

### Daily bereavements in oncology: Professionals' accounts of their elaborations

### *Os lutos diários na oncologia: Narrativa dos profissionais sobre suas elaborações*

### *Los duelos diarios en la oncología: Narrativa de los profesionales sobre sus elaboraciones*

### *Le deuil quotidien en oncologie : Récit des professionnels sur leurs élaborations*

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#### Abstract

Technological progress has made it possible to cure chronic diseases such as cancer, but it has also created the illusion that death is a misfortune. Oncology professionals have an ambiguous relationship with death, which, although present, is fought at all costs. We aim to analyze the meanings that professionals in the oncology field attribute to losses, death, and mourning. We conducted clinical-qualitative research, with semi-structured interviews of open questions with six professionals from a team at a High Complexity Oncology Unit, a public service located in a city south of Bahia. From the content analysis of the interviews, we identified four thematic groups in which we discussed the concepts of loss, limits, mourning, welcoming, listening, and bonding, interspersing them with themes such as religion, the docility of bodies, responsibilities, and the implications of the institution and the health professional in managing devices for mourning. The conclusion indicates that there is a recognition that death is yet another loss at work, which is improperly addressed, not because of its unimportance, but because of the pressure of work demands.

**Keywords:** death, mourning, suffering, health professionals, neoplasms

#### Resumo

*O avanço tecnológico permitiu a cura de doenças crônicas como o câncer, porém, criou a ilusão de que a morte é um infortúnio. Os profissionais da oncologia apresentam uma relação ambígua com a morte que, embora presente, é combatida a todo custo. Objetivamos analisar as significações que os profissionais da área oncológica atribuem às perdas, à morte e ao luto. Realizamos uma pesquisa clínico-qualitativa com entrevista semiestruturada de questões abertas com seis profissionais componentes de uma equipe de Unidade de Alta Complexidade em Oncologia, serviço público localizado em uma cidade no Sul da Bahia. Da análise de conteúdo das entrevistas identificamos quatro grupos temáticos em que discutimos os conceitos de perda, limite, luto, acolhimento, escuta e vínculo, entrecortando-os com temas como religião, docilização dos corpos, responsabilidades e implicações da instituição e do profissional de saúde na gestão de dispositivos para o luto. A conclusão indica que há um reconhecimento que a morte é mais uma das perdas no trabalho que não tem a devida elaboração, não pela sua desimportância, mas pela pressão das demandas de trabalho.*

**Palavras-chave:** morte, luto, sofrimento, profissionais da saúde, neoplasias

## Resumen

*El avance tecnológico permitió la cura de enfermedades crónicas, como el cáncer, sin embargo, creó la ilusión de que la muerte es un infortunio. Los profesionales de la oncología presentan una relación ambigua con la muerte, que, aunque presente, es combatida a todo coste. Objetivamos analizar las significaciones que los profesionales del área oncológica atribuyen a las pérdidas, a la muerte y al duelo. Realizamos una investigación clínico-cuantitativa, con entrevista semiestructurada de cuestiones abiertas con seis profesionales participantes de un equipo de Unidad de Alta Complejidad en Oncología, servicio público, ubicado en una ciudad en el Sur de Bahía. Del análisis de contenido de las entrevistas, identificamos cuatro grupos temáticos donde discutimos los conceptos de pérdida, límite, duelo, acogida, escucha y vínculo, entrecortando con temas como religión, docilización de los cuerpos, responsabilidades e implicaciones de la institución y del profesional de la salud en la gestión de dispositivos para el duelo. La conclusión indica que hay un reconocimiento que la muerte es una pérdida a más en el trabajo, que no tiene la debida elaboración, no por su falta de importancia, sino por presión de las demandas de trabajo.*

**Palabras clave:** muerte, duelo, sufrimiento, profesionales de salud, neoplasias

## Résumé

*Les progrès technologiques ont permis de guérir des maladies chroniques, comme le cancer, mais ont également créé l'illusion que la mort est un malheur. Les professionnels de l'oncologie entretiennent une relation ambiguë avec la mort, qui, bien que présente, est combattue à tout prix. Nous avons cherché à analyser les significations que les professionnels du domaine de l'oncologie attribuent à la perte, à la mort et au deuil. Nous avons mené une recherche clinique qualitative, en utilisant des entretiens semi-structurés avec des questions ouvertes auprès de six professionnels faisant partie d'une équipe d'une unité de haute complexité en oncologie, dans un service public situé dans une ville du sud de Bahia. À partir de l'analyse du contenu des entretiens, nous avons identifié quatre groupes thématiques dans lesquels nous avons discuté des concepts de perte, de limite, de deuil, d'accueil, d'écoute et de lien, en les entrecoupant de thèmes tels que la religion, la docilisations des corps, ainsi que les responsabilités et les implications de l'institution et des professionnels de santé dans la gestion des dispositifs de deuil. La conclusion indique que la mort est reconnue comme l'une des pertes au travail qui n'est pas correctement élaborée, non pas par manque d'importance, mais en raison de la pression des exigences du travail.*

**Mots clés :** mort, deuil, souffrance, professionnels de la santé, néoplasies

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The central theme of this article is the conceptions of loss, death and mourning of professionals who work in oncological care, from the perspective of psychoanalysis. The choice to restrict this investigation to this audience is due to the fact that cancer is a public health problem of epidemiological importance in terms of incidence, morbidity and mortality (National Cancer Institute [INCA], 2022). It is a chronic disease that is often associated with death due to its history of challenges for cure and the losses resulting from process of becoming ill.

Biological death is a natural event and dying is a biopsychosocial process that progresses until the definitive cessation of life. During this process, several emotions and feelings can be triggered, such as pain, anger, ignorance, sadness and longing (Faria & Figueredo, 2017). This is because the irrevocable certainty that one will die one day does not lead to acceptance or peaceful understanding, as there is no way to teach one how to die; nor to prepare for the mourning that will occur.

Grief is the means by which an individual can confront such issues, and for psychoanalysis, it is a painful process of meaning-making and re-signification that begins as a reaction to a loss, understood as the disappearance of something with emotional value to the subject, such as a person, an object, or an abstraction (Freud, 1917/1996b). In Western society, rituals are symbolic elements that help to comprehend, among other matters, death and mourning. However, in the current context, these rituals have become distant, mechanized, brief, and discreet, leading individuals experiencing grief to suppress their emotions in order not to disturb others, as grief is often considered morbid and, in many cases, pathological (Kovács, 2008). Thus, in contemporary times, we deal with our existence—and the existence of those who cross our paths—as if we were immortal, despite knowing that the processes of dying and death are inevitable (Soares & Castro, 2017).

In this context of silence and repression surrounding the topic, most deaths occur either publicly on the streets, due to violence and accidents, or discreetly in hospitals, due to illness (Kovács, 2008). In the hospital setting, death and the resulting pain become a source of fear for healthcare professionals, as advanced technologies and specialized training prepare them to cure diseases and save lives. Consequently, they often struggle to accept the inevitability of terminality (Gomes & Souza, 2017; Kovács, 2010). One paradigmatic pathology for examining this confrontation between advanced technology and the challenge of facing terminality is cancer.

Oncological care confronts healthcare workers with situations of pain, finitude, loss, and grief, such as death, mutilations, and adverse effects that provoke physical and emotional reactions in both patients and their families (Lins & Souza, 2018). Additionally, healthcare professionals face experiences that make their work burdensome, such as excessive bureaucracy, stress related to systemic healthcare issues, delivering bad news, and managing conflicts with patients and their families (Perboni et al., 2018). These circumstances foster experiences of disenfranchised grief due to the unacknowledged losses they endure. By repressing their emotions—often unconsciously—these professionals are also at risk of falling ill (Kovács, 2010). The main symptoms include psychological exhaustion, which begins with reduced concentration, potentially followed by substance abuse, and can escalate to depression and suicidal ideation.

Illness represents a moment of crisis for the ideal of invulnerability in the face of death, our primal anguish (Freud, 1920/1996d). Thus, healthcare professionals are daily confronted with the break in the idea of immortality. A loss that becomes tangible when faced with an illness that may lead to death (Moretto, 2019). Coping with grief, therefore, encompasses suffering from the anguish caused by the collapse of the immortality ideal and fear of the unknown (Perboni et al., 2018). Amid this painful confrontation, professionals often struggle to communicate with patients and their families about dying and feel unprepared to address the issues surrounding life's finitude (Carvalho & Honda, 2017).

The research conducted by Cunha et al. (2021) indicates that the oncology professionals interviewed strive to perceive death as a process inherent to life, recognize the suffering that permeates the dying process, especially in patients with advanced cancer, resort to religious beliefs to understand the meaning of death, recognize that their academic training is insufficient to deal with situations of loss and suffering, and highlight the lack of institutional support for psychological support and for the creation of an institutional culture that values physical and mental health care. To contribute to discussions on this topic from the perspective of psychoanalysis, this article aims to analyze the meanings that professionals in the oncology field attribute to loss, death, and mourning. The representation of death, and of any other phenomenon, is produced subjectively, based on the recognition, interpretation, and elaboration of social, cultural, historical, family, and individual elements (Reis et al., 2017). From this subjective production, the subjects were structured, outlined their presentation in the world and established social ties (Birman, 2014). Therefore, it is understood that it is, including around the meanings of loss, death and mourning that professionals organize their ways of functioning at work.

## Method

This is a clinical-qualitative study (Turato, 2008) conducted with workers from a High Complexity Oncology Unit (UNACON) within the Unified Health System (SUS) in a major city in inland Bahia, Brazil. The clinical-qualitative method is a derivation of qualitative methods. It recommends conducting semi-structured interviews with open questions that, for this research, had the following trigger questions for collection: (1) “What are the losses that you deal with in your work environment?”; (2) “How do you deal with these losses?”; (3) “What goes through your mind when a patient of yours dies?”; (4) “What processes do you and the team carry out to say goodbye to this patient who dies?”; and (5) “What interventions could help the team in this grieving process?”. Additional questions were asked to deepen the investigation of the subject, guided by the research objectives and the interviewee's speech.

Before entering the field, we presented the research to the managers of the Municipal Health Department and to the management of the Unit. To invite the participant, we asked the management of UNACON to indicate the professionals to participate, and we asked the participants to indicate colleagues for the research. The invitation was made by telephone and, after acceptance, we scheduled the place, day and time for the interview.

The interviewer's conduct was to welcome the emotions and feelings mobilized by the interview, respecting the interviewee's manifestations and, at the end of the interview, when necessary, guidance was given to seek care for the manifested suffering. Research results were returned individually, when the topics addressed, and the reflections provided were resumed. The psychoanalytic approach was a reference for listening, with a theoretical framework centered on the conceptualization of free association of ideas, transference and resistance. The professional posture was guided by the Code of Professional Ethics of the Psychologist (Federal Council of Psychology [CFP], 2005) and the research complied with the ethical precepts involving research with human beings, regulated by Resolutions 466/2012 (National Health Council [CNS], 2012), and 510/2016 (CNS, 2016). This study was approved by the Human Research Ethics Committee of the Universidade Federal do Sul da Bahia, through a Certificate of Ethical Presentation - No. 5,116,231.

All interviews took place in UNACON's service rooms, in a private, quiet and confidential environment. At this time, we explained the research proposal and asked the student to read the Free and Informed Consent Form (TCLE), for signature, if they confirmed their acceptance. The interviews were recorded and conducted from February to May 2022, by a psychologist, a psychoanalyst and PhD in clinical psychology, and accompanied by a scientific initiation scholarship holder, a medical student. The average interview time was approximately 46 minutes. We interviewed professionals with more than one year of experience, working at the selected UNACON, and excluded those who were on vacation or sick leave.

We closed the sample using the theoretical saturation criterion and considered that with six interviewees the answers already showed repetitions in their content and had enough elements to achieve the research objectives (Turato, 2008). The research participants were: a social worker, a nurse, a nursing technician, a massage therapist, a pharmacist and a receptionist. Since most participants were female, we used this gender when presenting the results.

To process the collected material, we followed the following steps (Turato, 2008): (1) first, we transcribed the recorded material from the interviews into a digital file, with the addition of observations made during the collection; (2) then, we performed cursory readings of the transcribed information, in which we did not privilege any element and aimed to understand the material; (3) from this, we grouped the statements, considering the repetition and relevance of the content, and identified themes that each grouping brought; (4) subsequently, we created categories for the themes, according to the theoretical and scientific collection, and organized the groupings by thematic proximity; (5) finally, we interpreted the categorized content with the psychoanalytic theoretical framework and discussed it together with the topics already addressed in the literature. From the cursory reading stage, we had the support of another undergraduate student for data analysis.

The research is validated by *the checklist Standards for Reporting Qualitative Research* (SRQR) (O’Brien et al., 2014). This *checklist* is a standardized guide for qualitative research reports and was used, in the end, to assess whether each item that qualifies an investigation was met and to write the development agency report.

## Results and discussion

The analysis of the six interviews allowed us to identify and correlate four large thematic groups with the scientific literature, which are summarized in Table 1 and will be presented and discussed in this section.

**Table 1**

*Summary of themes categorized from the interviews*

Title	Topics discussed
Meanings attributed to losses	Imposition of performing tasks to overcome limits and hide the pain of losses; attribution of kindness to the professional who performs his duties without questioning, relating this to religious foundations.
Meanings attributed to mourning and ways of processing it	Excessive demands and the imperative to work towards good care prevent the perception of the elaboration of grief; suffering is highlighted, but they bring mechanisms for coping and elaboration of grief.
Importance of the bond with the patient and family	Related to the examples in the previous section, the bond with the patient and family member is highlighted as an important resource for dealing with losses.
Responsibility and implications for oncology care	The lack of institutional support and individual responsibility to deal with losses and limits has the effect of not perceiving their implications for choosing oncology and the transformation in the field, waiting for others to change the environment.

### Meanings attributed to losses

The definition of the words *losses* and *limits* indicates that loss refers to the deprivation of something that one had or the absence of someone in a usual place (Ribeiro et al., 2023a). A limit is a line, real or imaginary, that delimits and separates one territory from another and, in its figurative sense, means an insufficiency, restriction or delimitation that leaves a mark from which one cannot continue (Ribeiro et al., 2023b). When asked about the losses they deal with in the work environment, the interviewees refer to the death of patients; the end or interruption of treatment and, therefore, the loss of coexistence with the individuals assisted and their families; the loss of functionality in patients, who, due to illness and treatment, lose physical and cognitive functions and change situations and lifestyle; the patient’s withdrawal from treatment; the loss of team colleagues, due to dismissals; and other elements that are more related to the limits for performing the work. These elements refer to insufficient resources in the public health system, such as reduced staff, lack of medicines and materials that should be offered, unsatisfactory space and material to meet users’ needs, limited working hours to respond to service demands, delays in scheduling exams and therapeutic procedures and decreased motivation to work, due to emotional exhaustion with the difficulties faced.

This indicates a conflation between losses and limits. According to Moretto (2019), when faced with a loss, it is necessary to process grief, whereas in the face of a limit, one must fight: analyze and utilize available resources to create new possibilities. When a limit is mistaken for a loss, there is no effort to seek alternative possibilities; conversely, when a loss is not recognized, grief remains unresolved.

In the interviews, we observed that although the professionals speak about losses, they acknowledge that they do not process them adequately, instead filling the time needed for emotional assimilation with work-related activities. Thus, we infer that in the absence of properly addressing losses and due to interpreting limits as losses, the interviewees overlook their emotional processing and potential to fight for better healthcare conditions, substituting these processes with action. The nurse exemplifies this when she states:

I have eight chemotherapy chairs; I schedule 22 people. It's inhumane for us! And, mainly, for the patients. (...) And this is very difficult to deal with. (...) I'm harming myself; I'm harming my team, I'm exposing them to heavy work.

Working in the healthcare field involves continuous exposure to various physical and psychological demands, and when demands exceed resources, professionals tend to develop stress and burnout (Sacadura-Leite et al., 2019). The pharmacist says that everyone on the team works at their limit, is always stressed, worried and resolving demands via cell phone. The nurse assesses that she suffers from anxiety, as a result of the difficulties and exhaustion of dealing with work demands, and adds that she goes without food and without bathroom breaks to be agile and decisive. She knows that this will lead her to illness and concludes that it is “the way to deal with the situation, either you work, or you leave”. She finds herself faced with a deadlock, either she does her job unquestioningly or she quits.

Illness can occur when it becomes complex and difficult to recognize the boundary between commitment to patient care and assistance and involvement with work issues (Vasconcelos & Dutra, 2020). Emotional suffering is configured in a cycle, characterized by anger, anxiety, and depression, in which one emotion stimulates the other (Faria & Figueiredo, 2017). The pharmacist, for example, reports that the day before the interview she cried a lot at various times of the day, feeling a mixture of anger and sadness due to the difficulties faced at work, identifying anger as predominant.

We noticed that the interviewees suffering is aggravated by the lack of institutional support to deal with the limits imposed by the lack of resources in the public system, which points to the neoliberal functioning of health (Gonçalves et al., 2015). Thus, because they do not identify a normative reference for the institution in which they work, each professional responds with their own repertoires and those who give more of themselves, who do not recognize the limits and act to meet the needs and demands of the service, are understood as kind, as explained by the nursing technician when evaluating as “kindness” the gesture of her colleague who routinely decides and goes, alone, on her own motorcycle, to the patients' homes, for example, to inform that UNACON was able to schedule the appointment, when it did not do so by phone, because the number provided was wrong.

We recognize and value the involvement of each professional in their work, but solving problems with users should not be a decision made out of “kindness” by a professional, but rather a decision discussed and shared with the team and supported institutionally. However, when responding with their own desires and subjective conceptions, another problem arises: the use of personal religiosity in the relationship with the patient and family. The nurse highlights this when she says that exhaustion at work is also pleasurable because “God gave her health” and the people she assists do not have it and place hope in the team, the doctors and the treatment.

Thus, kindness is linked to the divine grace of being healthy, and exhausting work is seen as gratitude or a price paid to stay healthy. This aspect is also highlighted by the massage therapist when she comments on the conflict experienced when observing the suffering of a patient who was “extremely religious” and “did a lot of charity”. For her, the conflict occurs due to the lack of explanation for the relationship between the person being good and the person suffering so much until death. Religiosity refers to a means to obtain other ends, for oneself and for others, such as consolation, sociability, distraction and *status* (Thiengo et al., 2019). The massage therapist, when consoling the husband of a patient who was on the verge of death, suggested that he hand his wife “over to God, with faith and trust, so that he can do his best”, because she believed that the husband's suffering and attachment to the patient prevented her death. This death was understood as the end of suffering.

The social worker mentions that the “presence of God” in her life gives her the strength to deal with her daily work and informs that she respects all religious beliefs, but the patient needs to leave the conversation with her with motivation and hope, which she conveys with her words and behavior. In other words, in addition to the technical and emotional communications linked to professional knowledge, there is the transmission of religious messages.

When considering the professional's religion, there is an ambivalence regarding the coexistence of technical-scientific and religious knowledge and, although it is assumed that religious beliefs should be respected, it is difficult to make this dissociation in contact with the patient (Fernandes et al., 2018). Religiosity can be a strategy for coping with suffering, since it can promote security and meaning to existence and attribute meaning to the experience of illness, encouraging the individual to take positions in the face of it. However, there are situations in which the use of religion, as support for what one feels, causes negative coping with suffering (Thiengo et al., 2019).

Discipline, proposed by institutional norms – such as hospital and religious norms – produces disciplined and docile bodies (Foucault, 1987), as it increases the body's strengths, in the sense of its usefulness, and reduces these same strengths,

in the sense of its obedience and subjection. Thus, religion can function as a form of discipline that reduces professional autonomy to fight for improvements in institutional functioning and, in function of the other, increases their actions to continue working in search of helping this other, as we have exemplified. In this context, these professionals experience a renunciation of themselves to perform actions that they consider good for the user, but they perceive themselves as having an excess of work that harms themselves and the care itself.

### **Meanings attributed to mourning and ways of processing it**

Mourning is the ideal way to deal with death. It is a slow and painful period that requires a willingness to process the loss. It is not an automatic process, nor is it a process of forgetting. On the contrary, it is a period of memories, resignifications, and reinvestments. Mourning begins with the painful recognition of the loss, followed by isolation from the outside world and a lack of interest in engaging in activities that do not bring back memories of the absent object/person (Freud, 1917/1996b). Later, one begins to identify what is truly lost when it is missing, and finally, one can withdraw libidinal investments in that object/person that is no longer present in reality and one begins to invest in other beloved objects. This moment is the end of the work of mourning, in which one adopts a new way of living.

When reflecting on these theories in the interviews, we observed that the professionals recognize everyday death and try to understand it, but they do not identify actions, either individual or collective, aimed at mourning. In fact, they point out that the demands of continuing to resolve demands and the flow of patients end up interrupting this subjective construction. They bring the signifier “getting used to” the death of patients, seeming to perceive death as natural, as also pointed out by Cunha et al. (2021).

However, the example of the nurse’s speech shows another meaning for this, because, upon learning of the patient’s death, she feels sad about the loss, but her interest quickly changes to knowing what the next scheduled date would be for this patient, with the intention of excluding him and giving the vacancy to another. The nurse still considers this an insensitive attitude, as does the nursing technician, but she advances in recognizing the suffering. She reports that, upon learning of a death, although she is destroyed inside, she holds back her tears to show strength to the users and family members. Many times, she takes turns assisting a colleague to go to the bathroom to cry and be able to return to provide comfort to those who need it.

Crying in secret or among trusted colleagues and, in contrast, the requirement not to cry or show suffering to the patient and family are highlighted as a professional value, transmitted by everyone and to everyone. Knowing how to control emotions and expressions of feelings indicates a deservingness to occupy that position in oncology, it is an assessment of professionalism. Even with this, the pharmacist contests the “getting used to death”; she says that each loss is unique and even knowing that it will occur, when it happens it is bad, because experiencing it is different from knowing that it will happen one day. Other interviewees bring up the idea of differentiated affection and a closer relationship with the patient to assess the loss that can be grieved and the one that is less costly, similar to those interviewed by Cunha et al. (2021). The massage therapist, for example, classifies patients as: wise, serene, calm and with a good soul, angry, guilty and who do not accept death with resignation. He states that he sees the former as those he would like to spend more time with in order to learn more.

We noticed that the interviewees’ elaboration of their losses is experienced as a conflict in several directions: pressure to meet excessive demands, demands for the ideal of professionalism in the exercise of their functions, demarcations regarding involvement with the individuals assisted and assessments of when and how much they can suffer. All this pressure is intensified by current demands, reinforced by the evolution of technology and academic training by specialty, with cure as a goal to win the race against death (Gomes & Sousa, 2017; Kovács, 2008). Death comes to be seen as synonymous with failure, a feared enemy to be defeated in a war.

In agreement, but from another point of view, the interviewees report that the feeling of having done everything they could for the patient and the family member helps them to deal with the loss. The social worker states that she feels like “a mission accomplished”, for having been useful in the patient’s life and having done everything she could to act as a professional, which suggests that the professional technique is a resource for elaboration, but that it also brings the feeling of work overload. The expression “mission accomplished” indicates the militarized way of approaching the work, like a soldier in battle who performs a task ordered by someone else.

In the presence of death, professionals rationalize and seek to explain it through dialogue, questioning and justifications. These rationalizations end up permeating guilt which, when not reinterpreted, leads to poor elaboration of grief and/or illness (Gomes & Sousa, 2017). Guilt is explicit in the massage therapist’s speech when she mentions that she feels “a strange sensation” of relief and pain due to the death of a patient in suffering, and that she needs to process it to understand that the relief does not come from a desire for death, but because the painful process has come to an end.

Regarding this need for elaboration, the pharmacist states that she dreams about many elements of work and understands that this is a way of dealing with the mobilized anguish. Dreams are manifestations of the unconscious, in which there is an attempt to construct one’s own knowledge about an experience and mix daytime remains, affections, thoughts and desires

repressed in the unconscious (Freud, 1933/1996e). The latter two appear in a disguised form, symbolized in elements that are initially enigmatic. Thus, the dream is a formation of a commitment of the self to manifest something that needs to be elaborated by the subject but cannot appear in its raw state. Furthermore, the interviewees comment on personal experiences as a way of elaborating professional situations, and vice versa. The nursing technician says that observing the patients' problems helps to perceive their problems as "minimal", however, her report denotes her fragility:

Each day I gain more strength, and it's through this. (...) That way, I manage to leave here without wounds, feeling at peace. But at the same time, I can't just stand by or sit still, knowing there's someone there who needs me.

The expression "I can't just stand by" indicates a contradiction with the message expressed in speech and, therefore, can be interpreted as a parapraxis. This is understood as a language error that reveals unconscious content that wants to be expressed, even when the subject wants to hide it (Freud, 1901/1996a). Parapraxes are conscious mistakes, but unconscious successes, since they are successful in transmitting knowledge. "Not standing by" can have the meaning of tiredness due to the need to always be firm in one's workstation and be a call for care for one's suffering.

In line with the resources for dealing with death, the interviewees also spoke of small farewell rituals, such as thoughts directed at a particular patient who was close to death, conversations with the deceased's family, and memories kept of those who have passed away, such as the nursing technician who keeps gifts and photos of them. The receptionist believes he is immature in dealing with losses, reports great shock when the first deaths occurred, and says he still needs a short break between hearing the news of the death and resuming activities. One of the meanings brought by the professionals that point to consolation in the face of death is the word "rested," as also pointed out by Monteiro et al. (2021). Thus, thinking that the patient has rested from suffering soothes the feelings awakened by contact with the life and death of others.

Regarding the resources provided by the institution to address grief, some interviewees mentioned that none are currently available. Previously, there was a ritual involving ringing a bell accompanied by posters indicating the patient's last chemotherapy session as a celebration of "victory." However, they questioned this practice, as it was conducted in all cases of chemotherapy completion, including those where treatment ended because the disease no longer responded. The massage therapist highlighted an instance where a nurse refused to ring the bell and even hid it to prevent its use, as many patients already had metastases. Nevertheless, the doctor would discharge them from chemotherapy, including the celebratory ritual, and transition them to palliative care to maintain their morale. This raises questions about whether such practices truly help patients maintain hope for a cure or serve as a protective mechanism (Monteiro et al., 2021) to deny losses and suffering in that environment, thus avoiding deeper, more honest conversations with the patients.

The challenges that healthcare professionals face in dealing with death and the dying process in the workplace have both positive and negative sides (Carmo et al., 2019). In the interviews, it is possible to perceive a routine that is negatively characterized as stressful, sickening, tiring, and full of suffering, which arouses denial, guilt, anger, frustration, and helplessness. On the other hand, care is taken to realize that the vulnerable party is the patients and family members, who need support at this time and this is what helps them give meaning to the work they perform, even if they go beyond some limits.

### **Importance of the bond between the patient and family**

A cancer diagnosis forces the individual to face a reality that they are living that hides their mortality. This confrontation produces psychological repercussions, understood as traumatic. Trauma exposes the individual to something that makes no sense, causing them to feel lost, in a moment of disorientation and helplessness (Almeida, 2020). "Why is this happening to me?" This common question leads the individual to try to find explanations and, in the face of traumatic conditions, such as the discovery of cancer, the presence of another human being can serve as support for those who are suffering. The privileged moment to establish this supportive relationship is when communicating the diagnosis of the disease, which is the responsibility of the physician and who, at that moment, often has no connection with the patient, providing few resources to alleviate the anguish and helplessness felt (Bianchini et al., 2016). However, the patient will need communication skills to provide comfort in the face of the unknown that lies ahead, which includes emotional preparation.

Thus, health care includes the mobilization of emotions, and the interviewees report moments in which they become destabilized, stunned, angry, with conflicting ideas and feelings, crying profusely, feeling anxious and sad about the suffering of others. Affects are qualitative translations of the amount of energy that affects the subject's psyche and which, originally, are supported by what the other person returns to the subject (Zimerman, 2008); they are related to subjective history, since the experience that produces the energy that invades the psychic apparatus will be translated by affects already experienced by the subject in associated situations. In other words, affects can be manifested by emotions, feelings and acts.

In analyzing the interview statements, we noticed how the entire oncology team, even considering the particularities and difficulties of each role, shares the importance of welcoming the emotions of patients and family members, making this welcoming something effective in the daily life of the Unit. This is made clear in the social worker's speech about welcoming as an essential guideline for all health actions, including primary care. It is therefore understandable that

UNACON is a place that no one wants to be, but since it must be there, the patient must feel they are in the best place. Therefore, patients are usually told that they are welcome in that space and that they should feel embraced by the team, so that they do not feel alone and know that the reference for care is that Unit.

There is no specific time or place for welcoming, nor does there need to be a specific professional to put it into practice (Ministry of Health, 2013). It is an ethical stance common to all health professionals and involves listening to the user to validate their complaints, recognize their role in the health-disease process, and hold them accountable for their autonomy and resolution of the situation. To do so, the professional needs to expand their technical skills in listening and share knowledge with the team, users, families, and the community.

In mental health, guided by psychoanalysis, we advocate singular listening to the subject from the reception clinic as decisive for directing clinical treatment. This singular listening must permeate all treatment and means an implied listening, which produces an “effect of responsibility” and promotes, on both sides, the production of knowledge (Dunker & Thebas, 2019, p. 34).

The interviewees perceive the diagnosis as an intense moment of emotional mobilization for the patient and family and seek to establish a flow for welcoming these emotions, including raising the issue of treatment abandonment, associating their listening and receptiveness as necessary to avoid it. They consider that the best professional for this listening is a psychologist, but in the absence of one, they try to organize themselves in order to support the patient and their family. The concern with welcoming extends to other moments of bad news, such as relapse, palliation and death. The receptionist worries about the most appropriate way to welcome the pain of loss, because, no matter how much they relate to the person, it is very difficult to find the right words to offer.

The nurse corroborates this statement and says that she does not like this role of “comforting” others, because she feels awkward and does not know what to say. The massage therapist, although highlighting the specific knowledge of the psychologist on the team, brings up an interesting point about who the patient and family end up directing their speech of pain and suffering to: “sometimes, they get attached to technicians, sometimes to the girls from general services, and when the girl is cleaning they are at the door talking, so it has to be with the person they feel most comfortable”. This transfer of a place of listening, made by the patient and directed to a specific professional, is essential that it is perceived and managed by the team, so that the patient can be involved in their treatment (Moretto, 2019).

The interviewees mentioned listening as a method of support, but they did not directly associate professional training with this approach, which indicates that it is a skill exercised more by sensitivity and experience than by education and training (Vogel et al., 2019). The nursing technician says that, often, patients just want professionals to stop everything and listen to them. She believes that, in moments of despair, listening, for them, “is the best thing in the world”. The social worker adds that this attention helps in the individual assessment of the emotional state of the patient and family member to handle each situation in a unique way.

This interviewee mentions that her professional experience in primary care gives her knowledge about the importance of the bond formed between herself, the patient, the family member and the entire health network. For her, these bonds are essential for the progress of the treatment. In addition, we observe that the massage therapist seeks to develop bonds with patients based on what each one, with their singular expressions, has transmitted to her in terms of unique knowledge.

Thus, this perspective aligns with relational psychoanalysis, which understands the bond as a constitutive element of the unconscious subject, the family, groups, and institutions. A bond is defined as “the specific unconscious psychic reality constructed by the encounter of two or more subjects,” and this construction occurs through a process that includes “the more or less stable movement of investments, representations, and actions that associate two or more subjects in the fulfillment of some of their desires” (Kaës, 2011, p. 159). One cannot live without bonds; however, it is essential to learn to distinguish between bonds that foster growth and life and those that become obstacles, chaining the subject to a specific way of living or preventing them from fully living.

In this sense, the interviewees identify that the central objective that links them to patients and their families is to cure and provide care. These objectives are inseparable, as they seek to understand that there is other care to be offered beyond cure, but for this to happen, it is necessary for them to be a reference for the family from the beginning. For example, the receptionist shows concern and proactivity in helping the patients’ families with whatever is necessary, as he realizes the need for guidance regarding procedures after the patient’s death. This indicates that these interviewees, despite all the challenges, difficulties, suffering and contradictions, have been seeking to build oncology care from the perspective of care.

## **Responsibility and implications for oncology care**

Oncology demands a high level of complexity in terms of care and assistance throughout the health-disease process, in addition to requiring technical, relational, and affective skills from health professionals, due to the needs and particularities of users (Lins & Souza, 2018). This environment requires professionals to adopt constant coping mechanisms during the

operationalization of patient care. Therefore, the complexity of practicing the profession, the fascination with its discovery, the uncertainty about the status of the chosen work, and the financial return and security begin to compose questions that professionals ask, from graduation onwards, in search of developing self-knowledge, building their professional identity, and their way of exercising it (Buetto, 2009).

Most of the interviewees did not choose oncology as their area of specialization, reported being surprised when they were appointed or transferred to another department due to injuries and accidents at work, and admitted to having no prior knowledge of the area in question. The nurse says she “landed in oncology by chance,” without knowing anything or even the name of a single medication. However, she decided to accept it because she believed that God was giving her an opportunity. We observed that the work is seen by the nurse as a divine message and not as a personal desire, decided and achieved by her.

On the other hand, the pharmacist said that she chose oncology after an internship she did during her academic training and emphasizes that she loves working at UNACON and cannot imagine herself without her job there. In agreement, the professionals point out that it is in the area that they found professional satisfaction, such as the social worker who mentions that she is completely in love with everything she does at the Unit and where she “found her own self”. For this reason, and because she realizes the challenges of her role, the aforementioned worker says that as soon as she started working there she sought a specialization in social work in oncology.

The interviewees commented on their training during the interview, but not as a primary resource for dealing with loss, death, and limitations, as if academic-scientific knowledge were a secondary element to support them with human issues, which are seen as more intuitive and personal. This points to a dissociation in health training, in which technical skills for the complexity of human relationships are not truly included as basic health knowledge (Kovács, 2010, Vogel et al., 2019). Furthermore, the health institution itself does not include this knowledge as essential and, therefore, takes very little care to ensure that it is developed by professionals (Cunha et al., 2021).

With this, the professionals highlight the psychologist as a reference for support for crying and grieving. The nursing technician, when recalling the period when the team was without a psychologist, mentions that all the support for patients’ crying fell to the team working at the reception. However, she emphasizes that, when there is a psychologist, if the patient is crying, complaining or thinking that he is going to die, he calls the psychologist and hands it over to her. She shows relief in no longer having this responsibility.

This is the delicate role of the hospital psychologist, because although her commitment is to alleviate the suffering of the patient and the family, her role cannot be reduced to moments of crisis. The psychologist must work in the clinical field – listening to the patient to build an assessment of mental functioning and plan conduct – and in the institutional field – field of decision-making with the team, building therapeutic planning (Moretto, 2019). Without this coordination, in a moment of helplessness, the psychologist has very little to do for the individual, in her professional specificity. The risk of this reduction is that the psychologist receives many referrals, but without dialogue with the team for shared decision-making.

The number of these referrals increases when they are combined with requests to assist team members who are showing some psychological distress, which often results from the complexity of this work in public health. The professionals interviewed draw attention to the need for psychological help for the team, although no one undergoes psychotherapy, as reported by the pharmacist. The nurse believes that she needs psychotherapeutic treatment, and the social worker believes that she has emotional balance in handling cases, due to her personality and her religious beliefs.

Based on psychoanalytic theory, we defend the importance of psychological support for health professionals as part of their training, as it helps professionals to recognize and work on issues that interfere with patient care (Freud, 1919/1996c). However, worker health care should not be an individual responsibility alone; the institution needs to be involved, especially because there are sufferings that are crossed by structural issues in society, such as discrimination and prejudices based on race, social class, religion, gender, and other intersections that configure the heterogeneity of Brazilian society. In addition to structural issues of the institution, such as fragile job and professional security, lack of organizational studies, and lack of a career plan (Bitencourt & Andrade, 2021).

It is necessary to be supported by effective public policies and, thinking further, the regulations established politically by ordinances should direct financial and human resource contributions. However, each institution must develop actions focused on the unique experiences of its team. Campos and Amaral (2007) advocate participatory management in hospital institutions, in which communication is central to sharing problems, decentralizing decisions and involving workers in achieving results. Participatory management aims to develop autonomous subjects, users and professionals. Thus, it values motivation for health production and the integration of the hospital into the care network.

In this participatory and decentralized management, the discussion of cases for a shared team decision can help professionals, as they feel like participants, sharing responsibility and reducing the feeling of individual decision-making in the management of cases. We also consider the creation of spaces for discussion of topics that touch on oncological treatment, for example, the professional-patient relationship. At this point, the experiences of groups inspired by the *Balint psychoanalytic model* can provide methodological support (Nascimento & Garcia, 2020). In these groups, the aim

is not only to discuss cases for decision-making on the therapeutic project, but also to express and discuss the feelings aroused in health professionals in their relationship with a given user, a kind of discussion of cases from the perspective of the professionals' feelings. We work with transference and its management, central operators of the clinic and which can direct the treatment.

Continuing the contributions of psychoanalysis to health education, Freud (1919/1996c) advocated an open course so that students from different branches of knowledge could study health and humanities topics from a psychoanalytic perspective. Here, a space for study and discussion is idealized, in which professionals from the health team can read texts from different areas with the aim of collectively redefining these themes that appear in patient care. For example, the meanings of words such as *kindness*, *care* and *giving* can be worked on based on texts from the human sciences. Religion and spirituality can be discussed in a less passionate way based on philosophical and anthropological texts.

Therefore, the team, which can be extended to the extended health network team, is seen as a privileged group for decision-making, sharing responsibilities, affections, knowledge and, therefore, for dealing with loss and death. It is in the pronunciation of words and in the discussion of topics that the meaning that escapes the linearity of the discourse and the subsequent understanding of what causes suffering to emerge (Carvalho & Honda, 2017). The professionals interviewed highlighted the unity of the team, the dialogue with colleagues and the commitment of everyone to learn and do the appropriate work as favorable for themselves and for the user. The pharmacist says that she learns a lot from her colleagues and confirms the importance of having a mechanism for dialogue in the location, such as “conversation circles”, because the team itself does not talk about losses, death and mourning. She emphasizes that conversations occur more on weekends, when there is a death, and the staff sends it to the messaging app group. Other interviewees also mention these messages as a way of sharing the subject, which points to a brief communication device, with reduced interaction and which can be invasive, since the sending and receiving of the message has no delimited time or place.

In the absence of institutional support, of initiative by the employees themselves to create participatory and democratic spaces, and of therapy for the work of individual resignifications, the professionals report that the feedback of gratitude from patients is essential for motivation and encouragement in the area. The nurse illustrates this conflict by saying that she realizes that she no longer has any interest in her profession due to stress and fatigue. She adds that she does not give up on the area because of the recognition of the patients, who are very grateful for her professionalism and dedication, and consequently, she feels proud of the trajectory built. Other professionals also bring feedback of gratitude from family members as a way of understanding their work. This favorable feedback has the meaning that the effort and sacrifice were worth it, because the objective of the actions in favor of the patient was achieved.

## Conclusions

On observing the incidence of religion in the interviews, we hypothesized discrimination and prejudice as a way of constructing health actions, by transmitting religious faith to deny or calm dissident affections or by interpreting religious precepts as a form of superiority in relation to users, with the implicit notion of poor sick sinners. However, this was not investigated, and the new research project was directed towards investigating the conceptions that oncology professionals have of the people they assist. In fact, the research that led to this article was limited to investigating the meanings and significance of loss, death and bereavement for a specific public, which provides oncology care in a city in the interior of Bahia, far from the major cancer centers and not linked to a university. Thus, the focus of the experiences is also specific. Some other themes related to death were not explored, such as the difference in senses and meanings between the death of young and elderly patients, which were brought up in the interviewees' speeches, as it would require a different direction of investigation from the more emerging and frequent themes brought up by the professionals interviewed.

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