PALLIATIVE CARE AND COVID-19: PERCEPTION OF INTENSIVE CARE UNIT HEALTH PROFESSIONALS

CUIDADOS PALIATIVOS E COVID-19: PERCEPÇÃO DOS PROFISSIONAIS DE SAÚDE DE UNIDADE DE TERAPIA INTENSIVA

CUIDADOS PALIATIVOS Y COVID-19: PERCEPCIÓN DE LOS PROFESIONALES DE LA SALUD DE LA UNIDAD DE CUIDADOS INTENSIVOS

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Objective: to apprehend the perceptions of health professionals working in the Intensive Care Unit on palliative care in the care of patients with Covid-19. Method: descriptive-exploratory study, qualitative, conducted with professionals who worked in an Intensive Care Unit of a public hospital. The collection took place in 2021, through semi-structured interviews. The data were organized and analyzed using the IRAMUTEQ® software, considering the reference of Content Analysis. Results: 10 professionals participated. Three categories emerged from the speeches: There is still a lack of knowledge: barrier to the implementation of palliative care; Palliative care is not a death decree!: expanded perception of the concept; It helps maintain the dignity of the person: palliative care in the context of the Covid-19 pandemic. Final considerations: in the context of the pandemic, professionals felt insecurity and unprepared to implement palliative care, especially due to incipient knowledge, although they understood it as an important tool to maintain human dignity.

Descriptors: Palliative Care. Patient Care Team. COVID-19. Intensive Care Units.

Objetivo: apreender as percepções dos profissionais de saúde que atuam em Unidade de Terapia Intensiva sobre os cuidados paliativos na assistência aos pacientes com Covid-19. Método: estudo descritivo-exploratório, qualitativo, realizado com profissionais que atuavam em Unidade de Terapia Intensiva de um hospital público. A coleta ocorreu

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em 2021, por meio de entrevistas semiestruturadas. Os dados foram organizados e analisados mediante o software IRAMUTEQ®, considerando o referencial da Análise de Conteúdo. Resultados: participaram 10 profissionais. Dos discursos emergiram três categorias: Ainda falta muito conhecimento: barreira para a implementação dos cuidados paliativos; Cuidado paliativo não é decreto de morte!: percepção ampliada do conceito; Ajuda a manter a dignidade da pessoa: cuidados paliativos no contexto da pandemia da Covid-19. Considerações finais: no contexto da pandemia, os profissionais sentiram insegurança e despreparo para implementação de cuidados paliativos, especialmente em decorrência do conhecimento incipiente, embora o compreendesse como importante ferramenta para manter a dignidade humana.

Descritores: Cuidados Paliativos. Equipe de Assistência ao Paciente. COVID-19. Unidades de Terapia Intensiva.

Objetivo: Comprender las percepciones de los profesionales de salud que actúan en Unidad de Terapia Intensiva sobre los cuidados paliativos en la atención a los pacientes con Covid-19. Método: estudio descriptivo-exploratorio, cualitativo, realizado con profesionales que actuaban en Unidad de Terapia Intensiva de un hospital público. La colecta tuvo lugar en 2021, a través de entrevistas semiestructuradas. Los datos fueron organizados y analizados mediante el software IRAMUTEQ®, considerando el referencial del Análisis de Contenido. Resultados: participaron 10 profesionales. De los discursos surgieron tres categorías: Aún falta mucho conocimiento: barrera para la implementación de los cuidados paliativos; Cuidado paliativo no es decreto de muerte!: percepción ampliada del concepto; Ayuda a mantener la dignidad de la persona: cuidados paliativos en el contexto de la pandemia de Covid-19. Consideraciones finales: en el contexto de la pandemia, los profesionales sintieron inseguridad y falta de preparación para la implementación de cuidados paliativos, especialmente en el marco del conocimiento incipiente, aunque lo comprendieran como una importante herramienta para mantener la dignidad humana.

Descriptores: Cuidados Paliativos. Grupo de Atención al Paciente. COVID-19. Unidades de Cuidados Intensivos.

Introduction

In March 2020, three months after its identification, Covid-19 was declared a pandemic by the World Health Organization (WHO). The disease, caused by the coronavirus (Sars-CoV-2), was configured as a public health emergency of international importance. This is because it caused demographic, epidemiological, economic and social changes, reordering work processes and organization of health services and systems, as well as various repercussions and sequelae to affected individuals, which vary according to the severity of the disease(1).

As of July 2023, more than 768 million confirmed cases and more than 6.9 million deaths have been reported globally(1). In Brazil, up to August 4, 2023, 37,728,415 confirmed cases and about 704,794 deaths from the disease were reported(2).

At the beginning of the pandemic, patients with Covid-19 and their families reported multidimensional symptoms and concerns, which could be physical, such as fever, shortness of breath, fatigue, cough, or psychosocial, concerns and spiritual/existential anguish caused by the threat to survival and clinical uncertainty, or also related to the economic and social impact triggered by the reordering of the way of life and work in the face of recommendations for distancing and social isolation for coping with the health situation(3-4).

Given this scenario, the high mortality caused by the disease and the consequent uncertainty of diagnosis, as well as the need for hospitalization for cases considered more severe, were widely observed in the Brazilian population. Thus, there was need to increase the number of beds of Intensive Therapy Units (ICU), intended for the treatment of these individuals, who required complex care and continuous monitoring(5). In this context, Covid-19 cases, especially the most severe ones, resulted in pain and suffering, as well as physical and emotional overload not only for patients, but also for families and health professionals involved in the care(6-7).

In this perspective, in many situations, palliative care has become the most appropriate therapeutic option(8), since its principles focus on relieving pain, suffering and other stressful symptoms; reaffirming life and death as natural processes; integrating psychological, social and spiritual aspects into the clinical aspect of patient care; not accelerating or postponing death; offering a support system to help the family cope with the patient's illness; offering a support system to support patients to stay active until their death; employing an interdisciplinary approach to identify and intervene on the clinical and psychosocial needs of patients and their families, including advice and support for grief(9).

According to the WHO, palliative care consists of assistance promoted by an interdisciplinary team, based on a holistic approach that seeks to promote human dignity and the quality of life of patients and their families who face diseases that threaten the continuity of life. Care actions occur through prevention and relief of suffering, treatment of pain and symptoms of a physical, psychosocial and spiritual nature(10). They should occur in conjunction with curative care and at different points in the health care network. Palliative care goes beyond the hospital environment and, depending on the clinical conditions of the patient, can be followed in primary health care or outpatient sectors(9).

This approach plays an important role in critical situations, such as in the context of a pandemic, by providing protocols for symptom management, disseminating quality information to non-specialists, and involving the identification of demands and provision of psychosocial care and mourning(3).

Therefore, palliative care has been configured as a central component for the management and coping with Covid-19, for improving quality of life, controlling symptoms, supporting decision-making and optimizing health resources(11). However, sometimes, there is a global difficulty in inserting palliative care into the routine of health work, since many professionals still associate it only with the terminal phase. This results in therapeutic obstinacy, dysthanasia, overcrowding of the ICU(9,12) and the prolongation of unnecessary suffering to patients and their families(3).

Given the complexity surrounding the implementation of palliative care for individuals with Covid-19, as well as the shortage of specialists working in the area, in part because the specialization in the country is relatively new (only 10 years old), becoming a major challenge for the scientific community and health professionals, it becomes important to investigate the perception of health professionals who worked in the care of people who developed the severe form of the disease and who were out of the possibility of cure. Such understanding can produce subsidies that foster strategies for care and decision-making, in order to provide holistic, balanced, quality and timely care, minimizing harm and suffering to the patient and the family, especially in crises, such as the Covid-19 pandemic.

In this perspective, the present study has the following question: What are the perceptions of health professionals who worked in an ICU during the first and second waves of the Covid-19 pandemic on palliative care in the care of patients with the disease? In this sense, this study aims to apprehend the perceptions of health professionals who work in an ICU on palliative care in the care of patients with Covid-19.

Method

This is a descriptive-exploratory study, with a qualitative approach, developed with health professionals working in the ICU of a public university hospital, located in the Southern Region of Brazil. This study was described considering the recommendations of the Consolidated criteria for reporting qualitative research (COREQ)(13).

This hospital is a tertiary reference of the state health care network. It has an adult ICU with eight general beds that have been qualified as exclusive for the treatment of patients with Covid-19. This implementation occurred in 2020, due to the need to expand the supply of care beds for people with severe diagnosis of the disease.

The participants of this research met the following inclusion criteria: being a health professional with a higher level, and having worked in the ICU with patients with Covid-19, regardless of the time of operation or experience with palliative care and/or the contract regime (employed, accreditation, resident). The study excluded health professionals who were removed from their duties for any reason (vacation, leave, medical leave), during the research period. Considering these criteria, the interviews followed until reaching exhaustion (when the information started to be repeated), ending the data collection.

Participants were selected by convenience of access of the main researcher, through contact with health professionals in their field of work. Data collection took place in two stages:

1) initially, an email was sent to the coordinator of the Permanent Education sector and the ICU headquarters of the research, explaining the objectives of the study and how the participation of employees would be given. After this contact and authorization, the main researcher personally invited health professionals. Those who positively signaled their participation in the study, signed the Informed Consent Form (ICF), in two copies and scheduled a time for the interview to occur;

2) by prior scheduling, the interview was conducted in the workplace, in a reserved environment, through individual, semi-structured interview, performed only once with each participant. The interviews were conducted by the main investigator, who is a nurse, and at the time worked in the same hospital as an emergency resident. The researcher already had experience in collecting qualitative data and was previously trained by a team of researchers, nurses and doctors.

Data collection took place between September and December 2021. The interviews were guided by an instrument composed of questions of characterization of the participant (sex, age, professional category and time of performance), followed by the following trigger question: What is your perception of palliative care in the care of patients with Covid-19 who developed the severe form of the disease? Other questions could be asked in order to broaden the collection of information and contemplate the proposed objective. The interviews were recorded and fully transcribed, and the files were properly destroyed after this stage. The field notes were performed immediately after the interviews and were intended to record the researcher's impressions about the non-verbal language of the interviewees.

The sample size was based on the repetition of the information(14), following with the collection until the moment when no new themes were found. Among the 12 higher education health professionals available, 10 agreed to participate in the study. Those who declined to participate (n=2) said they were unaware of the activities related to palliative care and, therefore, did not feel comfortable addressing the subject.

The qualitative data were initially analyzed based on the methodological framework of Content Analysis proposed by Bardin(15), following its three stages: pre-analysis; exploration of the material and treatment of the results; and inference and interpretation. This process led to the identification of broad initial categories, which were then operationalized through the software *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*, (IR+AMUTEQ®) version 0.7 alpha 2(16). Thus, based on the initial categories, the textual corpus was constructed, with excerpts from the interviews that contemplated the objective proposed by this study.

The Similitude Analysis was then used, which allowed the identification of the occurrence of words and the connection between them, present in the textual corpus. Subsequently, they were grouped into central and peripheral zones, generating a tree of similarity that assists in the identification of structures(16). The convergence between the initial categories, obtained after the content analysis and the organization of the data by the software, originated three final categories: "There is still a lack of knowledge": barrier to the implementation of palliative care; "Palliative care is not a death decree!": expanded perception of the concept; and "It helps maintain the dignity of the person": palliative care in the context of the Covid-19 pandemic. The findings were discussed based on the current and relevant literature on the subject.

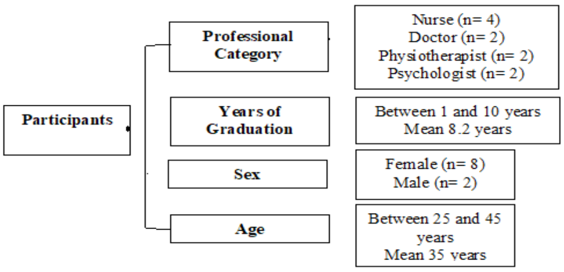
In order to ensure the methodological rigor of the study, the interviews were recorded in audio and performed by a researcher with training and experience in qualitative research. In addition, the analytical process and data interpretation were guided in the exercise of reflexivity, and previous assumptions about the phenomenon under investigation were identified and kept in suspension. This was necessary mainly because the researcher worked in the studied ICU. During the analysis, when there were doubts or divergences, the team of researchers met and discussed the analytical and interpretive process of the data, seeking consensus. Finally, in order to maintain reliability and confirmability, an audit trail was recorded and filed, ensuring that the relevant and supporting documentation (field diary and theoretical, reflective and analytical notes) was available for future consultations.

In order to keep the identity of the participants confidential, the following codification was adopted: professional category and the number referring to their entry into the study (Ex: Psychologist, 1). The study followed in line with the ethical precepts contained in Resolutions n. 466/2012 and n. 510/2016, of the National Health Council. It was approved by the Standing Human Research Ethics Committee, under Opinion n. 2,797,519 and Certificate of Presentation of Ethical Assessment (CAEE) 92926618.5.0000.0104.

Results

The study included 10 health professionals who worked in an exclusive ICU for the care of patients with Covid-19. Characterization data can be checked in Figure 1.

Figure 1 – Characterization of study participants. Maringá, Paraná, Brazil – 2022. (N=10)

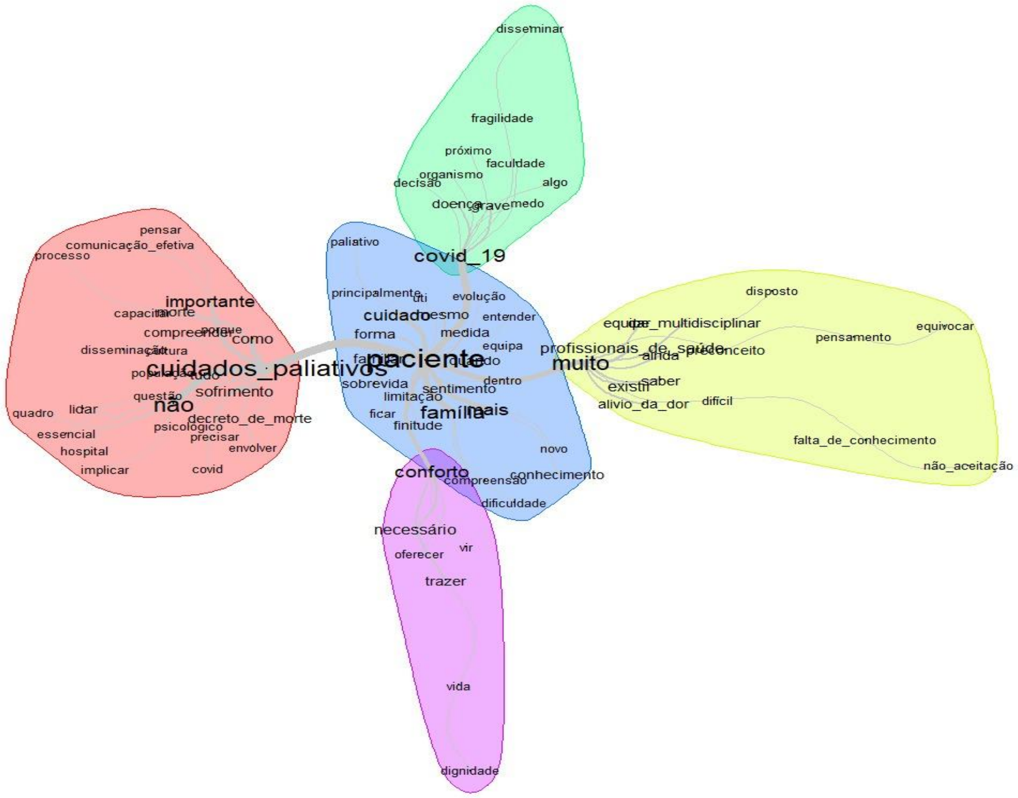


Source: created by the authors.

The Similarity Tree, presented in Figure 2, allows the identification of the occurrences between words and indications of connexity between the words *Patient* (n=104), *Palliative Care* (n=48), *Comfort* (n=34), *COVID-19* (n=27) and *Health Professionals* (n=11). Among the words indicated, there originated categories that helped identify the structure of the representational field about the perceptions of health professionals about palliative care in the care of patients with Covid-19 and who developed the severe form of the disease.

The *Patient* and *Professional* nuclei joined and gave rise to Category 1, called*: "There is still a lack of knowledge": a barrier to the implementation of palliative care.* This nucleus revealed stronger connections with the *Palliative Care* and *Comfort* nuclei, which contracted and resulted in Category 2, entitled: *"Palliative Care is not a death decree!": perception of the concept.* Finally, the *COVID-19* nucleus raised Category 3: *"It helps maintain the dignity of the person": palliative care in the context of the Covid-19 pandemic*.

Figure 2 – Similarity analysis: perception of health professionals working in an Intensive Care Unit regarding palliative care for patients with COVID-19. Maringá, Paraná, Brazil – 2022



Source: created by the authors.

Category 1 - "There is still a lack of knowledge": barrier to the implementation of palliative care

In this category, the word present in the central nucleus was *patient* (n=104), and in the respective periphery of the similarity tree, there were: *care* (n=35), *family* (n=49), *feeling* (n=6), *finitude* (n=7) and *limitation* (n=6). Thus, health professionals perceive that patients and their families do not understand palliative care in its essence, correlating them to giving up and lack of care. This type of care is only considered when suffering is extreme and finitude, imminent.

> *Patients still have a lot of distortion about palliative care, they have feelings of abandonment, restrictions in care, that no more medication will be given, that is it and it is over, there is nothing more to be done.* (Psychologist, 1).

> *For patients and their families, it is a feeling of loss, of limitation, seeing that there is nothing that can be done, that it is the end. This is their distorted perception.* (Nurse, 2).

> *Many patients think that what we do is always to cure and that it is always better to try to invest in something that cures than to deal with loss, with death.* (Psychologist, 10).

> *They* [patients and family] *still lack a lot of knowledge about this and I think they only understand when they are already suffering*. (Doctor, 4).

In addition to the perception that patients and family members do not understand the essence of palliative care, the *(lack of)knowledge* (n=4) on the part of health professionals also constituted an important barrier faced for their employment to patients with Covid-19 assisted in the ICU. The reports show that the health professionals themselves disseminated misguided thoughts about the subject, limiting its applicability and resulting in low adherence.

> *It is all very challenging, you have to deal with the team who, often, have not defined the concept of palliative care*

> *and deal with families' emotions. In terms of knowledge, I still do not feel prepared to deal with palliative care, there is still a lot to be learned.* (Nurse, 9).

> *I hear from colleagues that palliative* [patients] *do not need much care, it is as if we had killed the patient before anything else, forgetting about comfort. Even we health professionals do not know what palliative care is, we think that the person is at the end of life.* (Physiotherapist, 7).

Category 2 – "Palliative Care is not a death decree!": expanded perception of the concept

The second category shows that, although some health professionals do not adequately understand the term *palliative care*, this was pointed out as a strategy for humanized care and that values and deals with the total pain of the human being (physical, emotional and spiritual). The words *palliative care* (n = 48) were presented as a central concept of the nucleus, they were understood as an instrument for the promotion of *comfort* (n = 34) and relief of *suffering* (n = 25), when departing from stigmas that associate it with a decree of death (n = 18). Therefore, it is necessary to adopt an effective communication (n=4) between the multidisciplinary team (n=32), patients (n=104) and their family (n=49), as shown in the following excerpts:

> *For the patient, it consists of alleviating suffering, not just pain, avoiding prolonging something that no longer brings comfort. For family members, embracement and understanding that nothing was left undone, but other care was prioritized and, when it is well exposed, acceptance is easier. For the team, it consists of the relief of not prolonging something that is no longer effective. It is important to disseminate knowledge, especially in the differentiation between palliative care and end-of-life care, also to make sure that the family understands that it was a choice so that their loved one would not suffer, to break the addictions of thinking that it means turning off devices, stopping doing something for the patient.* (Doctor, 4).

> *Palliative care favors a dignified death. It is the relief of physical, psychological and spiritual pain, in order to promote a better quality and perception of death. This is the time to communicate effectively with families, to be clear.* (Doctor, 5).

> *It is about giving special care, comfort, humanized treatment and not making distinctions. Palliative Care is not a death decree! Mainly to patients with Covid-19, whose virus affects the patient's body as a whole and not just one organ. Supporting the family, generating care, affection and love is one of the objectives of health professionals.* (Physiotherapist, 6).

Category 3 – "It helps maintain the dignity of the person": palliative care in the context of the Covid-19 pandemic

In the third category, the word *Covid-19* (n=27) was the central figure of the nucleus and determined the other words. The disease was described as *severe* (n=11) and affects the whole organism (n=3). When understanding the *fragility* (n = 11) of the human being through the reach of the virus, feelings such as *fear* (n = 3) and *insecurity* (n = 3) were emanated. However, through palliative care, the team can provide holistic, humanized and sensitive assistance to the needs of the subjects *helping to maintain the dignity of the person.*

> *Fear, insecurity and perhaps precisely the fear that the person could die, as it is an acute and serious illness.* (Doctor, 5).

> *I see a film of what we experienced, my perception is that when the patient gets here* [in the ICU]*, we really do not know what is going to happen. Just like the last patient we intubated, a 24-year-old girl, she asked us to get her out of here and we were thinking: will we be able to do it? It is unknown. She is a girl who has two children, one aged four and one aged seven.* (Nurse, 8).

> *At first, I did not imagine how far this* [Covid-19 pandemics] *would go and its gravity. Today I understand that it is a very serious, lethal disease that has many physical and psychological consequences.* (Nurse, 9).

When faced with the severity and instability of the clinical conditions experienced by people with Covid-19, participants emphasized the importance of implementing palliative care for quality and humanized care. This is because, especially in an intensive care environment, the process of dying and death are part of professional daily life.

> *Palliative care contributes a lot, especially in patients with Covid-19, because it progresses very quickly or everything becomes prolonged, involves a process of death, becomes painful for the family and distressing for professionals.* (Psychologist, 1).

> *For patients with Covid-19, palliative care can help maintain the person's dignity. Even when they cannot speak for themselves, the family participates in the hospitalization process, in decision-making, this ensures that the family member is seen. In addition to helping us realize that there is a limit to therapeutic intervention, excess can take away that person's dignity.* (Psychologist, 10).

Discussion

The results of this study allowed the identification that the topic of palliative care, especially in crisis contexts, such as the Covid-19 pandemic, needs professional training and knowledge expansion to the general public. This is because, in the perception of the participants, there is still a lack of knowledge among health professionals working in ICU, as well as patients and their families, given the need to implement palliative care.

In the context of the Covid-19 pandemic, doubts intensified, given the high number of patients in serious condition who required palliative care, as well as the fear and insecurity of professionals in the face of the new disease. In this sense, it is notorious that palliative care contributes to comprehensive care, but its implementation in a crisis context is a challenge, related to the lack of knowledge of health professionals themselves, patients and family members about this approach with severe patients of Covid-19(12).

The lack of knowledge about palliative care, even in situations of diseases with potential for terminality, was already present even before the Covid-19 pandemic. Research conducted in China with 239 cancer patients noted that 81.2% had never had contact with palliative care or related policies. Despite this result, 54% wished to improve the quality of life instead of prolonging their life expectancy(17). Health professionals need to approach the subject with patients and family members as soon as possible in order to improve their understanding and thus facilitate decision-making(17).

However, the health professionals themselves revealed a need for greater knowledge on the subject. Similarly, a study conducted with nurses who worked in public and private institutions in Joinville (SC) identified that the participants had a median level of knowledge about palliative care(18). Similar findings were obtained in Fortaleza (CE), whose professionals reported feeling reasonably prepared to care for a patient in palliative care and to deal with communication in difficult situations (69.5% and 66.1%, respectively)(19).

Such data may, in part, be related to the fact that only a small proportion of health professionals, even working in critical care sectors, is qualified for this type of care, as well as the high turnover among professionals(18). Continuous training to deal with patients in the process of finitude is indispensable. Nevertheless, the technical and scientific training is poor since graduation(20), constituting a major barrier to adherence to palliative care at different levels of health care(21).

The participants of this study revealed low knowledge about palliative care, considering that only two of them revealed high experience with the theme, as well as when using the term *dignified death* and not *quality of life*. This shows that there is a gap with the palliative care approach, associating it only with end-of-life care. This fact leads to an impaired care, favoring dysthanasia, that is, the prolongation of suffering and delay in the death of a patient, worse clinical outcomes and reduction of survival(9). This is because there is no effective communication between the professional-patient-family, safety and assertiveness in care.

In Brazil, the Ministry of Health, through Resolution n. 41, of 2018, regulates the provision of palliative care as part of continuous care integrated within the Unified Health System (UHS). Among the objectives proposed for the organization of the approach in the UHS, there stand out the inclusion of contents on palliative care in graduation and specialization education, permanent education for health workers in the UHS and the dissemination of information to society(22). Although resolution and practice are increasingly recognized as essential for health systems, the country still has insufficient palliative care practices(9).

Regarding communication, a preponderant factor for the execution of care, the participants considered it as an important tool for building the bond and trust between team-patient-family. However, with the Covid-19 pandemic, there were restrictions on visits in most health environments, which made communication with other family members difficult(23). Qualitative research conducted with doctors and relatives of people with Covid-19 admitted to the ICU demonstrated that telephone calls were beneficial for sharing information and updating the clinical picture, while video calls were preferable to align therapeutic perspectives. Despite the reported advantages, they were considered inferior to face-to-face personal communication(24).

A study conducted in the United States of America (USA) with families of people who received palliative care and/or end-of-life care and who died during the Covid-19 pandemic identified that 81.3% of participants reported positive comments regarding the use of remote communication for the mourning process. Those who reported excellent general end-of-life care were statistically superior (69.5% vs 37.5%) among those who received information about the health condition and participated in making decisions about the conduct to be taken on therapy with their loved one(23). Thus, teams must be trained to support families, optimizing communication during crisis scenarios, pandemics and other moments of restriction of face-to-face visits(23), optimizing existing resources and technology.

With increased pressure at work, changes in coping policies, reduced interaction with the patient and the use of Personal Protective Equipment (PPE) make palliative care provision a challenge for health professionals(25). It is important to expand the training of health professionals to approach palliative care, providing conditions to apply it in the daily life of health services, even in crisis scenarios(12).

Participants in this study highlighted the importance of raising palliative care for individuals with Covid-19. Palliative care promotes a holistic view of the patient and care, respecting life and human dignity, allowing the embracement, qualified listening and recognition of the preferences of the assisted persons and their families(12). It should be implemented as necessary, and not only in the diagnosis or prognosis as previously thought out, simultaneously with curative care or disease modifiers, from home to the most specialized services(9).

In this sense, palliative care goes beyond its mission of alleviating the symptoms and suffering of patients, families and health professionals(8), by leveraging human resources, ICU beds and emergency services, reducing public spending(3). This approach consists of an important component for the management of the Covid-19 pandemic. To do so, government officials and policymakers must prioritize them, incorporating physical, psychological, social and spiritual concerns in the management of patients with Covid-19(3).

A limitation of this study concerns the fact that data collection was performed in only one ICU service and in the workplace itself, during the working day. This led to interviews sometimes needing to be interrupted and resumed at another time. This aspect was decisive for the interviews to have an average duration of 20 minutes. In this sense, there should be caution in the interpretation and comparison of the data with other national and international contexts. Although there has been such a restriction, the study contributes to providing timely and critical knowledge about the perception of health professionals about palliative care to severe patients in the context of the Covid-19 pandemic, which can be very useful in other crisis contexts.

Final Considerations

Based on the results of this study, it was possible to grasp the perceptions of health professionals who worked in an ICU on palliative care in the care of patients with Covid-19. The participants felt insecure and unprepared for decision-making about palliative care. The main barriers faced are related to incipient knowledge on the subject, based on stigmas that are perpetuated among the general population and health professionals themselves. However, even being considered challenging, palliative care was understood as an important tool for promoting the quality of life of patients, humanization and dignity in the finitude process.

There is need to invest, increasingly and gradually, in permanent and continuing education for the qualification of professionals in the development of skills aimed at the provision of humanized assistance, whose main objective is the well-being and quality of life of people. Therefore, palliative care policies should also be strengthened, with well-established protocols and team alignment, in order to promote the necessary support to professionals-patient-family, minimizing uncertainties and insecurity regarding decision-making. Moreover, it becomes relevant to invest in future research on the subject, seeking to know in more depth how interventions that offer knowledge to health professionals and students in the area can enhance the provision of palliative care.

Collaborations:

1 – conception and planning of the project: Nathalie Campana de Souza e Nelly Moraes Gil;

2 – analysis and interpretation of data: Nathalie Campana de Souza, Caroline Sala and Nelly Moraes Gil;

3 – writing and/or critical review: Nathalie Campana de Souza, Thamires Fernandes Cardoso da Silva Rodrigues, Gabriela Tavares Magnabosco, Mayckel da Silva Barreto and Nelly Moraes Gil;

4 – approval of the final version: Nathalie Campana de Souza, Thamires Fernandes Cardoso da Silva Rodrigues, Gabriela Tavares Magnabosco, Mayckel da Silva Barreto and Nelly Moraes Gil.

Competing interests

There are no competing interests.

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