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# Palliative care in light of the National Policy for Palliative Care and National Curricular Guidelines: specialty or generalist care?

*Cuidados paliativos à luz da Política Nacional de Cuidados Paliativos e das Diretrizes Curriculares Nacionais: especialidade ou cuidado generalista?*

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## ABSTRACT

**Introduction:** The National Palliative Care Policy (PNCP) was established in the Unified Health System (SUS) in 2024. One of its principles is the provision of palliative care by a multidisciplinary and interdisciplinary team. Its objective is the integration of Palliative Care (PC) into the Health Care Network, with emphasis on Primary Health Care (PHC).

**Objective:** Since the National Curricular Guidelines (DCN) of health courses focus especially on changes in the health care model, the objective was to analyze converging relationships between the PNCP, and the DCN of the undergraduate medical course.

**Method:** An exploratory qualitative study was carried out through documentary analysis of the undergraduate medical course DCNs published in 2001, 2014, and 2022, to examine their perspectives on Palliative Care.

**Results:** The first DCN outlined specific competencies and skills for medical training in monitoring the death process, focusing on the physiological aspects of human development, from gestation to death. The 2001 and 2014 DCNs made no mention of Palliative Care. The 2022 DCN, however, included specific competencies and skills for PC, along with end-of-life care considerations. This inclusion appears in the comprehensive care section, spanning health promotion to rehabilitation.

**Conclusions:** As health care continuously evolves, new fields emerge, including Palliative Care. While discussions remain open—such as whether PC should be a specialist or generalist field - the path toward integrating palliative care into medical training is outlined.

**Keywords:** Palliative Care; Medical Education; Health Policy.

## RESUMO

**Introdução:** *Em 2024, a Política Nacional de Cuidados Paliativos (PNCP) foi instituída no Sistema Único de Saúde (SUS). Um de seus princípios refere-se à prestação do cuidado paliativo por uma equipe multiprofissional e interdisciplinar, e um dos objetivos é a integração dos cuidados paliativos (CP) à Rede de Atenção à Saúde, com ênfase na atenção primária à saúde (APS).*

**Objetivo:** *Considerando que as Diretrizes Curriculares Nacionais (DCN) dos cursos da saúde relacionam-se diretamente às mudanças do modelo de atenção à saúde, o objetivo deste estudo foi analisar as relações de convergência entre a PNCP e as DCN do curso de graduação em Medicina.*

**Método:** *Realizou-se uma pesquisa qualitativa exploratória com análise documental das DCN do curso de graduação em Medicina publicadas em 2001, 2014 e 2022, a fim de avaliar as perspectivas adotadas no que se refere aos CP.*

**Resultado:** *Constatou-se que as primeiras DCN exigiam competências e habilidades específicas da formação médica para o profissional atuar no acompanhamento do processo de morte, com foco nos processos fisiológicos do desenvolvimento humano, da gestação até a morte. Nas DCN de 2001 e 2014, não há menção aos CP, enquanto, nas DCN de 2022, foram incluídas competências e habilidades específicas para a realização dos CP e a consideração de cuidar na terminalidade da vida. Essa inserção se situa na seção de cuidados integrais, da promoção da saúde à reabilitação.*

**Conclusão:** *Com a saúde em constante transformação, novos campos de saber e prática se constituem, como o CP. Há questões em aberto, como a discussão de os CP se constituírem um saber especializado ou generalista, mas o caminho para a inclusão deles na formação médica está delineado.*

**Palavras-chave:** *Cuidados Paliativos; Educação Médica; Política de Saúde.*

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## INTRODUCTION

Changes in the epidemiological, demographic, environmental and technological scenarios have posed growing challenges for the organisation of the health system and professional training. Preventive practices and technologies prolong life; chronic non-communicable diseases contribute to the burden of illness, and care settings have been changing. In response, the field of health is moving and new areas, including Palliative Care, are being structured.

While the concept of palliative care, related to the relief of pain and suffering, dates back to the 1950s and 1960s in England and to the nurse and doctor Cicely Saunders, creator of hospices, it was in 1974 that the term was coined. The physician Balfour Mount took the concept to Canada, set up a service and used the term 'palliative care' to emphasise attention to patients' quality of life until death[1]. It is in this area of hospital care, as an offer of relief and dignity to people with incurable illnesses, that the term developed. The World Health Organisation (WHO) adopted it and the Cancer Committee began to study it[2].

In 1989, the report Cancer pain relief and palliative care, published by the WHO and experts from Europe and North America, marked the advocacy of Palliative Care (PC) as an essential practice in the treatment of people with cancer. PC is presented as a broad, integrative care approach that requires different professional training and understanding of health, illness, death, and interaction between professionals and patients and their families[2].

> *Palliative Care: affirms life and regards dying as a normal process; neither hastens nor postpones death; provides relief from pain and other distressing symptoms; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patient's illness and in their own bereavement.*

From care provided in specialised tertiary services, PC has expanded to reach all levels of the healthcare system. As Pessini[3] states, it is not about the settings, but about the "philosophy of care, which is materialised in the service provided wherever the patient is".

In Brazil, there have been PC initiatives since the 1970s. But formal provision began in the 1980s, following the international pathway, in oncology and chronic pain services. Since the 2000s, there has been a significant increase in provision, currently recorded by the National Academy of Palliative Care at 234 PC services in the country, the majority of which are in the south-east region[4].

The structuring of the Unified Health System (SUS) and the establishment of health as a right[5], as well as the role of the National Cancer Institute (INCA) not only in the care of cancer patients, but also in the design of care parameters and guidelines, influenced the path of PC in Brazil. In 1997, the Brazilian Association of Palliative Care (ABCP) was set up, outlining the field of the speciality[1].

The formulation of policies on PC followed WHO guidelines and received input from the associations and services created. Ministerial Directive 19, enacted in 2002, instituted the National Programme for Assistance to Pain and Palliative Care[6] in the SUS, aimed at chronic pain. In 2005, Ministerial Directive 2.4397 was enacted, including PC in the National Policy for Oncological Care[7]. In the same year, the National Academy of Palliative Care (ANCP) was established, the multi-professional representative body for the practice in the country.

In 2011, with Resolution 1973/2011 of the Federal Council of Medicine (CFM)[8], Palliative Medicine became an area of medical specialisation, offered as a sub-specialty of clinical medicine, oncology, geriatrics, family and community medicine, paediatrics or anaesthesiology.

In 2012, the CFM enacted Resolution 1995/2012[9], endorsing the patient's right to express the care and treatment they wish (or not) to receive, when they are unable to express their will, through Advance Directives of Will. This represented a milestone in the discussion on autonomy and the dignity of dying. In addition to caring for the physical body, the CFM resolutions include, together with the multi-professional team, psychological, social and spiritual care, aimed at the comfort and well-being of patients and their families.

Resolution 41 of 31 October 2018[10] included PC in health policy, establishing guidelines for its implementation in the SUS as part of the comprehensive care offered by the Health Care Networks (RAS). The resolution encouraged the inclusion of the content in undergraduate and specialised health courses.

Covid-19 (2020-23) was a turning point for PC. The resulting suffering brought elements of pain in the physical, psychological, social and spiritual spheres, revealing the complexity of human suffering in extreme situations. Issues such as symptom management, resource allocation and communicating bad news have come to the fore, as well as the absence of funeral rituals and their impact on mental health and bereavement.

In the political and academic spheres, reflection continued and, in 2024, the National Policy for Palliative Care (PNCP) was established in the SUS, maintaining the perspective of comprehensiveness and integration into the Health Care Network – RAS, with an emphasis on primary care[11].

For this comprehensive care to be realized, collaborative work and qualified teams are essential. The PNCP provides for both direct care and matrix support teams, minimally including

physicians, nurses, psychologists and social workers, as well as nursing technicians. The roles and responsibilities of the care teams range from drawing up a PC plan based on assessment of the physical, psychosocial and spiritual needs of the person being cared for to assisting bereaved relatives[11].

Although the PNCP does not specify the roles and responsibilities of each team member, it is understood that one of the medical dimensions is the physical dimension, which includes "actions to treat and manage symptoms such as pain, dyspnoea, discomfort and nausea, through the use of timely medication and appropriate dosage, non-pharmacological techniques and therapeutic approaches to provide comfort to the person" (art.2, §1, I)[11]. We also see it as the doctor's responsibility to "maintain open communication with the person and their family or carer, supporting the exchange of information about the cared-for person's clinical condition, care options and expectations regarding the palliative care process" (art. 8, V)[11].

Considering the scope of PC, we ask: are doctors prepared for these tasks? Do the National Curriculum Guidelines (DCN) for undergraduate medical courses guide this comprehensive training, considering the complexity of medical care within the framework of the health-illness continuum?

Higher education in health in Brazil has been widely debated and reformulated with a view to transforming professional practices and the organisation of work in order to meet the health needs of the population and strengthen the SUS. The DCNs for undergraduate health programmes, published by the Ministry of Education (MEC) in 2001, represent a set of principles, foundations and guidelines that seek to guide educational institutions in the formulation, structuring, development and evaluation of their pedagogical proposals. Developed collaboratively, the DCN define broad frameworks, competencies, and curricular content with flexibility, ensuring university autonomy in curriculum design.

The aim of this study was to analyse the DCN for undergraduate medical courses in order to discuss the perspectives adopted with regard to PC as a subsidy for the training of professionals who will work in primary care and integrate the matrix support (EMCP) and direct care (EACP) teams for Palliative Care in the SUS, according to Resolution MS/CNS No. 729/2023[12] and Ministerial Directive GM/MS No. 3681, of 7 May 2024[11].

## METHOD

This is an exploratory qualitative study with a documentary analysis of the DCNs for undergraduate medical courses published in 2001, 2014 and 2022 to analyse the perspectives adopted with regard to Palliative Care.

The choice of the DCNs for Medicine is justified by the fact that the physician is one of the members of the PC care and matrix support teams, but also because, among the course guidelines for the professions provided for in the PNCP care and matrix support teams, Medicine was the only one to include PC. We assume, according to the historical and critical perspective, that the analysis of a phenomenon must consider its most developed form in order to guide subsequent ones[13;14].

Initially, a survey was conducted with the DCNs of the Nursing, Medicine, Psychology and Social Work courses (higher education professions provided for in the PC care and support teams, according to the PNCP) using keywords related to the object of study (death, mourning, palliative care, end of life and finitude) and it was identified that, until the period of data collection, October and November/2024, PC was only present in the Medicine DCNs. Once this course had been selected, data from the Medicine DCNs published up to the period of data analysis, between December 2024 and April 2025, were analysed. The first stage was an exploratory reading of the DCNs to identify the key words; followed by an investigation to understand the context in which these key words were inserted; subsequently, a comparative analysis between the DCNs of 2001, 2014 and 2022 was performed, focusing on the object of study of this research; finally, connections between the DCNs and the PNCP were sought, using the historical and critical perspective on education in Palliative Care as a reference. According to Saviani[14], we understand that human beings "are not born knowing how to feel, think, evaluate and act. In order to know how to think and feel, to know how to want, act or evaluate, we need to learn, which involves educational work."

## RESULTS AND DISCUSSION

The DCNs emphasise that medical training should include the development of general competencies, enabling professionals to be critical, reflective, ethical and generalist, with the ability to address real world societal issues within the SUS, with quality, efficiency and effectiveness. To this end, they focus on three areas: Comprehensive Health Care, Health Education and Health Management.

The first DCNs for undergraduate medical courses included attending to the process of death as a specific competence and skill in medical training:

> *Art. 5 The aim of medical training is to equip professionals with the knowledge required to exercise the following specific competencies and skills:*
> *XIII - work to protect and promote health and prevent disease, as well as treat and rehabilite health problems and provide care during the dying process*[15]

To this end, the core contents included an understanding of the physiological processes of human development, from gestation to death.

> *Art. 6 Core contents for the Undergraduate Medical Program must be related to the entire health-illness continuum of the citizen, including their family and community, integrated into the epidemiological and professional reality, providing comprehensive care actions in medicine. They should include:*
> *VI - promoting health and understanding the physiological processes of human beings – gestation, birth, growth and development, ageing and the death process, physical activities, sports and those related to the social and environmental setting*[15].

Although there is a reference to content that involves "the whole health-disease process" for "comprehensive care actions", and the inclusion of "understanding the social and cultural determinants [...] of the health-disease process" (art.6, II), the requirement to understand death was focused on "physiological" processes and only mentioned "taking care of the death process", without detailing how it would happen[15].

In 2014, an inclusion in the DCNs[16] steered medical training towards the SUS, outlining a model that would be followed by the DCNs for other health courses. However, "attending to the process of death" as one of the skills and competencies in the practice of medicine is removed from the text, leaving only the physiological understanding of life processes, from gestation to death.

As with the 2001 DCNs, the 2014 DCNs does not mention PC as a medical competency, nor does it list the other keywords defined for this study: bereavement, end of life and finitude.

On 3 November 2022, the CNE approved Resolution 3, amending the 2014 DCNs, adding PC as a necessary set of competencies and skills in medical training[17].

Death and dying, no longer reduced to physiological processes, include the various dimensions that involve medical care at this time, in an article that deals with competencies and skills in PC:

> *Art. 6:*
> *III - Knowledge, competencies and skills in assisting patients in palliative care, within the scope of training and developing specific competencies in interpersonal relationships, communication, communicating bad news, listening attentively to the patient's biographical history, managing pain and other symptoms, acting in accordance with the principles and philosophy of palliative care, as well as identifying the criteria for early palliative care when diagnosed with a life-threatening illness and indicating and managing end-of-life care, including, in addition to controlling symptoms of physical suffering, addressing psychosocial, spiritual and cultural aspects of care, identifying and preventing the potential risks of prolonged bereavement*[17].

The 'attending to the dying process', which lacked detail in previous DCNs, now guides the broadened development of medical competencies, based on the principles and best practices of Palliative Care (art. 12, V)[17].

It should be noted that the insertion of content referring to PC is detailed in a way that is absent in other specialised areas of care, which are considered more generally in the Section "comprehensive care, from health promotion to rehabilitation"[17].

If the DCNs are generalist, establishing principles, foundations and aims for professional training, and if PC, which is geared towards comprehensive care, was included with these particularities in the latest DCN for medical courses, we understand that PC should be part of a doctor's basic training, and is therefore generalist care.

Considering that one of the guidelines of the PNCP (art.3, I)[11] is the "expansion of palliative care and universal access to it at all points of care in the Health Care Network - RAS", it is our understanding that the DCNs are aligned to the PNCP by including Palliative Care in initial training, since it must be present at all levels of care.

The WHO reinforces that since palliative care should not be limited to palliative services, but extended to all levels of care, there are different ways of considering it in training: as "basic palliative training", for all health professionals and technicians; "intermediate training", for professionals treating patients with life-threatening conditions; and "specialised palliative training", for the management of more complex symptoms and needs, and for those who will be teachers and researchers (p.33-34)[18].

In the 2022 DCNs, PC is considered "fundamental content" in medical training, with a view to comprehensive care:

> *Art. 23:*
> *VII - knowledge of the approach, concepts and philosophy of palliative care and hospice care;*
> *VIII - understanding of the biological, psychosocial and spiritual aspects surrounding the end of life, death and bereavement, considering the mastery of interventions and pharmacological measures for the adequate control of symptoms*[17].

This perspective is in line with the estimate that, in higher-income countries, roughly 55% to 70% of the necessary palliative care is provided in primary care[19]. However, according to WHO estimates[20], 86% of people who need PC do not receive it, that is more than 56 million people in the world.

Unlike the 2001 and 2014 DCNs, the 2022 DCNs display an understanding of the dying process that includes psychosocial and spiritual aspects. For the first time, there is a reference to

mourning. In Article 6[17], part of the knowledge, competencies and skills of palliative care should include the identification and prevention of "potential risks of prolonged bereavement". To this end, it is necessary to understand finitude not only from a biological point of view, but also from a psychosocial and spiritual point of view, aspects that involve "end of life, death and bereavement" (art. 23, VIII)[17].

It should be noted that there were specific inclusions regarding PC in the DCNs for the Medicine course in 2022, but not a coherent revision of the entire document. In this sense, we question whether these guidelines for training general practitioners to work in the death-bereavement process will be present and, above all, how they will be present in the (re)formulations of the pedagogical projects of higher education courses.

## FINAL CONSIDERATIONS

The evolution of Palliative Care in Brazil, whose culmination is the publication of Ministerial Directive GM/MS No. 3.681, of 7 May 2024, establishing the National Policy for Palliative Care in the SUS[11], responds to demographic, social and epidemiological changes and reflects the expansion of care beyond biological aspects, in line with international guidelines[18] and those of national specialist organisations.

These policies require competent professionals to carry out the activities involved. Their construction requires professional involvement, engagement and participation in the advocacy for public policies that meet the rights of the population, as was the participation of health professionals in the defence and drafting of Law No. 8080[5], that established the SUS

The first DCNs for undergradutate medical courses (2001 and 2014) mentioned the need for knowledge about the process of dying, but only the 2001 DCNs established attending to this process as a medical activity. In 2022, the DCNs incorporated and detailed PC as an integral part of medical training and practice.

Regarding the non-inclusion or incipient inclusion of death, mourning and palliative care in the first DCNs, one hypothesis is the cultural denial of death found in modern Western societies[21], which impacts teaching and care.

Although our analysis focused on the guidelines for initial training in Medicine, we believe that one of the challenges for implementing the PNCP is not only initial training, but also the ongoing training of health professionals, both general and specialised, to integrate care and matrix support teams in PC, given that its inclusion in the DCNs only took place in 2022.

Another challenge is to overcome the biomedical model. Although public health policies in Brazil are based on the principle of comprehensive care[5], the biomedical model has historically been and remains instilled in health training, action and management of the health-disease-care process. This model fragments the subject and aims to cure rather than care.

We hope that the PNCP will fulfil its commitment, set out in its objectives, to "stimulate training, continuing education, appreciation, provision and management of the palliative care workforce within the SUS" (Art. 4, IV)[11].

One limitation of this study was that it only analysed the DCNs for undergraduate medical courses, while the PNCP includes nursing, psychology and social work professionals, which could be the subject of future research.

With society and, consequently, health constantly changing, new fields are emerging, including palliative care. How and in what depth should the concepts be included in medical and health training? As a discipline or perspective? Approach or intervention? Considering how the curricular guidelines deal with the subject, the field is under construction, guided by international regulations, oriented by SUS guidelines and ordinances and influenced by the social and epidemiological scenario, as observed in the experience of Covid. These are points to be considered in the new revision of the DCNs, which should be approved in 2025.

## CONTRIBUTION OF THE AUTHORS

Paula Vilhena Carnevale Vianna, Alessandra de Andrade Lopes, Danusa de Almeida Machado, Denise Stefanoni Combinato, Elenice Bertanha e Mônica Manir Miguel contributed to: conception and planning of the study, data analysis and interpretation, and drafting and revising of the manuscript.

## CONFLICT OF INTEREST

We declare no conflict of interest.

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## STATEMENT OF DATA AVAILABILITY

Research data is available in the body of the document.

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