Health professionals and death: emotions and management ways

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ABSTRACT

This article will treat two dimensions of social relations: death at the hospital , and the way in which health professionals manage their emotions regarding death and suffering. The hospital has been chosen as a privileged location for this research for it is a central and almost naturalized place concerning services directed to health, disease and death. Accounting that this institution has become, in contemporary western society, the place of social delegation of care for the sick, especially those who are about to die, two public hospital units where taken as subject of ethnographic research: an Intensive Care Unit (ICU) and a Palliative Care hospital (PC), which attends patients with cancer "out of therapeutic possibilities". The two units present different forms of caring for the patients, in which the space and value given to the expression of feelings are also different. The analysis is centered on the way that the staff's emotions are managed, as well as on discussions regarding the contact with suffering, death and feelings wich involves the social actors.

KEY WORDS: Emotions, Suffering, Death, Decision-making

Leaving the reasons aside, let us retain to the correct manner to cry, understanding it as a cry that doesn't make a scandal, that does not insult the smile with its clumsy and parallel resemblance. The avarage or common cry consists of a general contraction of the face and a convulsion sound followed by tears and mucus, this at the end, for the cry ends at a final and harsh blow.
In order to cry, focus your imagination on yourself, and if this is impossible to achieve as we have the habit of believing in the outer world, think of a duck covered with ants and on the gulfs of Magalhaes strait in which nobody enters, ever.
When the cry arrives, you will gently cover your face, using both hands with the palms turned towards you. Kids will cry rubbing the sleeves of their coats on their face, and preferably in the corner of a room. Average duration of a cry, three minutes. (Julio Cortazar "Instruções para chorar", 1973: 6)

This Cortazar's tale (1973: 6) selected as epigraph illustrates a view over the social construction of emotional expressions. With an ironic and amusing tone, the author postulates the existence of an apprenticeship of the adequate form and duration of crying. Every society builds ways of expressing feelings, whichever they may be: sadness, happiness, anger, pain or fear. According to Mauss (1979: 153), all the expressions of the individual and group feelings configures a kind of language, socially expressed : the manifestation of emotions is essentially a symbolic action. The emotional expression is, for Mauss, the evidence of the articulation of three domains: the biological, the psychological and the sociological.

The same can be said of death: the dying process is not only a biological fact, it is also a social construction. As in any other phenomenon of social life, death can be lived and interpreted in many ways, according to different meanings shared on this experience, the historical moment and the social and cultural contexts. All societies elaborate ideas and organize rituals related to death, what constitutes , for Elias (2001: 12), one of the aspects of the process of socialization. Thus, death does not distinguish from other aspects of social life.

This article will treat two dimensions of social relations: death at the hospital , and the way in which health professionals manage their emotions regarding death and suffering. The hospital has been chosen as a privileged location for this research for it is a central and almost naturalized place concerning services directed to health, disease and death. Accounting that this institution has become, in contemporary western society, the place of social delegation of care for the sick,

especially those who are about to die, two public hospital units where taken as subject of ethnographic research: an Intensive Care Unit (ICU) and a Palliative Care hospital (PC) [2]

The methodology used on both investigations were seeing from a qualitative point of view. The first ethnographic investigation was done at the ICU of a public university hospital in Rio de Janeiro – Brazil and consisted of a total of one hundred hours of participant observation, complemented with recorded and consented interviews with ten professionals of the sector (doctors, physiotherapists, psychologists, nurses and auxiliary nurses), also accompanying the exams of admitted patients, ambulatory consults, home visits and meetings of relatives and the staff. The second done at the Palliative Care Hospital consisted in observing seminars along with doctors and nurses about palliative assistance The researcher followed exams at the patient beds, formal and informal staff meetings, and observed shift changes.,. The observation was complemented with interviews with twenty-two hospital professionals and the research time lasted one year. This article focuses on emotional management of health professionals at these two services that present quite different discourses and practices.

THE OBSERVATION FIELDS

Following many authors that postulate that the practical exercise of medicine is constituted by a double dimension – "knowing / feeling", "technology/ humanism", "competence/ care", "objectivity/ subjectivity", "rationality/ experience", among other denominations – it is possible to consider that the two hospital units selected for observation represent perfectly the two extremes.[1] According to Good and Good (1993: 91), during researches done with medical students, doctors must be competent and have caring qualities. The "competence" is associated to the language of basic sciences, to knowledge, to technique, to performance and to action, whereas the "care" would be expressed in the language of values, of relations, of compassion and empathy, associated to the "humanities". These authors associate the juxtaposition of "competence" and "care" to other opposite pairs of western scientific rationality, such as "technology/ humanism" and "science/ culture". In his ethnography of medical learning, Bonet (1996) observed the frequent manifestation of two representational groups– "knowledge" and "feeling" –in hospital practices. For Carmago (2003:126), in the practical exercise of medicine, a paradox emerges between the "subjectivity" of the patients suffering experience and the "objectivity" of the laboratory data that the doctor deals with.

The ICU was chosen for being a sector that concentrates highly specialized technological and personal resources treating patients on critical situation. It consists of a social space where the

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[1] This double dimension can also be articulated to the "*undeniable tension*" between Romanticism and Rationalism, analyzed by many authors, in special Duarte (1998: 15).

health staff favors competence, technology and the objectivity (Menezes 2000a: 7). By its turn, the PC hospital aims to support the diseased until the end of his life, minimizing his pain and offering emotional and spiritual aid to his relatives (Menezes 2001b). Both hospital sectors deals with extreme situations, at the borderline that concerns life and death. The ICU professionals work focusing on the cure of the disease and the struggle against death, whereas the palliative staff begin their assistance when there are no more possibilities of cure left. Considering that the two units represent two distinct forms of attention, the identities of its professionals are built over diverse principles, what leads to, in its daily practice, different ways to manage emotions while in contact with suffering.

Death appears systematically as an object of study in social sciences from the 1960s on, when many authors produced relevant studies about the subject. From this production, one can initially identify two social and symbolic configurations of death in different historical moments, named as "traditional death" and "modern death". The historical approach of Ariès (1975; 1977) is founded by the conception of a progressive degradation to the relation with death established by western individuals and societies. This author's investigation comprises a vast historical period, from the High Middle Ages to the 20th century, the "traditional death" being related to the "traditional" society and the "modern" death a characteristic of the 20th century. These death models are taken and treated as ideal types as in a weberian sense (Weber 1978: 6).

In comparison to the 20th century, the "traditional death" would be less concealed and more present. The birth and death, as other animal aspects of human life, had a public character: they were social events, less private than in the last century. From the social consolidation of the hospital institution on – medically administrated and controlled – there was a medicalization process in the 19th century, developed during the 20th century (Foucault 1999: 111). As a consequence of this process, the assignments related to death were dislocated: from houses, in the community, to the hospital, an institution ruled by the scientific knowledge of body and health.

In its first years, the 20th century was the stage of the decay of the "traditional death" and of the expansion of the "modern death", utterly established from the First World War on. Due to the social delegation of the patient to the medical knowledge and its institutions, the family and the infirm are gradually silenced. Death becomes socially hidden, turning into a rationalized and institutionalized thing, configuring the model of "modern death". According to Elias (1997) this process of concealment of death was part of the civilizatory impulse initiated in European societies around five hundred years ago. His analysis of the history of habits (Elias 1997) considers that many changes on social rules have occurred, modifying behaviors and feelings, producing a process of internalization and consequently an increased self-control. Life in the 20th century – if compared

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to previous periods – became more predictable, demanding from each individual a higher level of anticipation and passion control (Elias 2001: 14). The attitude towards death and the image of death nowadays can be comprehended in reference to the predictability of the individual life, considering that there is a higher life expectancy (Elias 2001: 14). Death's spectacle, due to the chronic disease, does not prevail anymore.[2]

In the 20th century, with the appliance of medical technology to the maintenance of life, specially with the creation and usage of the artificial ventilator, there were many deep changes in the dying process and in the concept of death itself. The brain death diagnosis is built, articulated to the organs transplant (Lock 2000: 233). The borders between life and death are transformed: the death of distinct body parts, of which Bichat spoke, became a successive death of the same individual with the usage of medical technology (Le Breton 1995: 62). The frightening image of death was also changed: the traditional skeleton with the sickle was substituted, in the 20th century, for the image of the ICU intern, utterly alone, with his body invaded by tubes and surrounded by devices.

The hospital is the central *locus* of reference to diseases and death. To Herzlich (1993: 6), anguish is always present in this institution, despite the indifference seen in its routine. The inscription of death in the medical work produces a change in representations: not inserted in the category of sacred anymore, but instead in the action and technical efficiency. To the doctor and to the hospital, death becomes, primarily, a failure: it is convenient that this event loses its importance and ceases to consume resources and energy (Herzlich 1993: 7). Thus, it is the task of health professionals to administrate the expression of emotions of everybody involved in the dying process: patients, relatives and the health staff itself.

THE INTENSIVE CARE UNIT

The ICU was created with and keeps the objective of concentrating three critical components: the most critical patients, the most expensive and sophisticated technical equipment and the staff with the knowledge and experience to take care of these patients and specific devices (Civetta 1988: 7).[3] The observed ICU does not have emergence services, only ambulatory services and hospitalization, having about five hundred beds. The patients in this ICU – seven at most – comes from various sectors of the hospital.

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[2] One should emphasize that, differently from the social concealment of death due to diseases, the 20th century saw the increasing exhibition in the media of the spectacle of death by disasters, war and violence.

[3] The ICU (or CCU) was created on 1946 in the United States, due to the poliomyelitis epidemics and to the use of artificial respirators, in search of the maintenance of the patient's life. There were many attempts to organize the ICU's, but only with the development of certain equipments the implementation and execution of these units were possible (Menezes 2000b: 29).

This unit presents very specific characteristics: the service and its devices is introduced through an explanatory video – indicating the relevance of technology. The environment is very bright, artificially illuminated, having the windows always closed and covered with a filter, being impossible to see daylight. The temperature is cold and kept stable by a central air conditioning. Many noises can be heard in the place: the voices of professionals, alarm sounds of the equipment, the bells of service telephones and the professional's cell phones, apart from lounge music – a cacophony. A mixture of odors is omnipresent: the scents of disinfectants, medications, healing material and of the patients' secretions. The mixture is sickening and variable. Such characteristics make the ICU a place where there is a total abolition of time and isolation from the outside world (Menezes 2000b: 30). The spatial structure of the observed ICU allows maximum visibility from its central point, allowing a permanent control and observation possible.

Around one hundred professionals of many categories circulates in this environment, such as doctors, nurses, auxiliary nurses, nutritionists, psychologists, physiotherapists and medicine and physiotherapy trainees – a multidisciplinary staff. Despite the differences between distinct professional categories, one can assert that there is a common identity in the whole team: that of the professional that works with intensive care, based on the technical knowledge and practical experience while dealing with technological resources, serving the preservation of life. These professional have an important place in the hierarquical system of specialties field: his power refers to the possible regulation, control and negation of death, utterly linked to his technical competence. In the ICU it is possible to artificially extend life.

PALLIATIVE CARE AND THE MODEL OF "CONTEMPORARY DEATH"

From the ending of 1960s on, opposing to the increasing expansion of medical power, many patients rights movements and humanization of infirm assistance movements appeared. The claims covered from the right of "dying with dignity" to the regulation of euthanasia, converging on a speech proposing new practices related to death due to chronic degenerative diseases, in which the power relation between the patient (and his relatives) and the professional staff would be transformed. Thus a new model of death emerges, named by the authors that research the topic as "neo-modern", "post-modern" or "contemporary" (Walter 1996). This model is represented by the *Hospice* Project or the Palliative Care.[4]

This proposition emerged in the ending of the 1960s in England and in the United States and, since then, it has been broadly spread. It corresponds to a new social representation of dying and the kind of role of the involved social actors: patient, relatives and professionals. In the bulge of this proposition some new institutional practices and an extensive discursive production over the

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[4] I use here the term *hospice* in English, for there is no Portuguese equivalent.

deliberations of who is about to die have been developed. It is in fact an innovative project in the medical practice – not eminently healing anymore, but prioritizing the comfort and easiness of the patient. The PCs postulate a transformation of the relation between health professionals and the diseased and his relatives. Death becomes an object of new meaning constructions by the health staff, in which the feelings of all who follow the dying process are valued and must be expressed. The pain, suffering and loss must be demonstrated, what configures a diverse attitude of what still happens with professionals of other specialties, indicating the construction of a new *habitus*.[5]

The PCs philosophy is centered on the patients autonomy: his feelings and preferences having precedence over standard institutional regimes. The ideal is the patient to have maximum control of his dying process, making choices from the information given by the doctor. Dying in his own residence is encouraged by the staff, if that is the desire of the infirm and his family. For the diseased to choose it is necessary for him to know the stage of his disease: the tone of the ideas is the sincere communication, the treatment must be discussed, in its various stages, between all the social actors. The rule is the dialogue and the refusal of heroic proceedings on limit situations.[6] Once that the action possibilities of the doctor are explicit, the patient can deliberate over the lifetime he still has, choosing certain conducts and giving his farewell, with the support of the multidisciplinary team.

The proposition of the PCs appeared in Brazil after a few decades after the foundation of the first *hospices* in England and the United States. The first public unity of palliative assistance created in Brazil (Rio de Janeiro) was the observed hospital: it has a distinct environment from others and its decoration is also part of the proposition. There is the intention of making it as cozy and personalized as possible. Its environments are bright, naturally illuminated, with modern and colorful decoration. According to a professional, the proposition is that:

> *The patient feels that there is life within: they are not arriving in a 'death house', this is a place where there is joy, people talking, no whisperings neither hidden nor occult things.*

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[5] According to Bourdieu's definition (1994: 15): the *habitus* characterizes a group of uses and forms of social relations practices of a certain social group. It tends, thus, to conform and guide the action, but since it is a product of social relations it tends to guarantee the reproduction of these objective relations that generated it.

[6] Heroic proceedings would be the reanimation or revival of the diseased after a cardiorespiratory stop. The central aspect of the decision of not doing heroic acts would be not to artificially increase the patient's life, especially at the expense of his sufferings.

The palliative assistance aims to implement a change in the social representation of death. However, the professionals are trained in a pre-eminently healing biomedical model, [7] with a specific professional posture and ways of reaction. In order to develop the PC, it is necessary training, focused on the acquisition of technical knowledge and the construction of a new professional *habitus*, that allows hearing and expressing emotions. There are activities such as courses, social gatherings and workshops, "*making possible to work with the pain and suffering of the patients and relatives*", according to one of the interviewed professionals. The appreciation of this work is necessary, for these professionals are discriminated by their colleagues from other specialties, being named as "*death certificates* specialists". It is indispensable the construction of the professional identity that works with palliative care, characterized by the acquisition of knowledge and the development of certain personal characteristics, such as patience, "*being attentive*", "*having good sense*", "*having empathy*", "*knowing how to listen*" and "*not making precipitated judgments*", according to some observed professionals. While dealing with death, for an interviewed doctor, the professional "*must have emotional and spiritual preparation*", and "*elaborate the matter of death inside life itself*". These sentences make the broadness of the proposal evident, towards death acceptance: with no doubt, a challenge for these professionals.

MANAGEMENT OF HEALTH PROFESSIONALS' EMOTIONS WHILE DEALING WITH DEATH

Health professionals face suffering daily and, so that they can perform their social role, they go through one of the longest rites of passage of the western world: the process of socialization in medicine (Becker 1992: 4). For many authors, such process is not only the incorporation of new knowledge, nor does it restrain to the discussion of technical aspects, but it is an existential process of learning to inhabit in a new world, constructor of a *habitus* (Menezes 2001a: 117). The professional posture and the reaction manners when in contact with death, the containment of emotion and feelings configures the medical habitus. For Herzlich (1993: 6), the choice of the medical career does not show insensibility to suffering, but shows, on the contrary, an unconscious sorrow – and sometimes conscious – particularly intense while dealing with suffering. Depending on the collective representations in which the professionals are inserted, different ways of managing emotions can be produced. According to Le Breton (1998: 133), health professionals, on the daily presence of suffering, must tame their tendency of empathy, not crying for the patients destiny. For

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[7] Biomedicine according to Camargo's definition (2003: 101): the medical rationality in Contemporary Western Medicine, constituted by the knowledge produced by scientific disciplines in the field of Biology, compound by human morphology and anatomy; a vital human physiology or dynamic; a system of diagnosis; a system of therapeutic interventions and medical dourine. Besides these constitutive elements, the foundations of rationalities abide in a cosmology.

this author, one of the marks of their professional identity would be the positioning of an adequate emotional distance.

EMOTIONS IN THE INTENSIVE CARE UNIT

The ICU is an exemplar place of the "modern death" model, hidden, turned into routine and banal. During the observation period no expression of feelings was noticed on part of the professionals, patient and their relatives. The routines are organized to make the highest technical efficiency possible, in a way of silencing the emotional expression of the social actors. The closeness of a professional with a patient and his suffering, beyond a certain limit, is perceived as a menace to the technical work. As said by a nurse, while referring to the possibility of emotional "involvement": "*when I see that the frontier is diminishing, I reinforce it: I run away*". The association of the professional with the situation lived by the infirm or his relative may produce feelings and influence on technical decisions, what can be exemplified by an observed episode: an overnight doctor changed shift with his colleague and, when he heard the account of a eleven year old patient, with the same name as his own son, he reacted: "*For God's sake, what a serious case, and he has the name of my son...*". From these data the doctor decided to change the medication dose: "*increase it for the kid not to cry and so that the father, does not get stressed, also ourselves, for God's sake*".

The sensibilization of the professional in certain cases is not well seen by the staff, for an eventual "involvement" is interpreted as a blurring of professional limits. Sometimes a member of the team points out, accusing a colleague: "*what is it, you are involved with a patient, you can't!*". Nevertheless, despite vigilance and control, occasionally "involvements" occur, as reported by a nurse:

> "*My barriers were not sufficient and I ended up 'taking' John Doe to my house. I would arrived at home and my husband asked: how was it with John Doe today? I brought my daughter to meet him... I involved myself so much with him that, even being a overnight nurse, I went to direct assist him*".

The nurse's account demonstrated the displacement of her function: usually the overnight nurse does not directly assist the patient. On the other hand, emotional distance due to the social disqualification of the patient can be equally problematic. One episode is illustrative: an admitted diseased with HIV got worse and the doctor said: "*probably our little promiscuous waiter is not going to live more than today*". In the next day, talking about the same patient, a woman doctor said: "*let's not give this diseased up: he is young, reacting and can be saved*". His lifetime has maybe been diversely evaluated due to the sexual stigma of his disease. By positioning himself at an excessive distance, the doctor runs the risk of dealing with an infirm as if dealing with an object, losing the notion of a person, with a singular history.

The teams are formed with the intention of positioning themselves at an "adequate" distance from the patient and his suffering: not as near to start the identification with his drama, nor as far as not having the minimum contact necessary to the development of a good doctor/patient relation. Hence, the ICU professional builds a series of artifices and ways of managing emotions, with time being the central reference. The observed ICU team had, by that time, only one psychologist, the professional officially commissioned to deal with emotions, who was frequently excluded and disqualified by the team, maybe for dedicating herself to feelings – objects equally not regarded by them. For some members of the staff, to deal with emotions – whether theirs, the patients or relatives – is considered as a "waste of time". The work regarding organ functions, measures, technical and therapeutic procedures is more valued by the staff than the contact with feelings. Dealing with patients' emotions may demand time and affective management of the professionals, which are considered "interferences" in the good development of work (Menezes 2000a: 61).

During the observation period at the ICU, the main ways of emotional management used by the team were: the fragmentation; the change to an opposite feeling and to action; the medicalzation, with the use of medicines or medical categories in relation to suffering – being all these mechanisms still quite frequent in Brazilian hospitals (Menezes 2000a: 82). The fragmentation is presented when the professionals refer to the diseased using parts of his body, of his parameters, organs and functions. Such situation can be illustrated by the sentence of a doctor: "*the electroencephalogram is rectifying*", what means brain death. An episode is exemplar: in front of a senior lady's clinic chart, with proved brain death, a doctor was giving orientations to the team not to try "heroic" maneuvers, for the family was already aware. The doctor then spoke to the resident colleague (and, thus, recently graduated), saying:

> "*I got to know, when I left the ICU to another sector in the hospital, that you let her die. Why did you do that? The tendency, with the altered dose, was that the electroencephalogram gradually rectified, until it reached a flat line.*"

And the resident replied: "*it reached the calcium dosage, it was low, I administrated calcium and it normalized*". The doctor with more experience asked: "*what for? We know it is a matter of hours*". The psychologist asked the resident: "*what did you feel when you saw the low dosage?*". And he replied: "*I did not feel anything, I just did what I thought I should do: the dose was altered and I balanced it. I knew that if the patients heart stops I must not reanimate him, but balancing it was so easy*". This dialogue points out the distinct attention focuses of the professionals: the younger doctor, with a fragmented vision, centered on the dosage, the more

experienced doctor accepted the limits of her role and the psychologist concentrated on the feelings of the professionals.

The change to an opposite emotion – usually learnt and incorporated during the medical formation – occurs when there is a difficult event, as, for example, a death, and there is an alteration of the mood, with a joke or amusing comment. During a meeting with relatives, the brain death of a patient was annunciated. When they understood the imminence of loss, two elder ladies hugged each other, crying. A little after when the relatives left, some doctors laughed, making comments such as: "*what a ridiculous thing! They cried just because they got the news of a worsening! And here in the ICU is the place for crying!*". The group laughed, reproducing the event. The humor, especially by psychoanalysis, has been understood as an exhibitor of truths – often painful – that can only surface by jokes or metaphors. Considering that death is viewed in the "modern" model as failure, amusing comments or black humor jokes were often observed in relation to difficult situations. It is remarkable that rarely the intensive care professionals use the term death, substituting it with euphemisms: he is "*going down the hill*", "*leaving*", "*delivered to God*" or "*stopped, they tried to revert it and it was not possible*" (Menezes 2000a : 72).

The medicalization is another way of feelings management, what can be illustrated by the episode in which a mother received the news of her young daughter's brain death. The lady, noticing the doctor heading towards the medicines locker, said: "*it's ok, I had enough tranquilizers today. Now what I must do is to say goodbye to my daughter*". This lady expressed quite clearly the attitude – practically automatic – of the professional in the sense of medical intervention in the moment of contact with the loss. The medicalization, as a way of distancing of the professional, can also be done by the use of medical categories, such as, for example, a diagnosis, what can be illustrated by the speech of a doctor while announcing the death of a sixteen years old patient, only son, victim of medical error: "*he stopped. And now the boy's mother is there, hysterical*". The speech of professionals that works with intensive care demonstrates that even on a situation of extreme suffering – a mother losing her only young son – the reference is done by a "diagnosis". Their attitude is a elucidative process of hiding feelings while facing death, especially when there is an inversion of the "natural" sequence of events: the fact of a young boy dying before his ancestors is, in our modern western society, particularly sad, due to the value given to the group age.

The delegation of death assignments to the ICU staff does not supply the professional with the means of elaboration of the contact with suffering and an onus is created, as said by a doctor: "*what makes one tired in this job is the contact with death: it is a lot of death, it is too much death*". It is important to emphasize that the number of deaths is high in this hospital sector. According to

the researched staff, legislation limiting the workload in the ICU is necessary, following the example of other countries, such as the United States.

The physical and mental exhaustion of these professionals, associated to the lack of space for reflection on suffering has been the object of new constructions. After the end of the ICU observations, I got to know about the implantation of Humanization Programs in some ICUs. One can suggest a demand of new constructions around dying – from professionals, diseased and relatives – as propitiators of new ways of managing emotions and new professional practices.

PALLIATIVE CARE: A PROPOSITION OF NEW PRACTICES AND SOCIAL REPRESENTATIONS IN RELATION TO DEATH

In a first contact with the PC hospital, it becomes evident that it is a different hospital from others: besides being a modern construction, the visitor is received by the staff in an attentive and calm manner, what constitutes an indication of the attention of the professionals towards the diseased and/or relatives. The contemporary idea of dying presents an ideal course to reach the goal of a "good death": parting from the diagnosis of "out of therapeutic possibilities" (OTP), it is necessary that the diseased and his relatives get to know about the development of the disease, through a sincere communication of the health professional. After that, the patient must state his desires to his relatives and the staff. Finally, the patient must be assisted by the professionals and by his family in regard to these desires and in the search for the maximum comfort possible.

The Brazilian team is formed in the paternalist medical model, so that the recently arrived professionals do not have the practice of open dialogue with the diseased and relatives. The professional that enters the unit goes through a course, wich a communication protocol is presented, stating themes that usually are not emphasized by some courses given to other health teams . The communication of the patient's situation is seen as a fundamental degree in the construction of a "good" doctor/patient relation, making the goal of a "good death" realized. Thus, the professionals are warned about the power of their words, to the risks of an "*iatrogenic communication*".[8] According to a doctor, the communication, "*just like the tumors, can be benign or malignant*". The objectives of information would be the reduction of uncertainty of the situation lived by the diseased; the strengthening of the doctor/patient relation and the necessity to offer a direction to the infirm and his family. In order to do such, the professional must be aware of their body posture, facial expression, voice tone and the maintenance of visual and physical contact with the interlocutor.

The professional must learn a behavioral code and go through a process of incorporation of a new identity, they act in similar way as an actor in a theater, when it rehearses and incorporates a

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[8] Iatrogenic: it is the pathologic alteration caused by any kind of treatment.

new character. A new value and conduct system is built, with attention and space for emotions, there is a transformation of the professional *habitus*. However, the emergence of emotions is seen, such as in the ICU, as being dangerous to the institutional stability.

To the observed professionals, the differential of palliative assistance when compared to the healing assistance model consists in the focus of attention: the professionals of palliative care regards the "bio-psycho-social-spiritual totality" of the diseased, while their colleagues from other specialties would only focus the disease. The PCs proposal favors the humanistic aspect of the assistance and, at the same time, depends upon the development of certain personal characteristics. But, curiously, the instruction of communication of the "bad news" to the patient and his relatives is done in the pre-eminent format in the medical formation: the protocol is presented in stages, just like the stages and treatments to the patient are transmitted. The professional must be aware of the patient conditions: if he can accept, what is his expectancy, his desire to know the truth and what is the influence of his family. In relation to what has been communicated, the professional perception of how much was assimilated over his condition and prognosis is emphasized. The palliativist is instructed to communicate "bad news" and some strategies can make his difficult task easier: subsequent to impact of the information, emphasize what medicine has to offer, such as pain and symptoms relief and the best "quality of life" possible.

The professional is trained to value and receive whatever emotions might emerge subsequent to the knowledge of the worsening and of his prognosis. Thus, he receives patients that, often, claim not knowing the meaning of given information. When this occurs, the palliativists gets angry and blame their colleagues for not making it clear, what can be illustrated by a nurse's speech: "*the patients come without explanations, are bad informed in relation to the proposition of the hospital*". For a psychologist, "*they are directed in an awful manner and I put on the chart : patient traumatized by lack of information on the part of the appointed, bad practice*". While the majority of these group complains about their colleagues from other hospitals, there is a doctor who has a different comprehension:

> "*When the patient and the family come here they already know, they have already been informed, but they want to hear it again to compare with what was previously said. We must stop wanting to condemn colleagues, and this is not in order to be protectionist with our class, and see that the patients are in a catastrophic situation, they want to hear some hope from someone*".

According to the observed professionals, diseased and relatives make "demands" about the reasons of the appointed and some of them get initially annoyed but, considering the seriousness of the infirm, the team gets touched. For a social assistant, that appoints patients to the PCs, the patients "*arrives with a second diagnosis: the first being when he finds out the cancer and the*

second when he knows there are no more treatments". Their task is to elucidate the situation and present the assistance proposal, welcoming emotions. However, at the same time that there is indignation for not making things clear, some professionals may present difficulties on a sincere dialogue, as this interviewed doctor:

> "*It is clear that the patient understands he has cancer, but it is like he doesn't want to believe this truth. He still hopes to live, and you may hear the patient saying that he will seek the church that will cure him. I tell him to go, who am I not to say so. It is very hard for me to lie, but it is logic that I can omit some data. If he asks me whether he has something in the liver and he indeed has, I will say he does. But I can say that it can decrease, increase or stagnate and not grow. I will not lie, but my experience tells me that, when I speak the entire truth to the diseases... I am afraid he might leave and commit suicide...*"

The professional's task of informing the diagnosis and the prognosis reveals itself to be extremely difficult, considering the idea of suicide constructed by the professional. The assignment of communicating a "bad news" produces various fantasies but, in the after all, the entire team gets touched when the relatives hide the truth from the patient and desire that the professionals join the "silence plot".

The care with an OTP patient produces many challenges, among which the respect of his desires. The palliative assistance prefers the autonomy principle, searching the "good death". The professionals find different ways of communicating the truth to the diseased and his relatives, administrating emerging emotions. During the observation, it was clear a situation in which the professionals presented great difficulty on controlling emotions: especially when the patient is young. The greatest team mobilization occurs when a young person is admitted in an infirmary, being the feeling of impotency expressed by the greatest part of the observed professionals, as a doctor said:

> "*Teenagers are very difficult patients for us and also for the family, for it is not the normal course of life for a son to die before his father*".

Considering that one of the basic conditions of the ideal of reaching the "good death" is the resolution of life pendencies, whether juridical, financial or affective, when a young person is involved some difficulties appear. The trajectory of the "good death" was constructed in reference to someone that would already have lived a certain amount of time and could "*complete well*" his life. The idea of a "*good ending of the life circle*", when treating youngsters, points out the limit of the professionals action that works in this area. The team's impotency towards this infirm is usually conjugated to a process of massive identification: whether the professional has sons of approximate age of the patient, or whether the age proximity with the patient itself. The protocol predicts identification with suffering, through all, on a daily basis, the professional points out his limits.

The second requirement of the PC proposition to reach the objective of a "good death" refers to the expression of the desires of the diseased. After knowing the worsening of the disease, it is necessary for the patient to solve and conclude his pendencies. The professionals guides relatives and patient over his rights and consider that the "death with dignity" is what occurs in the residence, surrounded by relatives and friends. Nevertheless, not all patients have families with material and/or emotional conditions to endure the charges of death. The OTP diseased ("out of therapeutic possibilities") that does not have a minimum of family and/or social insertion generally stirs the team, for he goes against the model of the "good death". Diversely of what occurred in "modern death", when the relatives were seen as social actors that "negatively interfered" in the treatment, in the model of "contemporary death", the relatives must actively join the treatment.

Concerning the second requirement, the expression of the patient's will, often what is sought by the team and patients occurs: the accomplishment of the desires. The words of a social assistant are illustrative:

> "*There is the case of a father who abandoned family and kids in the North. He ended up here and we managed for his family to come to Rio de Janeiro, to rent a house, and to host him and take care of him. This patient had run away for he had raped his own daughter. But she came to forgive him and take care of him till the end.*"

This patient died at home, under the care of his family: an exemplar case, for these professionals, a "*good life ending*" or of the realization of a "*rescue*", is a good reason for the staff's satisfaction. The professionals often referred to this episode, when asked about the gratification with their work. However, the realization of the "good death" is not always possible, what can be quite frustrating for the team.

Death is an event that can generate the emergence of emotions, of professionals and relatives. The team members produce personal ways of dealing with this crucial moment: the majority of the interviewed group think about a prayer, such as: "*may God be with you*", "*Please God have mercy and make that he rests soon*", "*Please God have mercy, may he stop suffering for it is not worth to die suffering*" or even "*Please God receive him well*". Such behaviors are usually done without the knowledge of diseased and/or relatives. Still, some professionals referred to situations in which they were asked by the relatives - probably after the perception of the possibility of agreement – to pray together. When facing death, the professional searches for religion.

Depending on how the death goes, the feelings of the professionals vary: if it happens without evident pain or suffering, there is relief and contentment for they reached their goal. However, when a patient dies in obvious agony, with symptoms not controllable with medicines,

the professionals suffers and expresses their frustration, often crying. On a certain occasion, I asked a doctor how a patient was, to which she replied, crying: "*she died yesterday, and what is worse, she died with a lot of pain. All I was trying to do was to control her pain and I couldn't make it...*". The feeling of sadness for the loss is conjugated to the feeling of impotency, due to the limits of action. Thus, in the PC hospital, different of what occurs in other hospitals, death is not a failure anymore, but the staff can feel defeated with the impossibility of relieving the diseased and controlling his symptoms.

In the moment of death the emergence of emotions is not exclusively from the staff: the relatives get emotionally and the professionals are receptive and stimulate the expression of these emotions. The cry is "welcomed" by these group, on the condition that it must be discrete and not exceed the "adequate tone". Nevertheless, when the family presents difficulties in containing their emotions, as for example a despaired son holding himself to his father's body, not allowing its transportation to the morgue, the team interferes referring to hospital rules. Another kind of relative's emotions can emerge in the moment of death: angrer, usually towards the staff. Even though the families have been informed that the hospital does not have material for reanimation neither an ICU, often the relatives, in despair, require the doctors to revive the diseased and, being refused, try to attack them. This is a rare event, but, when it occurs, the attitude taken is to call the security. The professionals understand the feeling of revolt and offer tranquilizers. Generally, after the catharsis, the relative feels regretful and accepts, in shame, help.

There are no doubts over the construction of new ways of managing the emotions of professionals. In the search of a new social representation of death, the professionals of these area use different expressions and terms from their colleagues of other specialties, such as: "*rested*", "*the suffering ended*" and "*he's done the passage*". But, even though the staff's works focusing on the result of a "good death", situations that indicate the limits of bearable can emerge, as on a certain day, when six diseased died on a short time space. As said by a psychologist: "*that was too much. The entire team sat and cried with the relatives, that was what we could do*".

The onus of the duty of caring of those that are in the process of dying can become excessive, and the professional might get sick. Such situation is an object of attention of the psychologists team, that stimulates the dialogue among professionals, the expression of feelings with colleagues and values the search of leisure activities on the daily life. All the interviewed professionals alleged bigger tiredness and emotional weariness in the PC hospital then in other hospitals. Apart from this, the professionals find personal solutions for their balance, as said by a doctor: "*sometimes I leave this place, go to the mall and don't buy a pin. I go to see beautiful, colorful and healthy people, people having fun*".

For these group the work is in not finished with the patient's death: the staff makes monthly meeting named "post-death", for which are called the relatives of patients who have died at least one month ago. Under the coordination of a psychologist, the meeting is centered on the expression of feelings of all those involved in the accompaniment of the recently deceased. The participants are asked to present their desires and projects, after having told what they lived through their relative's disease. One of the objectives is the prevention of the pathological mourning and the elaboration of a certain feeling of guilt that may occur, linked to the diseased's death. In this way, there is another created space in the institution focused on the construction of a new representation of death. The relatives' return to the hospital after their loss is stimulated, with the proposition of disassociating the image of the institution and its staff with grief. It is in fact a space for the elaboration of mourning not only of relatives, but of all those social actors, in which the professionals are included. Going beyond, there is a process of construction of a new image of health professionals, as quoted by a relative, surprised with a doctor's cry: "*I never thought that doctors cried. Doctors are also people, but I didn't imagine they suffered like we do*". For the team, the return of the relatives is an indication of the satisfactory conclusion of their task.

The onus of the duty of caring for OTP patients are big, but for the palliative care team it is worthy to endure them, in special when there is recognition by the relatives. Still, for the professionals, the most relevant gain in the work of production of the "good death" is the "personal growth". The international bibliography over the "contemporary death" considers that the accompanying of an OTP patient can make "life learning" and "personal growth" possible, what is also referred by the professionals in the Brazilian hospital.[9]

CONCEALMENT AND CONTROL ON EMOTIONS MANAGEMENT

The two investigated fields represents different ways of managing emotions: while in the ICU the professionals tend to turn the patient into fragments and object, dealing with his parameters and organs, in the PC hospital the staff is concerned about the "totality" of the patient and his relatives. In the ICU the professionals count with a technological support in the care, for at many times the devices are responsible for the balance and maintenance of the main functions of the diseased. Thus, the intensive care professionals contact with the patient is mediated by the apparatus. The ICU's environment is built according to the prominent values, in such a way that there is almost no physical space for the relatives. The intern patient stays isolated from the external

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[9] As examples of this construction, some titles of publications on the topic can be cited: *La mort intime. Ce que vont mourir nous apprennent à vivre* (Hennezel 1995) and *Death. The final stage of growth* (Kübler-Ross 1975), among others.

world, not knowing whether it is day or night, if it is raining or if it is cloudy. It is if life was suspended. Just like the intern infirm, these professionals remain cloistered, connected to the machines. It is a hospital sector in which the horizons are marked by the struggle against death, event that can mean the defeat of the medical competence. The emergence of feelings is seen by the ICU professionals as disarray to the "good" flow of work and, thus, these group searches for a separation from emotions. Often the professionals recently arrived in the sector get shocked with the black humor of their more experienced colleagues. But, after some time, they incorporate the same language and attitude. In this way, one can assert with Le Breton (1995: 150), that the same circumstances lead to sensibly different affective behaviors, according to the environment in which the individual is inserted. The same can be observed in the PC hospital: while seeing two intern patients crying in the infirmary, a recently arrived doctor said, vexed: "*why are you crying? I don't want to see anyone crying here! Everybody smiling! And is there any reason to cry?*" The doctor's reaction was similar to her ICU colleague, who did not perceive the news of a patient's brain death as a reason for his relatives to despair. Though, after some time in the PC, the doctor changed her attitude, adopting the demonstration of feelings and crying in many occasions. This professional, such as others in this hospital, leaned to the ideal of the rules of palliative assistance: she incorporated the palliative identity.

The environment of the PC hospital is bright, colorful and with many windows, in such a way that it is possible to see outside. The main objectives of the palliativist team are the non exclusion of the OTP patient of the daily life, greater social visibility of death, conjugated with the acceptance of this event, which has to be treated as "natural", once it is considered part of life. It is a new conditioning related to death. While in the ICU there is a institutional process of hiding – and even negating – death, in the PC hospital the professionals openly speak about death and request the relatives' presence in the final period of the patient's life.

The implementation of the "contemporary death" model produces tension among the social actors involved in the accompaniment of the OTP patient. In the ICU there is a domestication of the process of dying, at the cost of its exclusion and concealment. Whereas in the PC hospital there is a soothing of death wich accounts a greater social visibility. In the ICU there is silence concerning the emotions related to death, while in the palliative assistance there is an extensive production of discourses about the "good death". The two ways of constructing emotions management refer to Foucault's affirmation (1993: 27) over the power device: it is the silence as incitement to discourse, as the social concealment as making things public. The central aspect of both constructions refers to the control of emotions.

The model of palliative assistance emerged opposing the increasing expansion of medical power. However, the project of humanization of death is built at the costs of dependency – of diseased and relatives – of a broad network of professionals. The field of action of the palliativist team starts containing new intervention areas, such as, for example, "spirituality". The palliativists get "emotionally affected" and learn a psychological language. The space and appreciation of subjectivity and interiority indicate a new elaborated *constructo* of emotional control. Still, the affective and emotional expression in the PC hospital must be restricted to certain environments and situations. Thus, a diseased, relative and/or palliativist that laughs or cries louder is possibly reprehended, in reference to implicit or explicit institutional rules, as, for example, the words of a doctor to a nurse: "*what's going on, do you have to laugh so loud?*" To Walter (1997: 132), the pacific *ethos* of the PCs goes against the proposal of authentic expression of the infirm, especially concerning the exteriorization of anger what reiterates the hypothesis of domestication of death in the ideal of "contemporary death". In the construction of the new model of death, the palliativists go through a process of reeducation of what concerns the expression of emotions for, then, transform themselves on pedagogic agents of the diseased, relatives and recently arrived professionals. The palliativist becomes an educator of attitudes towards death and feelings, configuring a process of extension of the social medicalization .

The social medicalization presented in both observation fields, the difference laying on the ways of expression concernig this process. Although the intervention object of the professionals in both services is the same, the patient as individual, the focuses of attention of the teams are different, due to distinct conceptions built over health, disease, suffering, life, death and emotions expression. Such variations of focuses come from the difference of values of the two constituting dimensions of medicine: "technology/ humanism" or, in other words, "technique/ care". The preeminent pole in the ICU would be the technology, objectivity, rationality, skill and knowledge – probably weakening the other pole. But in the PCs there is an appreciation of care, experience, subjectivity, humanism, without neglecting knowledge and technical competence. Both units seek a resolution of the existing tension between the two poles. In this way, both space and time dedicated to emotions are qualitatively and quantitatively unequal.

The preeminent values in the ICU – objectivity, competence, technique and action – can be conjugated to the male domain, while the subjectivity, the feeling would be related to the female. Thus, the PC project, taken as a contraposition to the medical power, could constitute an attempt of reply to the exclusion of universal emotions . Going beyond, it would be the search for a "feminization" of the medical practice, the inclusion of an eminently feminine activity – care – to the field of professional medical exercise. The pioneer of the "good death" cause, Cicely Saunders,

was originally a nurse and later graduated in medicine, perhaps aiming to have professional legitimacy. Currently the PCs are constituted in Brazil by a majority of professionals of the female sex. Since the palliativist assistance is frequently disqualified by professionals of other specialties, such depreciation can be linked to the feminization of this action field. The words of a nurse over the topic is illustrative:

> "*The majority of the diseased that we receive comes from main clinic of the National Cancer Institute, which is a very sexist clinic. In order to facilitate the appointment, we invited the doctors of this clinic to meet our hospital and we cooked lunch for them. Here, we were only women. A doctor then said: 'now I understand why everything here is so beautiful, neat and organized, it is because there are only women', to which I replied: 'sure, so that you can see that we, apart from being great housewives, are also excellent executives, for our numbers show that all of our goals were reached.' And I showed them our results*".

Thus, one can aver the hypothesis of disqualification of the PCs for their feminine activity, linked to the care of death. Furthermore, it is known that the historical and social representation of emotions is associated to the female domain, while logic and reason are referred to the male universe. The model of the contemporary death comprises a pacification of death and an appeasement of the fears related to this event, by means of "adequate" control of emotions and circumstances surrounding the end of life.

Many questions remain without answers, but I conclude with two pragmatic speeches over the two observed services. According to an intensive care professional, with technological development focused on the preservation of life, "*the intensive medicine is the medicine of the future*", while for a palliative care professional, the process of death is prolonged, in a way that "*the great medicine of the 21st century is the palliativist medicine*". The declarations of both professionals converge on what concerns the expansion of the domain of medicine and the medicalization of death. Both medicines construct ways of domesticating emotions and controlling the circumstances of death. The way of managing feelings of the intensivists indicates their limits, pointing out the need of construction of new spaces and new relations between team and relatives. Concerning the palliativist assistance, the management of emotional expression has being demonstrated, remaining only to examine its consequences for all those involved in the process of death.

BIBLIOGRAPHY

ARIÈS, Philippe. 1975. *Essais sur l'histoire de la mort en Occident, du Moyen Age à nos jours.* Paris: Éditions du Seuil.

ARIÈS, Philippe. 1977. *O homem perante a morte*. Lisboa: Europa-América.

BECKER, Howard. 1992. *Boys in White*. Chicago: University of Chicago Press.

BONET, Octavio A. 1996. *Saber e Sentir. Uma etnografia da aprendizagem em Biomedicina*. Rio de Janeiro: Dissertação de Mestrado em Antropologia Social, PPGAS-MN-UFRJ.

BOURDIEU, Pierre. 1994. "Esboço de uma teoria da prática". In: Ortiz, R. (org.). *Pierre Bourdieu*. São Paulo: Ática.

CAMARGO, Kenneth R. 2003. *Biomedicina, Saber & Ciência: Uma abordagem crítica*. São Paulo: Hucitec.

CORTÁZAR, Julio.1973. "Instruções para chorar". In: Cortazar, Julio. *Histórias de cronópios e faunos*. Rio de Janeiro: Nova Fronteira.

CIVETTA, J.; TAYLOR, R.; KIRBY, R. 1988. *Critical Care*. Philadelphia: J. B. Lippincott.

DUARTE, Luiz Fernando Dias. 1998. "Investigação antropológica sobre doença, sofrimento e perturbação: uma introdução". In: Duarte, Luiz Fernando Dias; Leal, Ondina Fachel (org.). *Doença, sofrimento, perturbação: perspectivas etnográficas*. Rio de Janeiro: Fiocruz.

ELIAS, Norbert. 1997. *O Processo Civilizador*. Rio de Janeiro: Zahar.

ELIAS, Norbert. 2001. *A solidão dos moribundos*. Rio de Janeiro: Jorge Zahar.

FOUCAULT, Michel. 1993. *História da sexualidade I: a vontade de saber*. Rio de Janeiro: Graal.

FOUCAULT, Michel. 1994. *O nascimento da clínica*. Rio de Janeiro: Forense Universitária.

FOUCAULT, Michel. 1999. "O nascimento do hospital". In: Foucault, Michel. *Microfísica Do Poder*. Rio de Janeiro: Graal.

GLASER, Barney; STRAUSS, Anselm. 1965. *Awareness of dying*. Chicago: Aldine.

GLASER, Barney; STRAUSS, Anselm. 1968. *Time for dying*. Chicago: Aldine.

GLASER, Barney; STRAUSS, Anselm. 1970. "Patterns of dying". In: Orville, G.; Brim, Jr.; Freeman, H. E.; Levine, S.; Scotch, N. *The dying patient*. London: Transaction Books.

GOOD, Byron Jay; GOOD, Mary-Jo Del Vecchio. 1993. "Learning Medicine. The construction of Medical Knowledge at Harvard Medical School". In: Lindebaum, S.; Coch, M. (ed.). *Knowledge, Power and Practice. The Anthropology of MedicineAnd everyday life*. California: University of California Press.

HENNEZEL, Marie. 1995. *La mort intime*. Paris: Robert Laffont.

HERZLICH, Claudine. 1993. *Os encargos da morte*. Rio de Janeiro: IMS/UERJ.

KÜBLER-ROSS, Elizabeth. 1975. *Death. The final stage of growth*. New Jersey: Prentice-Hall.

LE BRETON, David. 1995. "A síndrome de Frankenstein". In: Sant'Anna, Denise (org.). *Políticas do corpo.* São Paulo: Estação Liberdade.

LE BRETON, David. 1998. *Las pasiones ordinarias. Antropología de las emociones.* Buenos Aires: Nueva Visión.

LOCK, Margareth. 2000. "On dying twice: culture, technology and the determination of death". In: Lock, Margareth; Young, Allan; Cambrosio, A (org.). *Living and working with the new medical technologies, intersections of inquiry.* New York: Cambridge University Press.

MAUSS, Marcel. 1979. "A expressão obrigatória dos sentimentos". In: Mauss, M. *Mauss. Grandes cientistas sociais.* São Paulo: Ática.

MENEZES, Rachel Aisengart. 2000a. *Difíceis decisões: uma abordagem antropológica da prática médica em CTI.* Rio de Janeiro: Dissertação de mestrado em Saúde Coletiva, IMS-UERJ.

MENEZES, Rachel Aisengart. 2000b. "Difíceis decisões: uma abordagem antropológica da prática médica em CTI". *Physis, vol. 10, n. 2: 27-49.*

MENEZES, Rachel Aisengart. 2001a . "Etnografia do ensino médico em um CTI". *Interface. Comunicação, Saúde, Educação. 9:117-131 .*

MENEZES, Rachel Aisengart. 2001b. "Um modelo para morrer: última etapa na construção contemporânea da Pessoa?". *Antropolítica, 10/11:65-83 .*

MENEZES, Rachel Aisengart. 2004a. *Em busca da "boa morte": uma investigação sócio-Antropológica sobre Cuidados Paliativos.*Rio de Janeiro: Tese de Doutorado em Saúde Coletiva, IMS-UERJ.

MENEZES, Rachel Aisengart. 2004b. *Em busca da boa morte. Antropologia dos Cuidados Paliativos.* Rio de Janeiro: Ed. Fiocruz/Garamond.

SUDNOW, David. 1967. *Passing on. The social organization of dying.* New Jersey: Prentice-Hall.

WALTER, Tony. 1996. "Facing death without tradition". In: Howarth, G.; Jupp, P. C. *Contemporary Issues in the Sociology of death, dying and disposal.* New York: MacMillan Press.

WALTER, Tony. 1997. *The revival of death.* London: Routledge.

WEBER, Max. 1978. *Economy and Society, vol. 1.* Berkeley: University of California Press.

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"Etnografia do ensino médico em um CTI". 2001. *Interface, 9.*

"Um modelo para morrer: última etapa na construção social contemporânea da Pessoa?". 2001. *Antropolítica, 10/11.*

"Tecnologia e 'morte natural': o morrer na contemporaneidade". 2003. *Physis, v. 13, n. 2.*

Em busca da boa morte. Antropologia dos Cuidados Paliativos. 2004. Rio de Janeiro: Ed. Fiocruz/Garamond.