PORTUGUESE JOURNAL OF PEDIATRICS

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ORIGINAL ARTICLE

Pediatric death: perceptions and experience of healthcare professionals

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Abstract

Introduction and Objectives: As a result of its particular nature, pediatric death presents healthcare workers with personal and professional challenges that are complex to manage. The objective of this study was to characterize the experience of healthcare workers in a level II pediatric department, focusing on grief and the impact of death in a professional setting. **Methods:** A cross-sectional study was conducted in 2023. A paper-based questionnaire was used, with questions divided into three areas: biopsychosocial characterization, impact of death, and potential insecurities. **Results:** A total of 97 questionnaires were distributed, with 74 (76.3%) responses collected, mostly from nurses (47.3%) and doctors (39.2%). The experience of pediatric death was reported by 61 (82.4%) professionals, mostly in emergency situations (62.3%). The emotions most frequently mentioned were sadness (93.4%) and compassion (63.9%), with no differences between professional subgroups or experience ($p > 0.05$). Regarding the impact of death, professionals reported more difficulty falling asleep, particularly those with fewer years of experience ($p = 0.014$). Doctors were more likely to question the appropriateness of their professional practices ($p = 0.048$). When evaluating insecurities about a future event, professionals with less experience reported greater concern about scientific preparedness ($p = 0.031$), while professionals without children expressed more concern about delivering the news to caregivers ($p = 0.002$). **Discussion:** Pediatric death causes changes to the routines and behaviors of professionals in our department, which highlights the importance of finding tailored strategies to support grieving. The impact and concerns are heterogeneous, varying with professional experience and family background, indicating that interventions should be adapted to the specific concerns of each subgroup.

Keywords: Pediatric death. Healthcare worker. Grief. Emergency department.

Morte pediátrica: perceções e experiência dos profissionais de saúde

Resumo

Introdução e Objetivos: A morte em idade pediátrica representa desafios pessoais e profissionais complexos para os profissionais de saúde. O objetivo foi caracterizar a experiência dos profissionais de um serviço de pediatria, relativamente ao luto e ao impacto da morte em contexto laboral. **Métodos:** Foi conduzido um estudo transversal em 2023, utilizando um questionário com perguntas divididas em três áreas: caraterização biopsicossocial, impacto da morte e potenciais inseguranças.

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Received: 05-11-2024
Accepted: 20-05-2025
https://pjp.spp.pt

Available online: 04-06-2025
Port J Pediatr. 2026;57(1):31-38
DOI: 10.24875/PJP.24000088

Resultados: Foram distribuídos 97 questionários, obtendo-se 74 (76,3%) respostas, a maioria de enfermeiros (47,3%) e médicos (39,2%). A experiência de morte pediátrica foi relatada por 61 (82,4%) profissionais, principalmente em emergências (62,3%). As emoções mais sentidas foram tristeza (93,4%) e compaixão (63,9%), sem diferenças entre subgrupos profissionais ou experiência ($p > 0.05$). Relativamente ao impacto da morte, os profissionais relataram maior dificuldade em adormecer, em particular aqueles com menos anos de experiência ($p = 0.014$). Os médicos questionaram-se mais se as suas práticas profissionais eram adequadas ($p = 0.048$). Ao avaliar as inseguranças face a um futuro evento de morte, os profissionais com menos experiência relataram maior preocupação com a preparação científica ($p = 0.031$), enquanto os profissionais sem filhos revelaram maior preocupação em comunicar a notícia aos cuidadores ($p = 0.002$). **Discussão:** A morte em idade pediátrica provoca alterações nas rotinas e nos comportamentos dos profissionais, sublinhando a importância de encontrar estratégias ajustadas para apoiar o luto. O impacto e as preocupações são heterogéneas, variando com a experiência profissional e o contexto familiar, o que indica que as intervenções devem ser adaptadas às preocupações específicas de cada subgrupo.

Palavras-chave: Morte pediátrica. Profissional de saúde. Luto. Serviço de urgência.

Keypoints

What is known
- The impact of pediatric death in the workplace is well documented in contexts where it is more frequent, such as Pediatric Oncology and Intensive Care.
- Even though pediatric emergency situations pose a range of complexities in terms of management, workers rarely feel helplessness due to a greater sense of effective effort in attempting to prevent death compared to chronic untreatable diseases.
- Younger professionals may experience greater feelings of guilt and anxiety, with the incidence of post-traumatic stress reaching up to 81%.

What is added
- Even though death is less frequent in level II units, its impact on the lives of professionals is the same, and in some areas even greater than in other settings where death is more common.
- The feelings experienced by professionals do not depend on their years of experience or the specific responsibilities of each role, and include sadness and compassion.
- Younger professionals are more likely to feel an impact on their sleep quality after a death event.

Introduction

Death in pediatric age is a rare event and is associated with complex challenges on the emotional, cultural, procedural, and legal levels. In Portugal, the mortality rate for those under 19 years of age has substantially decreased due to improvements in healthcare and the population's quality of life, representing 0.4% of all deaths in 2023 compared to 6.9% in 1980. This decrease translates into pediatric professionals being less exposed to death events[1]. In the pediatric age, in European countries, the causes of death are shifting, with increasing prominence of prematurity and its consequences, trauma and accidents, neoplasms, and adolescent suicide, while the influence of infectious diseases and congenital malformations on pediatric mortality rates is progressively declining[2].

For healthcare professionals, the responsibility in situations that result in a patient's death is two-fold: on one hand, applying clinical and scientific expertise to prevent the fatal outcome; on the other, coordinating and leading multidisciplinary teams to ensure comprehensive and compassionate care throughout the process. Studies show that healthcare professionals may repress or delay grief due to professional responsibilities and self-expectations, which is linked to a high rate of secondary traumatic stress[3]. Other studies indicate that up to two-thirds of professionals experience high levels of psychological stress when caring for children who eventually pass away[4-5]. The social repression of grief, which positions the caregiver as the primary mourner, combined with the demand to maintain professional performance regardless of personal feelings, contributes to the phenomenon of the "forgotten mourner"[6]. In particular, professionals working in settings where death is less frequent may have different experiences in dealing with grief compared to professionals in palliative care, pediatric oncology, and intensive care, whose grief has been well characterized in the literature[7-9].

The objective of this study was to characterize the experience of healthcare professionals in a pediatric department regarding grief over deaths in a professional context. The study aimed to classify and characterize preceding clinical events, interpersonal difficulties, team management problems, and the

event's impact on personal and professional life in the weeks following the death. This study also aims to identify the strengths and vulnerabilities of professionals monitoring such events, in a department that lacks a defined local protocol for case analysis and review, as well as specific training in the area. The goal is to establish initial indicators that will guide the development and implementation of interventions.

Methods

A quantitative cross-sectional and correlational study was conducted in December 2023 in the Pediatric Department of a level II Portuguese hospital.

Participants were selected based on their workplace, covering all healthcare professionals (doctors, nurses, and assistants) working in the Pediatric Emergency Department (PED) and the Special Care Unit for Newborns (SCUN). The team consists of 97 professionals: 39 doctors, 41 nurses (20 in the PED and 21 in the SCUN), and 17 operational assistants (10 in the PED and seven in the SCUN). The PED is an emergency department with an average of approximately 20,000 admissions annually, providing healthcare to all those up to 17 years and 364 days who were admitted on their own initiative or referred by primary healthcare services, the SNS24 hotline, or through the National Institute of Medical Emergencies. The SCUN admits all newborns from its referral area with a gestational age of over 32 weeks who require special care, with an average of 340 admissions annually. The Pediatric Department also includes a pediatric palliative care team that provides support in the outpatient and inpatient settings. There is no specific, permanent team working or providing consultations at the Emergency Department.

In terms of death events in pediatrics within the department, occupational health provides informal support if needed, upon request or through self-referral by the healthcare professional. There is no established local protocol for conducting debriefings or annual mortality review meetings.

The instrument used in this study was a paper questionnaire, divided into three parts. The first part included closed-ended, single or multiple-choice questions about the participant's biopsychosocial characteristics. The second part (personal experience with death in Pediatrics) was to be completed only by professionals who had witnessed a pediatric death during their work and included closed-ended questions and five-point Likert scale questions about the circumstances of the death and how they coped with the situation. The third part (professional training), which applied to all participants, set out to assess knowledge about technical procedures after death, to classify factors triggering fear or insecurity in the face of a potential death, and to evaluate the number of professionals with training in palliative care. The questionnaire was completed by doctors and nurses in full, and a version excluding clinical questions was completed by assistants. To preserve participant confidentiality, questionnaires with non-anonymized content were excluded from the analysis. Before digitizing each document, a random code was assigned, separating the questionnaires into two parts: the biopsychosocial questions (part 1) and the questions included in parts 2 and 3.

Categorical variables were expressed as absolute and relative values, and continuous variables were expressed as measures of central tendency and dispersion according to their distribution type. Hypothesis tests were applied between categorical variables using the chi-square test or Fisher's exact test (for expected frequencies of below five), and differences in the distribution of continuous variables across categorical variable subgroups were assessed using non-parametric tests. To analyze factors with potential confounders described in the literature, logistic regression was used to adjust for the identified variables. Statistical analysis was performed using Statistical Package for Social Sciences (SPSS), software version 26.0.

This study was approved by the Hospital Ethics Committee in September 2023.

Results

A total of 97 questionnaires were distributed and 74 (76.3%) responses were obtained, 66 (89.2%) of which were from female participants. Regarding the professional category, most respondents were nurses (n = 35; 47.9%), followed by doctors (n = 29; 39.7%), then assistants (n = 9; 12.3%). One participant did not identify their professional group. Fourteen professionals worked exclusively in the SCUN. The most common age group among healthcare professionals was between 40 and 50 years old (n = 21; 28.4%), and 42 (56.8%) had 15 or fewer years of professional experience in pediatrics. Previous training in palliative care was reported by 31.1% of professionals, 26.1% of whom felt that this training was sufficient to deal with death.

The experience of witnessing a pediatric death was reported by 61 (82.4%) professionals, and it was significantly more common among professionals with more years of experience ($p < 0.001$). When adjusted for years of experience, no difference was found

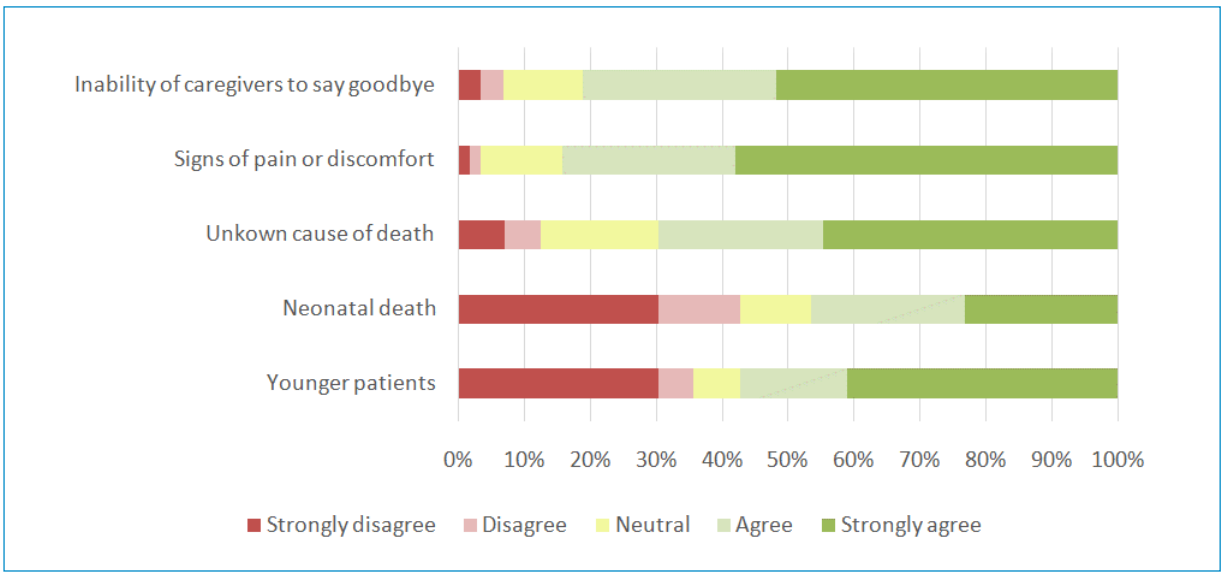

Figure 1. Agreement of healthcare workers about clinical factors that contributed to a more difficult management of death.

between the age of the healthcare professional (p = 0.575) or professional group (p = 0.268) and whether or not they had witnessed a pediatric death. In terms of the number of deaths, 32 (52.5%) had witnessed fewer than five deaths and 11 (14.9%) had seen more than 10. Twenty-two (36.1%) professionals witnessed their most recent death less than a year ago. The most frequent clinical context of death was pediatric emergency situations (n = 38; 62.3%), followed by neonatal emergencies, then chronic illnesses with a predictable clinical outcome (both n = 18; 29.5%) and chronic illnesses with an unpredictable clinical outcome (n = 1; 1.6%).

The emotions most commonly experienced by healthcare professionals were sadness (n = 57; 93.4%) and compassion (n = 39; 63.9%). Less common emotions were anger (26.2%), guilt (14.8%), and indifference (0.0%). No differences were found in the distribution of emotions experienced across professional groups or years of experience. None of the professionals reported feelings of indifference.

Most professionals (n = 50; 82.0%) talked to someone about how they felt, most often with colleagues (n = 47; 94.0%), spouses (n = 28; 56.0%), family members, or friends (both n = 17; 34.0%). No one shared their concerns with occupational health services. Among the group of professionals who did not talk about their feelings (n = 11; 18.0%), the reported reasons were: difficulty in expressing feelings, insecurity, lack of support from the institution, and respect for the patient's family.

The agreement with various clinical or social factors that contributed to making a death more difficult to manage is shown in figure 1. No differences were found in the agreement between the statements and the healthcare professional's age, years of experience, professional category, or the number of deaths witnessed.

Professionals also reported the frequency of a set of personal or professional situations and actions that occurred during the week following the death event they witnessed (Fig. 2).

Difficulty falling asleep was more frequent among assistants (p = 0.048) and professionals with fewer years of experience (p = 0.014). Doctors were more likely to question the appropriateness of their practices (p = 0.048). Professionals with children were more inclined to seek contact with close family members (p = 0.049). Professionals working exclusively in the SCUN reported less difficulty falling asleep (p = 0.003), less difficulty controlling their emotions (p = 0.009), and less introspection about their professional practices (p = 0.019). Difficulty falling asleep was more prevalent in the group of professionals who experienced anxiety (p = 0.001), fear (p = 0.021), or guilt (p = 0.001) when dealing with death, but it was not observed in those who reacted with anger (p = 0.960), sadness (p = 0.922), or pity (p = 0.438).

When asked if they had learned to cope better with death over time, 34 (55.7%) responded affirmatively, which was significantly more frequent in the group of professionals dedicated exclusively to the SCUN

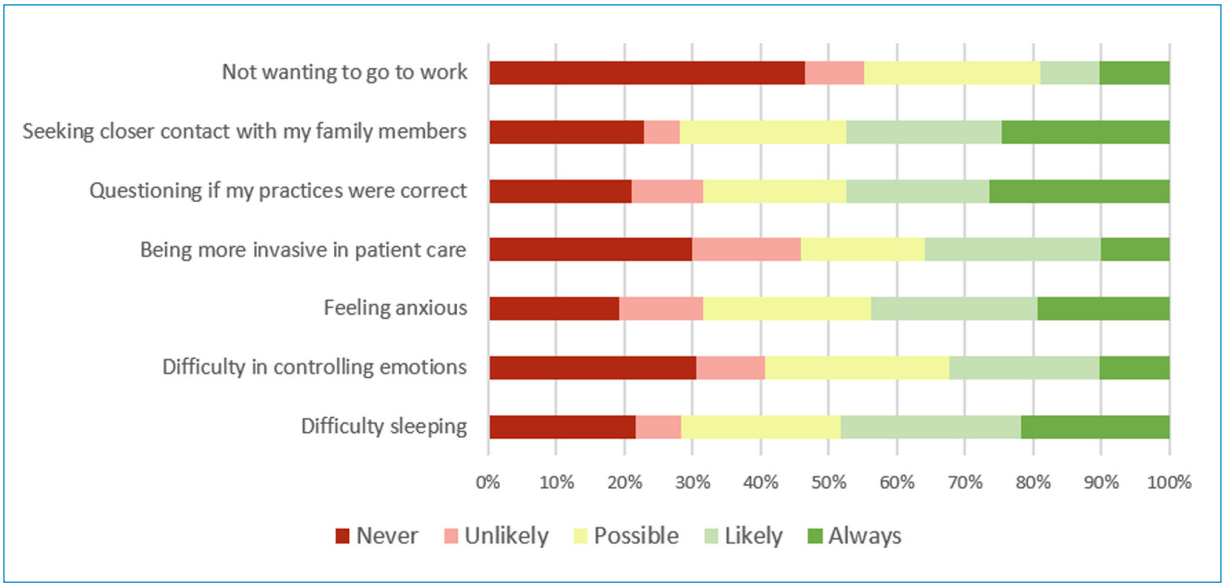

Figure 2. Frequency of situations and personal actions in the week following the pediatric death event.

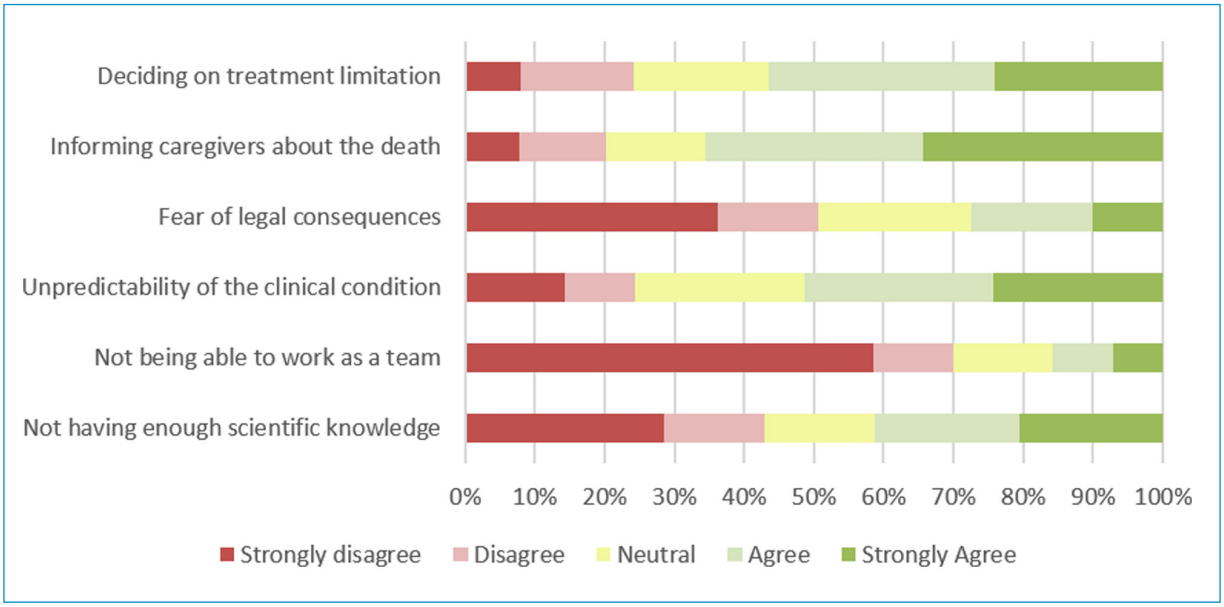

Figure 3. Fears and insecurities about dealing with a future pediatric death event.

($p = 0.048$), but with no differences between subgroups of professional experience.

The overall perception of healthcare professionals, including those who have never witnessed a pediatric death, regarding factors that may contribute to insecurity or fear in dealing with pediatric death, is represented in figure 3. Professionals with fewer years of experience more frequently reported concern about their scientific preparation, while professionals without children found it more difficult to deliver the news to caregivers.

Discussion

The perception and experience of healthcare professionals in situations involving pediatric death remains a complex subject. Although the incidence of pediatric death in our center is relatively low, each occurrence represents a profoundly disruptive event that significantly impacts the lives of healthcare professionals. The emotional weight of a child's death extends beyond the clinical context, often influencing both the personal and professional dimensions of a caregiver's life.

The response rate (76.3%) to our questionnaire was higher than that reported in the literature for studies with a similar methodology, which may indicate genuine interest among the professionals in the department regarding this topic[10].

In the department where the study was conducted, between 1997 and 2023, there were 71 deaths, with a median age of 2.5 years, 41 of which occurred in the Emergency Department and two in the SCUN. In the Pediatric Emergency Department, 83.8% of the deaths occurred within the first hour after admission[11]. Most of the healthcare professionals who responded to the questionnaire work in the Emergency Department, which corresponds to the subgroup of professionals most likely to have witnessed a death in the department. This aligns with our results, where the most frequent clinical context of death was pediatric emergency situations (62.3%). Studies in the same field report that the death of a child or adolescent in emergency care is a globally rare event, leading to few doctors feeling like specialists in managing these situations. However, most have some knowledge and experience that can be enhanced through collaboration with other healthcare professionals[12].

One important consideration is the wide range of clinical presentations seen when a child dies in the Emergency Department. This includes complex challenges such as determining when to stop resuscitation efforts, recognizing and managing signs of discomfort, communicating with and supporting families, meeting forensic obligations, withdrawing or withholding treatment in chronically ill children, and coping with the emotional toll of returning to work afterward. In our study, the most commonly reported challenges were breaking the news to caregivers, making decisions about therapeutic limitations, and dealing with clinical unpredictability and signs of suffering – findings that align with existing literature[12-13]. Additional factors known to influence the experience of a child's death include the child's age and the cause of death[5]. In our department, however, the cause of death played a more significant role than age in shaping how these situations were managed.

Emotionally, the feelings reported by teams often include anger, sadness, inadequacy, or guilt. In our department, sadness was the most common emotion (93.4%), which is consistent with the literature. Compared to other studies, guilt was a relatively uncommon feeling in our context. Research more frequently associates feelings of guilt with situations where the resuscitation chain of events was not effectively implemented or therapeutic limitations were decided upon[13]. In our department, however, most deaths occurred in previously healthy children, in emergency settings where efforts are typically exhaustive and unrestricted, which may contribute to a sense of inevitability following the team's maximal efforts.

Compared to another study conducted at the same institution, professionals in the delivery room dealt with gestational loss with a lower rate of sadness (45%), with the feeling of helplessness being more frequent (80%)[14]. In the literature, helplessness is less often associated with pediatric emergency contexts compared to perinatal death, due to the multitude of procedures and therapies used in resuscitation, contributing to a greater sense of effective effort in attempting to prevent death. Even in healthcare settings where death is more frequent, such as pediatric intensive care units, up to 46% of doctors perceive death as a professional failure, and 92% would like to receive training on how to manage these situations[15].

Younger professionals in the department, in particular, have different concerns from the more experienced subgroup, which is consistent with other studies identifying that interns report more self-doubt, reflecting their inexperience. Some even report that 67% of interns who witnessed a death had no training on the topic and 81% showed one or more symptoms of post-traumatic stress[16-17]. In our study, less experienced professionals more frequently experienced anxiety-related behaviors, such as difficulty falling asleep ($p = 0.014$), and greater concern about their scientific preparedness.

The concern over delivering the news to the family was a source of insecurity or fear (65%), particularly among professionals without children. This factor has generated scientific interest in methods for handling such situations, including taking some time to prepare emotionally and establishing in advance what to say[13]. In cases where the family is present during resuscitation, it can be helpful for the team leader to periodically summarize the resuscitation efforts and the clinical response, as well as to provide guidance on the short-term ongoing care of the patient[12].

A large proportion of our professionals showed changes in their routine and behavior during the week following the death event, particularly with changes in sleep patterns, personal introspection, and seeking to maintain closer contact with family members. Some of these changes may serve as coping mechanisms in the grieving process, but others may signal difficulty in dealing with emotions or signs of pathological stress. Some studies suggest coping strategies such as emotional regulation (social support or religion), helping with problem-solving (support

for bereaved families), cognitive restructuring (making a difference and investing in research), and distraction (breaks, physical activities, entertainment, and time with one's children)[18]. The lack of institutional support was considered a negative aspect in our institution, similar to other studies, highlighting the need for improvement in recognizing the role of healthcare professionals in the deaths of the patients they care for[19].

Overall, professionals facing pediatric death deserve measures addressing their concerns, including team management, communication with caregivers, and scientific preparation for these events. Some interventions in education have been proposed, including incorporating this topic into the Pediatric Advanced Life Support (PALS) course, which 79% of participants in this modality found very useful[20].

Implementing targeted supportive interventions for healthcare professionals who manage pediatric deaths is essential to promote emotional well-being, resilience, and professional sustainability. Regular discussion groups provide a structured space for team members to share experiences, process grief collectively, and foster mutual support, helping to mitigate feelings of isolation and emotional exhaustion. Individual supervision offers a more personalized approach, allowing professionals to explore their emotional responses, ethical dilemmas, and coping strategies in a confidential setting[21,22,23]. Studies highlight the importance of debriefing meetings after such events, discussing how the team worked, what could be improved, and how everyone felt, potentially reducing burnout and traumatic stress and improving compassion satisfaction[24]. Another potentially useful resource is performing a closure ritual. These rituals can include a brief statement by the leading element of the team, taking the time to thank everyone for their effort and acknowledging the feelings of losing the patient. Other types of rituals can include one minute of silence[25].

Palliative care training also equips staff with the necessary skills to deliver compassionate, patient-centered care, while simultaneously enhancing their ability to navigate complex conversations, manage symptoms effectively, and support families through end-of-life situations[26]. Combined, these interventions create a more supportive work environment, reduce burnout, and ultimately improve the quality of care delivered during profoundly difficult moments.

Incorporating death and mourning into the training curricula of health professionals is a crucial step toward preparing them for the emotional and clinical complexities of end-of-life care. Despite its inevitability in medical practice, death is often underrepresented in formal education, leaving professionals unprepared to cope with the emotional toll and interpersonal challenges it presents. A comprehensive approach should include both theoretical and practical components: theoretical instruction can provide an understanding of grief models, cultural variations in mourning, ethical considerations, and communication strategies, while practical training, such as role-playing, simulation exercises, and supervised clinical experiences, can build confidence in managing real-life situations[27,28]. By normalizing discussions about death during training, future professionals are more likely to approach these moments with empathy, clarity, and competence, ultimately improving care for patients and support for their families[27,28].

This study has several limitations that should be acknowledged. As a cross-sectional design was used, it is not possible to establish causal relationships between the identified factors and the experiences of healthcare professionals. A longitudinal approach would be more suitable for assessing how professionals' emotional responses and coping mechanisms evolve. Additionally, the study was conducted in a single pediatric department, which may limit the generalizability of the findings to other healthcare settings or cultural contexts.

In conclusion, the death of a pediatric patient, though infrequent, has a profound impact on healthcare professionals, affecting them both personally and professionally. Recognizing this reality underscores the importance of targeted training, emotional support strategies, and institutional policies that promote resilience and compassionate care.

Author contributions

I. Silva Costa: Conceptualization; Study design; Data collection; Data analysis; Drafting manuscript; Revision of manuscript; Final approval of manuscript. I. Melo: Data collection; Drafting manuscript; final approval of manuscript. C. Moutinho: Conceptualization; Revision of manuscript; Final approval of manuscript. S. Reis: Conceptualization; Study design; Revision of manuscript; Final approval of manuscript. L.M. Ferreira: Conceptualization; Study design; Revision of manuscript; Final approval of manuscript. C. Baptista: Conceptualization; Study design; Revision of manuscript; Final approval of manuscript.

Acknowledgments

This study was presented at VI Encontro do Internato Médico da Região Centro and was awarded the first prize for scientific communications.

Funding

None.

Conflicts of interest

None.

Ethical considerations

Protection of humans and animals. The authors declare that no experiments involving humans or animals were conducted for this research.

Confidentiality, informed consent, and ethical approval. The study does not involve patient personal data nor requires ethical approval. The SAGER guidelines do not apply.

Declaration on the use of artificial intelligence. The authors declare that no generative artificial intelligence was used in the writing of this manuscript.

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