, and a lack of confidence in view of the patient's suffering and the failure of professional actions.

## THE STUDY

As a teacher of the Nurse-Patient Relationship discipline to nursing undergraduates, one of the issues that makes me feel uneasy is their communication with terminal patients. I guide the students and, with them, analyze their experiences regarding patient relationships during care. Students often state the difficulties they face when they lose their patient. This restlessness urged me to study the phenomenon *taking care of terminal patients*; seeking to focus on students' experiences, in the sense of unveiling how they experience and deal with losing a patient. When outlining the project, I proposed a 4<sup>th</sup> year nursing graduate to participate as a collaborator. This initiative was thought in the sense of obtaining a greater approximation to the studied phenomenon by developing a partnership with someone closer to the universe of the object of investigation.

## OBJECTIVE

To understand how nursing undergraduates perceive themselves when taking care of terminal patients, and present the meanings of their experience.

## METHOD

Phenomenology was chosen as the most appropriate method for the study goals. The phenomenological method starts with a description, an everyday situation<sup>(12)</sup>. The description of the nursing student's experience is the expression of what he or she perceives, in the common sense,

which was not submitted to reflection. When the researcher asks them: *How do you perceive taking care of a terminal patient?*, they describe what comes to their mind at that moment, i.e. what was important and marked that experience they had. This data originates from a position anterior to the reflexive thought, named pre-reflexive, which consists of *going back to things*, things as they are perceived in their existence. Hence, the researcher obtained statements about what they see, exactly as it appears to them. It could be said that the statements show the phenomenon, but also hide it, because they show the appearance of the phenomenon, but hide essential truths that will only be unveiled through phenomenological analysis and interpretation. In this moment, the researcher's phenomenological attitude is important, since it permits an openness to live the experience in a *gestaltic* manner. i.e. in its totality and trying to isolate any and every judgment that could interfere in that openness to understand the description<sup>(12)</sup>. The researcher's goal in working with the phenomenon description is to search its essence, the most invariable part of the experience; hence, essence consists of the unique nature of what is questioned. When the researcher asks for the descriptions of the various participants about the studied phenomenon, (s)he understands that each participant describes the experience according to their perspective of perceiving the phenomenon. According to the researcher, the perceptions in different times and places, presented by different people, are perspective views on the phenomenon. The interpretation of this data permits to achieve a specific field of generalities, which belong to the general structure of the phenomenon – its essence<sup>(13)</sup>. In this movement to discover the essence of the phenomenon, phenomenological reduction is the fundamental resource to guarantee a trustworthy description of the phenomenon, based on the obtained data – the participants' descriptions. The reduction evidences the intention of the consciousness regarding the world, by indirectly stating the reality as common sense conceives it, and by purifying the phenomenon from everything that it *unessential* and accidental, so as to see what is essential<sup>(12)</sup>.

### Analysis procedures

The students' descriptions were analyzed and interpreted, first individually (*ideographic analysis*). After several careful readings of the descriptions, the *meaning units* were identified, i.e. the discourse excerpts that answered the researchers' question, and analyzed in the focus of the research phenomenon. At the end of the ideographical analysis, the researchers articulated their own comprehension about the statement. After analyzing each description individually, their convergences were searched (*nomotetic analysis*), which showed the confluence of the perspectives of every participant, unveiling the *invariants* of the studied phenomenon, its *essence*. In this move from *ideographic analysis* to *nomotetic analysis*, when assigning themes to the convergences and grouping them, it was possible to achieve the *general truths* about the studied phenomenon, from the perspective of those who experienced it<sup>(14)</sup>.

### Study participants

Fourteen nursing graduates were interviewed; ages between 21 and 25 years; 13 women and 1 man; students of the 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> years. All participants had experienced situations of care delivery to terminal patients. The interviews, which lasted 23 minutes on the average, were recorded and, after the transcription, the cassette tapes were discarded. As a guideline for the interview, the participants were asked: *How do you perceive taking care of a terminal patient?*

### Ethical procedures in the study

The research project was previously approved by the Research Ethics Committee at *Faculdade de Medicina de Botucatu*, UNESP (Protocol 1159/03); and was also authorized by the Nursing Undergraduate Course Coordination. The students were informed about the nature of the study, their freedom to participate or withdraw at any moment, and about the procedure of recording the tapes and later discarding them. Those who agreed to participate signed the Free and Informed Consent Form.

## CONSTRUCTION OF THE RESULTS

The convergences of the discourse meaning units unveil the structure of the research phenomenon, and were grouped into three essential themes: *facing the situation of caring for a terminal patient; the relationship with the patient and his family; the reflection about the experience*.

Next, in the analysis of the results, excerpts from the participants' discourse are reproduced, identified by fictitious names and the number of the statement at the end of the citation.

### Facing the situation of care for a terminal patient

The study participants report their difficulties when dealing with the patient's terminality, expressing their feelings of fear, anxiety, lack of confidence and pain. Paula describes:

It is very painful, because it is your first contact with someone experiencing great suffering. The person there, suffering, knows he's going to die... so it's very difficult to deal with that (P3).

Elisa, who has had previous experiences as a nursing technician, is ambiguous, and admits the same difficulties:

I think I handled it with more confidence because I already worked in an ICU, because I have experience as a technician, so I kind of took it more easily. But, anyhow, I guess I still felt the same anxiety the other girls felt (P7).

The feelings experienced while taking care of these patients affect the students' personal life. Cristiane says:

It was a very difficult experience. Every day it was like getting up to face death. The whole situation, the equipment,

including the patient's condition, which, for me, was always something new: will she still be alive today? (P8).

Vania speaks about attempting to deal with the situation:

I had several experiences with death, and they were not very pleasant. I feel bad, like, especially with family members around. I try to stay calm, to make them calm, too... but, deep inside, I'm shattered. When I get home, I feel bad (P9).

When there is no perspective that the patient will improve, taking care of him becomes extremely exhausting: it is a demanding, complex care that offers no reward for the efforts that were made. This perception prevails among the participants. Cristiane gives more details:

I had to do everything, the patient did not cooperate. It was very complicated. Besides the aspiration, he was intubated, I had to aspirate and mark the time. It was all complicated, really difficult to deal with all of it (P8).

Beth describes her frustration:

Caring for this patient gives us a real sense of powerlessness. You can't see the patient as a whole, as people always say. That is when you look more at the disease, the techniques... You get too focused on the technique, to escape from the situation... (P10).

Meire talks about her lack of preparation to meet the technical demands, resulting in anxiety and guilt:

He had chronic renal insufficiency, had been sedated, was really terminal... It was a frightening experience, because there were some problems with the IV infusion... I was worried because I thought I had killed the patient, you know (P13)?

Due to the patient's irreversible condition, the procedures gain specific characteristics and follow unusual norms: cardiopulmonary resuscitation resources and resources for maintaining physiological functions are not valid when there is a heart arrest. Adriana describes:

He had many other associated diseases, he was also under contact restriction due to sepsis. Taking care of him, in the beginning, was difficult. He was sedated, and then they removed the sedation to check for any response... They did those *pain tests*, you know? He didn't respond, so the doctors decided to leave just some necessary parameters, the oxygen ... just the basics, no medication, to wait. If there was a heart arrest, they wouldn't intervene (P12).

The students reported that there are rare opportunities to take care of terminal patients. Paula explains:

Since in the graduation course, in the nursing foundations class, we first look at the techniques, no professor will assign you a terminal patient. Later, in the "medical-surgical" class you get some, let's say, more serious cases. But, even then, you end up choosing a patient who is not in such a serious situation or in the ICU. You are allowed to choose your patients... (P3).

In these few opportunities to learn how to deal with the patient's death, the students say that they do not feel guided and supported. They believe this learning should happen, mainly, while in practice, and that little is explored in the curricular internship activities. Paula describes:

During graduation, there was no information, no type of knowledge about how to deal with these patients. Even in the wards, when something like this happens, we feel like running away: No way, I'm not looking after this patient... (P3).

Elisa says:

You know how to do the technical procedure, but there is no psychological approach, about how to deal with that. There is no preparation to work with the aspects of religion... religions, like how to help the patient cope with that considering his religion (P7).

On the other hand, although some students report having few opportunities to look after these patients, Beth describes a first experience in her first contact with the patient:

On the first day of my internship, the professor already put me with a terminal patient. He had cancer, already in metastasis and he was cachectic, he couldn't do anything by himself. But he wasn't unconscious yet, he could still speak... for this reason I created some attachment to him. I took care of him for two days, on the third he passed away and it was really sad... I thought I wasn't so prepared for that, for that situation... and I had to deal with it as if it were something natural, because the professor said: He died? So let's just move on (P10).

In the statements, the students revived their anxiety, expectations and difficulties. For them, dealing with death is difficult; they realize this in the moment they face the situation. These situations are due to their inability to accept the other's death, because it calls their own death to mind; as well as to the rare or inexistent contact that students have with people in these conditions, including outside the hospital environment<sup>(10)</sup>. Students also experience feelings of helplessness and powerlessness, particularly in their first experiences: when patients do not improve, the procedures used seem useless to them and result in frustration. In this universe, caring for patients becomes odd and frightening, and shows them how unprepared they are regarding the technical-scientific procedures needed for the situation. This also occurs when they need to have a simple conversation with the patient. Those that became closer with the patient, after spending a longer period with him, reveal feeling deep sadness and anguish regarding this care process. The data found are similar to those in the literature. Feelings of hopelessness and frustration regarding this *inefficient* care, which ends in the moment of the patient's death; students, in other studies on this subject<sup>(9-11)</sup>, also report their perception of how unprepared they are, technically, in addition to their inability to deal with their own feelings. Two studies<sup>(9-10)</sup> highlight the students' concern

about including the patient's family member in the care process.

### ***The relationship with patients and their family***

The relationship with the terminal patient becomes more complex due to the interference of variables and barriers that exist in the context. In some situations, the students feel blocked when trying to communicate with the patient. This is reported by Claudia:

She was HIV positive, had tuberculosis, candidiasis, and many other diseases... And... it is difficult because you don't have a close relationship with her, because she is either intubated or you're unable to communicate with her (P5).

Ana remembers her difficulties because of not being able to control her own feelings:

When we were going to perform the invasive procedures on the patient, who was unconscious, tears fell from his eyes. For example, aspirating the tracheotomy, or when his artery was punctured... we could realize that, only during those moments his eyes really were teary and he also had an expression... there was an expression on his face... So that made me feel ... [pause], I felt sorry when I saw that (P2).

Paula sees a fragile and lonely patient:

This patient needs more from me... everyone ends up kind of escaping, they just go there and do the basic things, what is mandatory, as their function. And at the moment, he needed someone to stand by him, give stronger support, but he had no one (P3).

Elisa talks about the patient's fears:

He had already removed a part of his stomach, intestine, and was scared that his *stitches could break* and he would have to undergo surgery again... for the 16<sup>th</sup>, 17<sup>th</sup> time... and behind this he was afraid of dying, which is something inevitable, right (P7)?!

Francisco talks about the fear of suffering when becoming closer to the patient:

If you get attached, then it gets complicated... if you spend little time with him, if you don't get attached, then it is easier. If you get attached and the patient dies... it gets difficult... (P11).

Ana describes:

The feeling that I had was like... kind of like feeling sorry... and this got a little more complicated when providing care. When you're going to perform any procedure, even when patients are sedated... well, you realized he was suffering with all of that, you know (P2)?

The same student reports her identification with the family members:

I was strong until the moment when we were preparing the patient's body. But then, when the family came in... For me... that was like seeing my mother there. I put myself in

their shoes, I was sure I didn't know how to deal with a situation like that (P20).

Luiza, taking care of a terminal young man, experienced the conflict between the impulse of running away and the duty of staying to help.

I felt really sad about him. I think it was because he was so young... I felt like leaving the room at any cost but I couldn't... I had to help. It was the first time that I faced such a serious experience (P4).

Paula talks about her anxiety and frustration:

You don't know what to do. You are afraid of the powerlessness you feel in that situation... You don't know at what time she's going to die. I would always think, as a student, what could I do to improve that moment, you know (P3)?

Beth describes her difficulties to deal with the imminence of death:

It's difficult for you to take care of a person whom you know is going to die. You have to apply the procedures. Do the same you would do with a conscious patient. I had to follow the procedures with him, who was barely alive (long pause)... Because it is difficult to consider him differently, right? So it messes with the person's mind... (P10).

For many students, the strongest memory of their experience is the frustration: besides the fact that there was nothing else that could be done for the patient, they were aware that they were unable to help them and their family. Vania expresses this feeling of helplessness:

You try everything and there are no other possibilities of helping... It is really complicated, you feel completely powerless. You are there, all day, doing things for him but it is useless... You are just relieving, making his death as honorable as possible. So it's complicated that you feel like that, because you're not going to help, there is nothing you can do... (P9).

As for the work environment, several students report they regretted the lack of support from the team professionals. Paula suggests:

People at the ward, the professors, nurses... they could share their experience, you know? How we could deal better with the situation... I think there could be a group for us to share our anxiety about taking care of a patient like this (P3).

Mariana is the only participant who claims not suffering with the patient's death. She states:

My greatest concern is with the family, with helping them. Even during the last minutes of the patient's life, I try to do what he wants, what is best for him. But the fact that the patient will die does not affect me, it has become part of the routine for me, it doesn't affect me (P6).

By establishing their feelings as the foreground, students shifted the service focus from what should be to *identify*

and see to the patient's needs. This inability to maintain objectivity would keep them from dealing with death in a professional manner, perceiving it as an inevitable part of life. Besides this excessive involvement, there is a conviction that the objective of providing care is always to save life: if there is no chance of reaching this objective, there would be no sense in taking care of a terminal patient. As a result, they are unable to see any other perspective for this care, such as knowing how to listen to patients, understanding their needs and offering them the palliative care needed to help them in this final moment. These data lead to reflection about the predominant mode of health care, which privileges technical-scientific care, setting aside the psychosocial needs of the person receiving the care<sup>(16)</sup>.

Some studies point at the need to guide and support nursing students in the difficult task of learning how to deal with the patient's death<sup>(6,11,15)</sup>. In addition to the theoretical learning, the practical learning with experienced and confident practitioners would be the most appropriate form of preparing and supporting future practitioners for this service. This would imply reflecting about professional development and reviewing the current health care practice, which is predominantly associated with the bio-technical paradigm of health care. For over a decade, there have been several studies addressing this issue<sup>(2,4,6)</sup>. Apparently, there have been no significant results, in practice, or effective changes in the development of these professionals. The *humanization* movement is restricted, in most hospital institutions, to reviewing the scheme of patient visits and forming volunteer groups to entertain them and give them some attention. To humanize means to review the education of professionals and invest in the development of their abilities to perceive the patient and themselves as peoples, and including the objective, within the health care service, of relating and effectively communicating with patients and their family members<sup>(1-6)</sup>.

### Reflections about the experience

In the statements, the students analyzed their own experience and reflected about what they learned and the repercussions it had on their professional development. Some find out, after the first impact, that it is possible to see other objectives for this care, which, different from cure, can be the goal of helping the patient to live these final moments in the best possible way. These care actions, called *palliative*<sup>(2-5,11)</sup>, have specific objectives and strategies that aim to meet that patient's particular needs, identifying what could improve his life condition. It is what Celina realized:

It is a stressful and exciting experience because, through a simple touch, a simple gesture, you see the patient's reaction, you realize what he is feeling. You see how much you are important for him in that difficult phase... (P14).

Some patients discover the possibility of offering care with a view to providing the patient with comfort and relief, as described by Paula:

As a student, it is very difficult to face this situation and then, over time, you get the hang of it and find out that your role is to improve quality ... So, about food, what he likes to eat, what he is allowed to eat, what he is still able to eat, what he is still able to do, stand up, or not, if he likes to watch TV, if he likes to listen to music. And you search for those things (P3).

Adriana talks about the difficulty to let go of the logic of curing, always:

It is bad because there won't be a positive result, right? But you have to do your part, right? It doesn't affect my difficulty in providing care... I would be much happier if he improved, you know? You have to take care of him, no matter if he will or not improve, what has to be done must be done (P12).

Several students express their concern about becoming familiar with this care process and learning about how to improve. They analyze how it happens during practice, when they share their experience with practitioners, working under the direct supervision of their professors. They analyze their limitations and difficulties due to their inexperience and lack of confidence. After the initial shock, Vania reports her adaptation to the particularities of this care:

The first terminal patient I assisted was a shock to me. When he passed away I cried so much... After a while, it changes, I don't know... I guess I got used to it, right? Even so, it is always a shock... (P9).

For some, the experience was traumatic, resulting in their rejection of the possibility of care delivery to for critical patients or cases with an unfavorable prognosis. Meire says:

I kind of got a trauma from working in ICU, it's something I didn't like to do and I hope I don't have to do it again. Working in an ICU... It's not for me, I really didn't like it. I don't know if I relate not being fond of the ICU with the patient. I think there is a connection... (P13).

Claudia states:

I, for one, don't enjoy taking care of terminal patients because I think they are very sad, and I like to get involved, I enjoy talking... (P5).

Two students focus on the process of learning about how to take care of terminal patients, and criticize the work developed by the practitioners from whom they expected to learn and receive support and guidance. Paula analyzes:

Health practitioners lack the preparation to deal with this. Perhaps because we always want the patient to live and our actions to be effective, and we can't admit that one day that person will die, and that you have to support them when the time comes (P3).

Beth talks about the pedagogical environment in the wards' activities:

The worst thing about taking care of this patient is knowing that you're being analyzed during the whole internship

time... So, besides it being a new situation, you are unable to see it as something natural. You can't show your feelings, or what you want... Because you know you're being evaluated, you have to do everything perfectly, perfect techniques, and many times you feel like hanging your head and crying – oh my, I don't want to look after this patient! That's it... (P10).

Paula, Mariana, Vania, and Celina reported being able to overcome their initial feelings of anxiety and lack of confidence, and they found out it is possible to help patients, even without the expectation of their improving or surviving. Something can be done for them. All it takes is to realize their pain, anger, sadness, loneliness, and listen to them talking about whatever they wish. From there on, they can focus on the patient's needs and improve their uncomfortable conditions and their satisfaction regarding those needs, including their family. Paula found out about these new perspectives in extracurricular activities, which she believes corrected any flaws of her undergraduate program regarding the preparation to take care of terminal patients. The others discovered this during the curricular activities as part of the supervised internship.

The students' descriptions show their concern with the deficiencies in their professional development, especially regarding the technical-scientific education, which corresponds to the biomedical model that prevails in health care<sup>(8-11,15-16)</sup>. Paula reflects about this issue in a critical way and realizes that the professionals lack preparation for the psychosocial aspects of palliative care. Beth complains about the supervisory aspect of teaching, involving the professors' concern with a precise evaluation of behaviors during the practical internship activities. Ana and Elisa show concern with other aspects of learning: how can you solve feelings of fear, anxiety and the lack of confidence when taking care of dying patients, without receiving any guidance and examples to follow? The other students did not make any clear statements of their thoughts regarding this issue; but showed, through their reports, dissatisfaction and refusal to agree to any further experiences with this patient. All participants reported they had few experiences with this kind of patient: 8 only once. Ana, Paula, and Cristiane showed they were aware they needed more opportunities to deal with terminal patients.

## COMPREHENSIVE SYNTHESIS

The tensions between the *personal ideal of care* regarding the patient and the *personal reality experienced while providing care*<sup>(7)</sup> appears in the students' discourse: there is a constant tension between what they believe that *should be done* to help the patient and what they are *able to do*, due to the feelings of frustration, anxiety, and the perception of their lack of preparation, all of which appear when they have to face the real situation. It was a painful experience for all of them. For some, it resulted in learning, because they were able to overcome the tension between

caring and the difficulties they found, and care for the patient. For others, the difficulties blocked any possibilities to work effectively, resulting in a refusal to deal with any similar situations in the future.

The students, when describing their experience, mention the lack of external support to deal with their difficulties: this would be an essential element to solve the tension between the *personal ideal of care* and the *personal reality experienced*<sup>(7)</sup>. Another important aspect to control tension, the *control of involvement with the patient*<sup>(7)</sup> appears to be a strategy that the students hardly achieve due to their inexperience in dealing with stressful situations. This inexperience is due to their poor use of the knowledge regarding therapeutic communication in the experienced situations, with some observed exceptions pointed out in the analyses (P3, P9 and P14).

The Nurse-Patient Relationship discipline gives students the resources to interact with the patient, which are applied in the daily routine of health care service activities. However, the feelings of great anxiety described by the students upon their first contact with the patient would create communication barriers, blocking their effective care action. If students are effectively supported and instructed in their curricular, theoretical and practical activities, they would probably feel protected and supported. Hence, they would be able to elaborate forms to overcome their anxiety and deal with the tension of the experienced situation in an appropriate way.

When analyzing the study's results, it is essential to contextualize the work and education of the nurses inserted in the predominant health system, which privileges care founded on technical-scientific knowledge and sets to the background the ethical and humanistic aspects of care<sup>(2,4-6)</sup>. It is not our, nurses and professors, responsibility to promote changes to this model, which complies with the norms of the current political and economic system. However, it is possible to discuss and reflect on the effects of this model on health care and elaborate proposals to introduce, in professional education, objectives and contents with a view to preparing nurses to assume integral care delivery to the patients. Perhaps preparing professionals focused on humanistic care is a possibility to change this reality, starting with changes in health care practice.

## STUDY LIMITATIONS

The study has the limitations of a qualitative study, contextualized in the time and place of the investigation. The results do not propose generalizations, however, they can be used in similar situations, contributing to the improvement of knowledge and reflections on the theme. Another limitation consists of the universe of the study participants: they are views of nursing college students. New studies on the theme, in other regions of the country, and based on different perspectives (professors, practitioners), would enrich the knowledge about care delivery to terminal patients.

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