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Establishing and implementing palliative care services

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Abstract

Since expanding palliative care services within general hospitals in Brazil involves confronting obstacles and establishing strategies to enable their implementation in the health system, this study sought to identify the process around establishing and implementing palliative care services in Brazilian general hospitals. An integrative literature review of four articles identified the following steps for establishing and implementing palliative care services: protocol development, humanized care, multidisciplinarity, and education. As for the obstacles, the analysis highlighted the lack of training and education in palliative care, difficulty in reaching consensus on palliative practices, communication, drug supply, and government support. In conclusion, public policy development is essential to guarantee the implementation of palliative care in hospitals.

Keywords: Palliative care. General hospitals. Hospital services.

Resumo

Implantação e implementação de serviços em cuidados paliativos

Considerando que a demanda de ampliação de serviços de cuidados paliativos nos hospitais gerais do Brasil torna necessário enfrentar obstáculos e estabelecer estratégias para viabilizar a implantação desses serviços no sistema de saúde, buscou-se identificar o processo de implantação e a efetivação de serviços de cuidados paliativos em hospitais gerais do país. Mediante revisão integrativa da literatura, que consistiu na análise de quatro artigos, foram identificadas as seguintes etapas para implantação e efetivação de serviços de cuidados paliativos: elaboração de protocolo, cuidado humanizado, multidisciplinariedade e educação. Além disso, detectaram-se os desafios a seguir: ausência de treinamento e educação em cuidados paliativos, dificuldade de consenso sobre práticas paliativas, comunicação, oferta de fármacos e apoio dos governos. Considera-se que o estabelecimento de políticas públicas é essencial para garantir a implantação dos cuidados paliativos em hospitais.

Palavras-chave: Cuidados paliativos. Hospitais gerais. Serviços hospitalares.

Resumen

Implantación e implementación de servicios en cuidados paliativos

Teniendo en cuenta que la demanda de servicios de cuidados paliativos en los hospitales generales de Brasil requiere el enfrentamiento de obstáculos y el establecimiento de estrategias para viabilizar la implementación de estos servicios en el sistema de salud, se plantea identificar el proceso de implantación y la efectividad de los servicios de cuidados paliativos en hospitales generales del país. Desde una revisión integradora de la literatura, que consistió en el análisis de cuatro artículos, se identificaron las siguientes etapas para la implantación y efectividad de los servicios de cuidados paliativos: Elaboración de protocolos, cuidado humanizado, multidisciplinariedad y educación. Además, se constataron como desafíos la falta de formación y educación en cuidados paliativos, la dificultad para llegar a consensos sobre prácticas paliativas, la comunicación, el suministro de medicamentos y el apoyo gubernamental. Es fundamental establecer políticas públicas para garantizar la implantación de los cuidados paliativos en los hospitales.

Palabras clave: Cuidados paliativos. Hospitales generales. Servicios hospitalarios.

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According to the World Health Organization (WHO), palliative care consists of assistance from a multidisciplinary team aiming to improve the quality of life of patients facing life-threatening illnesses. This improvement is achieved by preventing and alleviating physical, psychosocial, and spiritual suffering, as well as by assisting patients' families[1]. The increase of the aged population, despite being a conquest for mankind, contributes to the emergence of chronic diseases, such as heart disease and cancer, which are the main causes of death and disability[2].

Patients with no expectation of transformative treatment regarding their diseases crowd into hospitals and often get inappropriate assistance through high-tech invasive methods, aimed at finding a cure. In addition to characterizing dysthanasia, for being exaggerated and unnecessary and almost always ignoring suffering, such approaches can be ineffective, in general, for not getting information on treatments and more significant symptoms, such as pain. Palliative care refers to attempts to rescue the dignity of life, aiming at the necessary stability between scientific understanding and humanism[1].

Patients with life-threatening diseases must be offered treatment that favors quality of life in the diagnosis, during the illness, and at the time of death, taking the focus off the cure and directing it towards the suffering of people affected by diseases[3]. Chronic diseases may be part of the lives of patients for years and palliative care is not intended to hasten or postpone death during this period of illness, but to alleviate pain and suffering.

In cases of patients with impoverished life-preserving treatment possibilities and moderate to severe suffering, one of the recommendation criteria for palliative care is the life-time prognosis. In this situation, the threshold of six months of life expectancy can be used to indicate exclusive palliative care[1]. The individuality and autonomy of patients must be respected, allowing them to decide with the team which conducts of their treatment should be performed, seeking to provide them and their families a better quality of life[4].

According to Resolution 41/2018[5] of the Brazilian Ministry of Health, palliative care should be offered in all categories of the health care network: primary care, which accompanies users with diseases that threaten the continuity of life in their territory; home care, in which the accompaniment is delimited based on the degree of care and the specific therapeutic plan, giving priority to care in the period of terminality of life whenever possible; outpatient care, which consists of palliative care coming from other care locations in the network; urgency and emergency care, which offers care to attenuate acute symptoms, to favor the comfort of the person in palliative care; hospital care, focused on the control of symptoms that the other levels of care cannot attend to[5].

The Legislative Assembly of the state of Paraná[6] enacted and sanctioned Law 20,091/2019, which provides for the institution of precepts and fundamentals of palliative care, reinforcing that this care is a right for patients with evolving illness in the Unified Health System (SUS), as well as in private services.

Resolutions and laws may be attempts to overcome obstacles to the quality of death in Brazil. Some of them are: the restricted field and the limited entry of professionals trained in palliative care, especially in smaller cities. There is also an established contradiction between younger physicians, trained to share the diagnosis and prognosis of patients and older physicians, who avoid discussion about death and maintain a curative perspective[7].

According to worldwide estimates, for every million inhabitants it is assumed that 1,000 people need palliative care per year[8]. Thus, Brazil, with about 211 million inhabitants, according to the Brazilian Institute of Geography and Statistics (IBGE)[9], would need to design a structure to care for about 211,000 patients per year. However, less than 10% of Brazilian hospitals count on palliative care teams[9], a crucial service for patients with no perspective of transforming treatment for their diseases[10]. A survey by the National Academy of Palliative Care (ANCP)[11] shows only 177 registered services in the 2,500 Brazilian hospitals with more than 50 beds.

This information brings to light the need to expand palliative care in general hospitals in Brazil, which need to face such obstacles and determine means to implement such services in the health system.

Thus, an integrative literature review was conducted to formulate the main steps to implement palliative care in general hospitals in Brazil, pointing out possible obstacles in this process, in order to implement more easily this service. Thus, the guiding question of the research was: What are the main steps and possible obstacles found to establish and implement palliative care services in general hospitals in Brazil?

Objectives

The general objective of this study was to identify how to establish and implement palliative care services in general hospitals in Brazil. In addition, it was sought to list the main steps and obstacles to implement such services in general hospitals, also indicating its importance.

Method

The integrative review is a methodological approach to reviews, which allows the insertion of experimental and nonexperimental research so that the analyzed phenomenon is fully understood. The understanding of complex concepts, theories, and public health problems is sought, allowing the use of data from theoretical and empirical literature, *reviews of theories and evidence, and analysis of methodological problems of a particular topic* [12]. Thus, the integrative review construction method may occur in six phases [12]:

- Phase 1. "Elaboration of the guiding question": enables the delimitation of studies to be included, the criteria for assimilation and the information obtained for each defined research.
- Phase 2. "Search or sampling of the literature": search in databases in a comprehensive and varied way. The criteria for inclusion and exclusion of articles must be consistent to ensure the representativeness of the sample, according to the guiding question of the research.
- Phase 3. "Data Collection": operation of a previously prepared set to collect data from the selected articles, including *definition of subjects, methodology, sample size, measurement of variables, method of analysis, and the underlying concepts employed* [13].
- Phase 4. "Critical analysis of the included studies": the classification of evidence may occur at different levels, according to the research design, such as those reached in single research with experimental demarcation, quasi-experimental studies, studies with descriptive or qualitative approach, and case or experience reports etc.
- Phase 5. "Discussion of results": the comparison of the information presented in the analysis of the articles to the theoretical framework.
- Phase 6. "Presentation of the integrative review": the information must be pertinent and detailed, being evidenced in a clear and complete manner.

The research was conducted in the periodicals database of the Coordination for the Improvement of Higher Education Personnel (Capes), using the following descriptors in Portuguese: *cuidados paliativos* and *hospital geral* (palliative care and general hospital). Descriptors were delimited in three keywords, according to consultation with the Health Science Descriptors (DeCS), considering the general objective of the study.

The data search was carried out between October 2019 and January 2020. Inclusion criteria were defined as: articles published in Portuguese with abstracts available in the chosen databases; published articles whose methodology were experience report, exploratory-descriptive research, and systematic review; articles that dealt with the theme establishing and implementing palliative care services in general hospitals in Brazil. In addition, no time was established.

Results

In total, 30 articles were found in the Capes journals portal, among which only four articles were selected, from the SciELO and Elsevier platforms, published between 2008 and 2013. The remaining articles were excluded according to the following exclusion criteria: articles that did not address Brazilian general hospitals and were not related to the theme of this research (implementation and effectiveness of palliative care services in general hospitals in Brazil).

Chart 1 presents the synthesis of the articles included in this integrative review.

Chart 1. Presentation of the synthesis of articles included in the integrative review

Origin	Title of the article	Authors and year	Considerations/themes
SciELO	"Concepções da equipe multiprofissional sobre a implementação dos cuidados paliativos na unidade de terapia intensiva"	Silva and collaborators;2013 [14]	This study aimed to analyze the conceptions of the multiprofessional team on the implementation of palliative care in an adult intensive care unit. This is an exploratory-descriptive research, with a qualitative approach, carried out with 14 health professionals from a public teaching hospital. Interviewees reported partial knowledge of the palliative care proposal and in the care practice divergences are observed in the therapeutic conduct of the team, indicating lack of interaction and communication among professionals. It is necessary to elaborate a national policy to support care of terminal critically ill patients, permanent/continued training of professionals and creation of protocols.
Elsevier	"A estruturação de um serviço de cuidados paliativos no Brasil: relato de experiência"	Garcia, Rodrigues, Lima; 2014 [15]	Justification and objectives: in Brazil, palliative care (PC) is not yet adequately structured and this reality transforms this theme into a public health problem and makes relevant initiatives taken in this context. This work aimed to share the experience of a reference hospital in oncology in the state of Maranhão and presented initiatives that helped in the development of the PC service. Experience report: there was an outpatient pain and PC service in the hospital, but without specialized beds. Conclusion: this experience was a reproducible local initiative for the development of PC in a cancer hospital. Local initiatives are of great value in Brazil as they favor an expressive number of patients and show, in practice, their efficacy to governments and society.
SciELO	"Como implementar cuidados paliativos de qualidade na unidade de terapia intensiva"	Costa Filho and collaborators; 2008 [16]	Contents: although still developing worldwide, palliative care is progressively integrating curative care, including in intensive care settings. However, evidence show that this medical approach still needs to improve, either for patients with symptoms of significant discomfort or physical pain, in intensive care units, or in the perception of family members, which is also flawed, especially regarding basic recommendations such as diagnostic, prognostic and therapeutic interventions. Conclusions: the development of research in this area will promote performance indicators, which will guarantee efficiency, operational quality, and constant improvement of this care. This article highlights the importance of palliative medicine and proposes alternatives and plans for promoting palliative approaches in appropriate time, in order to bring general medicine closer to human values and dignity.

continues...

Chart 1. Continuation

Origin	Title of the article	Authors and year	Considerations/themes
SciELO	"Cuidados paliativos para idosos na unidade de terapia intensiva: revisão sistemática"	Fonseca, Mendes, Fonseca; 2012[17]	Objective: the use of interventional medical technology in terminally ill older adult patients needs to be associated with palliative care as clinical support measures in intensive care. This resource assists decisions at the end of life of patients and directs the attention of the health team to ensure comfort for patients and satisfaction for families. Prolonging life without the implementation of actions aimed at alleviating symptoms such as pain and dyspnea, contributes to family stress and death with suffering. The objective of this work was to know the advances in the use of palliative care in the intensive care unit. Method: systematic review on the relationship between elderly palliative care and intensive care in MEDLINE and Bireme portals. Results: 29 articles were analyzed, showing experiences of palliative care in intensive care units using the variables "family satisfaction when participating in discussions on palliative care" and "difficulties in implementing this type of care due to lack of technical training of professionals". Conclusion: "palliative care" should be deepened as a theme, aiming to improve the relationship among patients, families and the healthcare team. Considering the increase in the number of older adults in intensive care, it is essential to improve the training of health professionals to face challenges involving terminality of life.

Data analysis

Based on a full reading of the articles selected for the research, we identified contents related to the steps of establishing and implementing palliative care in general hospitals and their obstacles.

Establishing and implementing steps

Protocols

Fonseca, Mendes and Fonseca[17] note that, to establish palliative care in hospitals, it is necessary to implement protocols, together with clinical guidelines already in place, such as the protocol for prophylaxis measures for ventilator-related pneumonia. Thus, implementing palliative care protocols reduces suffering and improves the quality of life of patients with diseases that threaten the continuity of life[14].

Humanization

Garcia, Rodrigues and Lima[15] presented humanization as an indispensable criterion for the adequacy of palliative care in hospitals. Patients, and not diseases, need to be the focus of attention, understanding humanization by promoting the complete well-being of sick people.

Multidisciplinarity

Garcia, Rodrigues and Lima[15] emphasized that providing quality of life to patients that do not have disease-modifying treatment is a complex task that requires interdisciplinary planning and multidisciplinary action. The effectuation of palliative care in hospitals demands a work team that meets the continuous care in mental (psychologist and psychiatrist), social (social worker and volunteer), spiritual (priest, pastor, rabbi, etc.), biological (physician, nurse, physical therapist, occupational therapist, etc.) spheres, as well as other specialists and professionals that may be called to collaborate with the team.

All professionals in the palliative therapeutic approach are important to value the multidimensionality of patients, making the interaction among those included in the course of patient care indispensable [14].

Education

Garcia, Rodrigues and Lima [15] stated that specialized training, basic knowledge, and development of skills in palliative care are crucial to treat patients with life-threatening diseases, which makes education a fundamental element to establish this care. For the evolution of palliative care praxis in healthcare, there is a need to prepare and educate future professionals.

Obstacles in establishing and implementing palliative care

Education and training in palliative care

The great obstacle to the development of palliative care is the lack of knowledge of multiprofessional teams to recommend palliative treatment [14]. Another obstacle is the scarcity of centers specialized in palliative care education in Brazil [15].

Adoption of palliative care in intensive care units (ICU) may occur by means of technical qualification of intensivists to perform the care. Training programs for palliative care, which are scarce, may favor improvement in the quality of care [17].

Consensus on palliative practices

There is the obstacle of finding consensus within the multidisciplinary team to implement palliative care, especially for patients with life-threatening illnesses without life-changing treatment, who are candidates for palliative care [17,18].

Communication

The failure of dialogue among health professionals, patients and family members is considered a problem, since communication is essential in palliative medicine. The authors emphasized that one of the greatest difficulties in the daily practice of palliative care is the communication of bad news, considered as such any drastic and negative information that affects the future of the sick person. Thus, healthcare professionals must develop communication skills through planned strategies and techniques [16].

Structured and early communication with patients and their families is necessary to advance the execution of palliative care [17]. The lack of adequate communication among the team and registration in medical records, and different opinions regarding palliative care constitute hindrances to the development of this practice in hospitals [14].

Drug supply

The rapid and continuous supply of opioids is essential for the adequate structuring of palliative care in hospitals; however, the supply of analgesics for pain management is restricted in Brazil. Despite the federal government pushing an ordinance that expands the availability of analgesics for chronic pain management, it remains restricted to codeine, morphine, and methadone. Moreover, the WHO recommendations on the appropriate use of opioids are still unknown or discriminated by health professionals[15].

Government support

One of the obstacles to the feasibility of palliative care is the lack of government support for the precepts of this practice [15]. In Brazil, the difficulties in establishing palliative care are related to the lack of consistent government strategies. Thus, it is considered that the implementation of palliative care in Brazil is slow and disarticulated [15].

There is a need to develop a national policy to support the care of critically ill patients in palliative care by broadening the debate on the subject in the hospital environment, articulating patients, staff, and family, as well as providing continuing education for health professionals[14].

Discussion

Based on the data about the steps and obstacles of establishing and implementing palliative care in general hospitals in Brazil, some reflections were made.

The elaboration of palliative care protocols, as part of establishing and implementing palliative care services in general hospitals in Brazil aims to guide the team in relation to the care provided to patients. It is also intended to organize the work process in multiprofessional teams, seeking to favor communication among those involved. Thus, protocols are aimed at standardizing the way of caring for patients as in some existing palliative care protocols: palliative sedation protocol, subcutaneous infusion of medications and solutions[19].

Care protocols are established to describe the specific lines of care in detail and their structure includes norms, routines and care procedures. Thus, the team's work can be directed, and the care provided recorded in the solution or precaution of a complication. Protocols provide a description of certain situations or specific care, as well as operational details about the execution of interventions, and can be carried out through evaluation and investigation or care and practice[20].

The palliative care protocol in hospitals aims at: offering additional support regarding physical, psychological, social, and spiritual points of care to patients in advanced phases of a diseases that threaten the continuity of life; sensitizing, divulging, and informing on palliative care in treatments; orienting and intervening, seeking to provide care support involving life guides and organization for the occurrence of death; promoting the training of specialists and other professionals in palliative care[21].

The palliative care protocol consists in providing more humanized care. The practice of humanization was another factor identified in the description of establishing and implementing palliative care services in general hospitals. Humanization in health proposes to preserve the consideration of life, as well as to attend to biopsychosocial, spiritual, and educational aspects, considering the legitimization of the human circumstance of all people included in assistance of institutions[22].

The National Humanization Policy[23] sets out some guidelines, such as: welcoming, which is about providing qualified listening of workers in order to meet the user's needs; ambiance, which refers to the creation of welcoming spaces with the purpose of favoring privacy to serve the users' needs; and expanded clinical practice, as a theoretical-practical instrument aiming at collaborating with clinical perspectives of suffering, paying attention to the uniqueness of each person and the difficulties of the health/disease processes. The expanded clinic aims at qualifying the dialogue among teams, patients, and families in order to promote shared decisions respecting users' autonomy and health.

The autonomy of patients, based on the principles of clinical bioethics, is essential in palliative care, since it is important to guarantee that they can express their own decisions, with the purpose of offering quality of life and preserving dignity in the processes of illness, terminality of life, and mourning[1].

Patients in palliative care must be understood as people who suffer existential conflicts, besides physical pain, knowing that not all drugs and high-tech devices can alleviate their suffering. Healthcare professionals should express compassion and care in the bond with patients to provide the user with a sense of consolation and protection, aiming to promote inner peace[18].

The evolution of a more humanized health care, based on evidence, with equal and cost-effective access at all levels of health care is one of the reasons for the organization of palliative care in health services[5]. For humanized care, it is necessary that the work in palliative care is provided by a multidisciplinary and multiprofessional team, which is part of the process of establishing and implementing palliative care services in general hospitals.

According to Article 2 of Resolution 41/2018[5] in which the Brazilian Ministry of Health provides guidelines for the organization of palliative care, in light of the integrated continuous care within the scope of SUS, palliative care is formed by the assistance made available by a multidisciplinary team, with the intention of improving the quality of life of sick people with life-threatening illnesses, as well as their family members. To this end, the Article 3rd[5]of the same resolution points out that the organization of palliative care has as its purpose the stimulation of multidisciplinary teamwork and, as a guiding principle, presented in Article 4, the multiprofessional and interdisciplinary teamwork to contemplate the demands of patients and their families.

In this context of multidisciplinarity, palliative care involves several specialties, inserting various possibilities of clinical interference and treatment in different areas of specific knowledge, in addition to the knowledge of medical science[1]. The WHO, in 1986, established principles governing the performance of the multiprofessional team in palliative care. One of these principles is the multiprofessional approach to meet the needs of patients and their families, extending the follow-up to mourning, as mentioned in Resolution 41/2018[5]. The integration proposed by palliative care is about observing patients holistically, considering all their dimensions to provide a unique approach and comprehensive work of the multiprofessional team.

Another very important point observed in the implementation and deployment of palliative care in general hospitals is education, which involves specialized training, basic knowledge and development of skills in palliative care[15-17]. Education, qualification and training of professionals in palliative care should be part of the protocol to implement the service in hospitals, seeking to spread the concept of palliative care to hospital staff, offering them theoretical and practical deepening on the subject[21].

Some data showed that the implementation of palliative care began by means of continuing education actions, such as: meetings for reflection on palliative care, theoretical research on the theme, training of professionals in solemnities, and knowledge of other services[19]. Education and training are priorities in the process of implementing palliative care in hospitals, as they are fundamental for teams to exercise their profession with quality[16].

Education also appeared as an obstacle in the implementation phase, especially regarding palliative care, because, as pointed out by the ANCP[24], the education of health care professionals in Brazil presents gaps. This is because undergraduate courses do not instruct medical professionals to care for terminally ill patients, nor do they prepare them to act in a humanized way with such patients. Palliative care is not part of the undergraduate curriculum by the Ministry of Education, and few universities teach this subject to their students[14-24].

Thus, professionals begin to act with a curative vision, not knowing how to face situations in which diseases do not present possibilities of cure[25]. Colleges that provide students with information on palliative care are rare, which emphasizes the urgency of including the subject in the curricula of health courses[15].

The lack of understanding of palliative care is a difficulty for health care teams in implementing such practice. Such a gap also hinders teams in reaching a consensus about applying palliative care to patients[14-19]. No specific training in this area results in confusion on palliative practices in ICUs, even hampering communication among members of the multiprofessional team due to divergent opinions on palliative care[14,17].

Communication is fundamental in palliative care, and its establishment and implementation in general hospitals is a challenge[19]. According to Resolution 41/2018, Article 4, the guiding principle for the organization of palliative care is *the sensitive and empathic communication, with respect for truth and honesty in all issues involving patients, families, and professionals*[5].

Poor communication becomes a barrier to palliative care, considering that *continuous and accessible information to family members* *is the essential attribute that will allow them achieve an acceptable death process, without generating expectations that cannot be fulfilled. Family members need to be kept informed on what happens and what to expect in the death process of their loved ones. Thus, one of the most prominent needs of families is to establish clear, honest, and more frequent communication with the members of the team caring for patients* [18].

The multidisciplinary team is often deficient in providing an appropriate approach to deal with the ambitions and wishes of patients and families when no possibility of a disease-modifying treatment exists [21]. Communicating difficult news is one of the most painful tasks of health professionals, since they have learned to save lives and conquer health and not necessarily to deal with situations of illness, hopelessness, and death [18].

Thus, one of the aspects that healthcare professionals most want to achieve is the ability to communicate bad news, for instance, notifying a diagnosis of a disease with no possibility of modifying treatment, the worsening without reversibility of the clinical picture or even informing the family of the death [18].

Palliative care was inserted as a discussion and began to be practiced only in the 1980s in Brazil, but presented an important growth from the 2000s on, with the establishment of effective services, either as beginners or under construction [1]. These can be considered significant evolutions, but although some institutions in Brazil offer excellent palliative care services, most are yet to develop a culture of palliative care, lacking both explanations and guidance on their protocols and adequate academic training for health professionals regarding the communication of bad news.

Another obstacle found to establish and implement of such care refers to the limited supply of drugs in Brazil [15]. Resolution 41/2018, in Article 3, determines that the organization of palliative care should aim *to offer medications that promote symptom control of patients in such care*; and in Article 7, it determines that *access to medications for treatment of related symptoms, notably opioids, should follow the health standards in force and observe the pacts between the management instances of SUS* [5]. Nevertheless, in Brazil, the supply of analgesics for pain control is limited: codeine, morphine and methadone, and they are restricted to a few pharmacies and non-existent in some municipalities [15].

Finally, government support also figured as an obstacle in the implementation of this care, because the lack of commitment to palliative care guidelines becomes a major challenge [15]. In Brazil, it is still necessary to implement specific public policies for end-of-life care because, as mentioned before, professionalization in this area remains incipient [21].

The creation of palliative care committees in hospital services and its inclusion in health policies is important to: offer adequate support to cases with uninterrupted care needs; enable the extension of visits and the presence of families; stimulate the shared decision about patients' lives; and decrease the requests for ICU beds [21]. Moreover, the development of a national policy to ensure palliative care for critically ill patients is needed, promoting continued education for health professionals [14]. Thus, it is expected that this proposal will be developed and used by other services, such as those of the public sector, broadening the population's access to palliative care [21].

Final considerations

Through an integrative review, this study identified both steps and obstacles to establish and implement palliative care services in general hospitals in Brazil, also emphasizing the importance of these services to improve the quality of life of patients and families.

The philosophy of palliative care aims at ensuring the autonomy of sick people, mitigating suffering and providing quality of life in the absence of disease-modifying treatment. Thus, it is necessary to both include reflections on the theme among health care professionals in Brazil and provide resources for continued education on the subject.

The construction of public policies that guide how to establish palliative care in hospitals in Brazil, the elaboration of protocols of this service and the expanded offer of drugs to attend patients in their specificity are urgent requirements to implement palliative care services in general hospitals in the country.

In addition to the steps and obstacles to establish and implement palliative care in general hospitals in Brazil found in the literature, the collaboration of health professionals for the constitution of palliative care committees in hospitals is considered an important step to implement these services. Such committees should take care of the appropriation of knowledge on the subject and from service models of other institutions (for example, by conducting technical visits), as well as counting on the support of hospital managers. Furthermore, the construction of physical spaces in institutions that establish and implement palliative care sectors is desirable.

References

1. Carvalho RT, Parsons HA, organizadores. Manual de cuidados paliativos ANCP [Internet]. Rio de Janeiro: ANCP; 2012 [acesso 25 jan 2022]. Disponível: https://bit.ly/3tUqUhh
2. World Health Organization. Envelhecimento ativo: uma política de saúde [Internet]. Brasília: Organização Pan-Americana da Saúde; 2005 [acesso 25 jan 2022]. Disponível: https://bit.ly/3AH67l1
3. Nickel L, Oliari LP, Dal Vesco SNP, Padilha MI. Grupos de pesquisa em cuidados paliativos: a realidade brasileira de 1994 a 2014. Esc Anna Nery Ver Enferm [Internet]. 2016 [acesso 25 jan 2022];20(1):70-6. DOI: 10.5935/1414-8145.20160010
4. Pineli PP, Krasilcic S, Suzuki FA, Maciel MGS. Cuidado paliativo e diretrizes curriculares: inclusão necessária. Rev Bras Educ Méd [Internet]. 2016 [acesso 25 jan 2022];40(4):540-6. DOI: 10.1590/1981-52712015v40n4e01182015
5. Brasil. Ministério da Saúde. Resolução n° 41, de 31 de outubro de 2018. Dispõe sobre as diretrizes para a organização dos cuidados paliativos, à luz dos cuidados continuados integrados, no âmbito Sistema Único de Saúde (SUS). Diário Oficial da União [Internet]. Brasília, n° 225, p. 276, 23 nov 2018 [acesso 25 jan 2022]. Seção 1. Disponível: https://bit.ly/3V86y02
6. Paraná. Lei n° 20.091, de 19 de dezembro de 2019. Dispõe sobre a instituição dos preceitos e fundamentos dos cuidados paliativos no Paraná. Diário Oficial do Paraná [Internet]. Curitiba, 19 dez 2019 [acesso 25 jan 2022]. Disponível: https://bit.ly/3V61fxR
7. The 2015 quality of death index: country profiles. The Economist [Internet]. 2015 [acesso 25 jan 2022]. Disponível: https://bit.ly/3GFT9YD
8. Santos AH, Langaro F, Pfuetzenreiter F, Forte LT. Implantação de protocolo multidisciplinar de cuidados paliativos em hospital geral. Revista Interdisciplinar de Estudos em Saúde [Internet]. 2015 [acesso 25 jan 2022];4(2):169-79. Disponível: https://bit.ly/3FytrnO
9. Instituto Brasileiro de Geografia e Estatística. Projeção da população do Brasil e das unidades da federação. IBGE [Internet]. 2020 [acesso 25 jan 2022]. Disponível: https://bit.ly/2EIT9bH
10. Collucci D, Versolato M. Menos de 10% dos hospitais têm equipes de cuidados paliativos no Brasil. Folha de S.Paulo [Internet]. 14 out 2018 [acesso 25 jan 2022]. Disponível: https://bit.ly/2pSAFvt
11. Academia Nacional de Cuidados Paliativos. ANCP divulga Panorama dos cuidados paliativos no Brasil. ANCP [Internet]. 2022 [acesso 25 jan 2022]. Disponível: https://bit.ly/3EZh7N9
12. Souza MT, Silva MD, Carvalho R. Revisão integrativa: o que é e como fazer. Einstein (São Paulo) [Internet]. 2010 [acesso 25 jan 2022];8(1):102-6. DOI: 10.1590/s1679-45082010rw1134
13. Souza MT, Silva MD, Carvalho R. Op. cit. p. 104.
14. Silva CF, Souza DM, Pedreira LC, Santos MR, Faustino TA. Concepções da equipe multiprofissional sobre a implementação dos cuidados paliativos na unidade de terapia intensiva. Ciênc Saúde Colet [Internet]. 2013 [acesso 25 jan 2022];18(9):2597-604. DOI: 10.1590/S1413-81232013000900014

15. Garcia JBS, Rodrigues RF, Lima SF. A estruturação de um serviço de cuidados paliativos no Brasil: relato de experiência. Rev Bras Anestesiol [Internet]. 2014 [acesso 25 jan 2022];64(4):286-91. DOI: 10.1016/j.bjan.2013.06.007

16. Costa Filho RC, Costa JLF, Gutierrez FLBR, Mesquita AF. Como implementar cuidados paliativos de qualidade na Unidade de Terapia Intensiva. Rev Bras Ter Intensiva [Internet]. 2008 [acesso 25 jan 2022];20(1):88-92. DOI: 10.1590/S0103-507X2008000100014

17. Fonseca AC, Mendes JWV Jr, Fonseca MJM. Cuidados paliativos para idosos na unidade de terapia intensiva: revisão sistemática. Rev Bras Ter Intensiva [Internet]. 2012 [acesso 25 jan 2022];24(2):197-206. DOI: 10.1590/S0103-507X2012000200017

18. Silva MJP, Araújo MMT. Comunicação em cuidados paliativos. In: Carvalho RT, Parsons HÁ, organizadores. Manual de cuidados paliativos ANCP [Internet]. Rio de Janeiro: ANCP; 2012 [acesso 25 jan 2022]. p. 75-85. Disponível: https://bit.ly/3tUqUhh

19. Lourençato FM, Santos AFJ, Ficher AMFT, Santos JC, Zoppi D, Giardini MH *et al*. Implantação de serviço de cuidados paliativos no setor de emergência de um hospital público universitário. Revista Qualidade HC [Internet]. 2016 [acesso 25 jan 2022];127-33. Disponível: https://bit.ly/3hZrdo6

20. Conselho Regional de Enfermagem de Sergipe. Protocolos assistenciais [Internet]. Aracaju: Coren-SE; 2017 [acesso 25 jan 2022]. p. 1-3. Disponível: https://bit.ly/3U5wzM6

21. Marcucci FCI, Mendes IAS, Dias CAM, Nascimento LA, Pedri WLN. Implantação de uma unidade de cuidados paliativos num hospital de média complexidade de Londrina – PR: relato de experiência. Espaç Saúde [Internet]. 2017 [acesso 25 jan 2022];18(1):196-203. Disponível: https://bit.ly/3iazeH2

22. Oliveira FT, Flávio DA, Marengo MO, Silva RH. Bioética e humanização na fase final da vida: visão de médicos. Rev. bioét. (Impr.) [Internet]. 2011 [acesso 25 jan 2022];19(1):247-58. Disponível: https://bit.ly/3GJzN4W

23. Brasil. Política nacional de humanização [Internet]. Brasília, 2013 [acesso 25 jan 2022]. Disponível: https://bit.ly/3tZ47Re

24. Academia Nacional de Cuidados Paliativos. ANCP e cuidados paliativos no Brasil [Internet]. [s.d.] [acesso 25 jan 2022]. Disponível: https://bit.ly/3VjqpZE

25. Kira MC, Montagnini M, Barbosa SMM. Educação em cuidados paliativos. In: Oliveira RA, organizador. Cuidado paliativo [Internet]. São Paulo: Cremesp; 2008 [acesso 25 jan 2022]. p. 595-612. Disponível: https://bit.ly/3m4Qjkn

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Luciana Tiemi Kurogi participated in the development of the text and the study (introduction, methodology, data collection, results, discussion and final considerations), adapted the text to the standards of the journal and submitted the article. Caroline Aparecida Leindecker Garçoa Vieira contributed to the data collection, the writing of the introduction, the discussion and the final considerations, and adapted the text to the Vancouver standards. Rosa Maria Ramalho participated in the introduction, data collection, and discussion. Angelita Wisnieski da Silva reviewed the text.

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