

Advanced directives as perceived by healthcare professionals

Anne Karolyne Santos Barbosa¹, Walter Lisboa¹, Anali Póvoas Orico Vilaça²

1 Universidade Federal de Sergipe, Aracaju/SE, Brasil. 2. Universidade de São Paulo, São Paulo/SP, Brasil.

Abstract

Advance directives are instruments that aim to ensure the fulfillment of patients' will in circumstances where they are unable to express themselves freely. This study investigated how health professionals perceive the use of this tool in palliative care, as well as the main ethical dilemmas and gains or losses related to it. Semi-directed interviews were conducted with nine professionals and the data underwent content analysis. Five categories emerged, pointing to a good reception of the resource, as it ensures patient autonomy, strengthening the perception of care, facilitating decisions and providing psychological comfort. On the other hand, the adversities or challenges involved the need for better technical preparation and greater team integration, professional overload, legal uncertainty about its use, end-of-life as a taboo and society's lack of knowledge about the subject.

Keywords: Advance directives. Palliative care. Bioethics. Patient care team.

Resumo

Percepção de profissionais da saúde sobre diretivas antecipadas de vontade

Diretivas antecipadas de vontade são instrumentos que buscam garantir antecipadamente o cumprimento dos desejos do paciente em circunstâncias em que ele não consiga se manifestar livremente. Neste trabalho investigou-se a percepção de profissionais de saúde sobre o uso dessa ferramenta em cuidados paliativos, além dos principais dilemas éticos e ganhos ou prejuízos decorrentes de seu uso. Foi realizada entrevista semidirigida com nove profissionais, e os dados foram submetidos à análise de conteúdo. Evidenciaram-se cinco categorias, que apontaram para uma boa receptividade do recurso, por assegurar o exercício da autonomia do paciente, fortalecendo a percepção do cuidado, facilitando as decisões e propiciando conforto psicológico. Por sua vez, as adversidades ou desafios envolveram necessidade de melhor preparo técnico e maior integração da equipe, sobrecarga profissional, insegurança jurídica com eventual uso do instrumento, finitude como tabu e desconhecimento da sociedade acerca do tema.

Palavras-chave: Diretivas antecipadas. Cuidados paliativos. Bioética. Equipe de assistência ao paciente.

Resumen

Percepción de los profesionales de la salud sobre las voluntades anticipadas

Las voluntades anticipadas son herramientas para garantizar el cumplimiento de las decisiones del paciente cuando estos ya no pueden expresarse. Este estudio evaluó las percepciones de los profesionales de la salud sobre el uso de esta herramienta en cuidados paliativos, así como los principales dilemas éticos y las ganancias o pérdidas derivadas de su uso. Se realizó una entrevista semidirigida a nueve profesionales, y los datos se sometieron a un análisis de contenido. Surgieron cinco categorías, que apuntan a una buena acogida del recurso, pues garantiza el ejercicio de la autonomía del paciente, reforzando la percepción de los cuidados, facilitando las decisiones y proporcionándole confort psicológico. Por otro lado, las adversidades o desafíos involucraron la necesidad de mejor preparación técnica y mayor integración del equipo, la sobrecarga profesional, la inseguridad jurídica sobre el posible uso del documento, la finitud como tabú y el desconocimiento de la sociedad sobre el tema.

Palabras clave: Directivas anticipadas. Cuidados paliativos. Bioética. Grupo de atención al paciente.

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Palliative care (PC) is care provided by a multidisciplinary team to patients facing a life-threatening illness, aiming to improve the patients' and their families' quality of life, preventing and relieving suffering, as well as reducing physical, social, psychological, and spiritual symptoms¹. It therefore includes not only diagnosis and illness but also finitude and mourning².

Paying attention to the patient's wishes before incapacitating situations or death thus becomes necessary, giving rise to ethical debates and possible strategies to resolve dilemmas. In this sense, advance directives (AD) are a set of wishes previously expressed by the patient regarding the care and treatments they want to receive or not in circumstances that prevent them from expressing their wishes³.

ADs are manifestations aimed at medical treatments that require a dynamic approach and can be reviewed periodically. Among such ADs, two have been emphasized in the literature: the living will, which focuses on the possibility of refusing medical treatments that aim only to prolong life in the face of an irreversible or vegetative state; and the durable power of attorney for health care, which refers to appointing people to make medical decisions when the patient is unable to do so⁴.

Historically, ADs emerged with medical technological advances associated with life-sustaining treatments in terminal cases or in cases with a guarded prognosis⁵. Under these conditions, ADs allow patients to express themselves about medical conduct in situations in which they would not be able to express opinions and wishes, bringing to light the subject's exercise of autonomy. In 2012, the Brazilian Federal Council of Medicine (CFM) approved CFM Resolution No. 1,995/2012³, which legitimated the patient's right to express their wish for medical treatments, as well as the nomination of representatives to express their wishes in situations in which they are unable to do so.

With such Resolution, dialogues about the care of terminally ill patients, their autonomy and their rights emerged, in addition to being possible to observe greater acceptance among companions regarding the use of the living will⁶. Currently, one discusses about advance care planning (ACP), which, unlike AD, is a process of discussion between

health professionals and patients, with continuity and dynamic approach regarding present or future health care.

The following are considered ACP elements: 1) patients' understanding of diagnosis and prognosis; 2) identification of the patient's wishes, priorities, and concerns; 3) discussion about available treatment options suited to the patient's needs and values, and 4) elaboration of an AD in the form of a living will or appointing a health care agent⁷.

In this sense, the AD role is fundamental to legitimize the patient's will and preserve their autonomy, especially in circumstances in which their ability to express themselves is compromised. With these conditions, there is a greater predisposition to ethical uncertainty in decisions⁸ and, consequently, higher chances of dysthanasia and/or therapeutic obstinacy. The AD is also an important instrument for measuring bioethical conflicts, and its use is a means of resolving conflicts.

Despite the recognized acceptance of ADs by patients, families and health professionals, implementing them requires additional effort, as it depends on several factors, both institutional—such as authorizations, standards and protocols—and team-related—technical knowledge and adequate instrument use, for example.

ADs have raised the interest of many terminally ill patients and acceptance in search for a quality life, without suffering prolongation caused by procedures that do not lead to cure⁹. Understanding the health professionals' perception of ADs can enable the formulation of strategies that promote patient autonomy and qualify the care provided.

Given this context, this study aims to investigate health professionals' perception of AD use in PC, understanding the main ethical dilemmas experienced by the team and addressing the identification of possible gains or losses from using ADs.

Method

The research was carried out in a general hospital in the state of Sergipe, Brazil, which has surgical and medical units, with PC provision. Sampling was non-probabilistic and by saturation¹⁰,

and participant selection was made by convenience and by the snowball method¹¹. The following inclusion criteria were adopted: being male and female healthcare professionals, aged 18 years and older, members of the institution's PC advisory team working directly with patients. In turn, the exclusion criteria were: being a professional on leave or not performing a care role, being a medical resident or multidisciplinary physician.

Nine health professionals participated in the study, two men and seven women, 39 years as the mean age, ranging between 35 and 55 years old, with different academic backgrounds: social work, dentistry, occupational therapy, physical therapy, speech therapy, nursing, psychology, and medicine. Two participants had doctoral degrees, two had master's degrees, and five were specialists.

All participants had taken courses and training in the PC area; the mean academic training time was 17 and a half years; the mean length of work at the institution was eight years and three months, and the mean time working with PC was five years and six months. Six professionals declared using the SPIKES protocol, two did not use any type of protocol, and one declared nothing. All participants reported contact with the ADs through experience, reading, classes, and training and qualification courses.

The following data were collected: age, gender, undergraduate degree area, education level, training time, time working at the hospital, time working with PC, specialties, other training courses, time working professionally, adoption or not of communication protocols, and contact or not with AD.

Eight questions were asked, divided into two axes: 1) PC and guarded prognosis, addressing understanding and dialogue, inability to communicate, and ethical dilemmas; 2) AD, involving losses and gains from using it, skills and abilities necessary to work with the instrument, in addition to its implementation and adversities.

Participants were invited to an interview, which was recorded and later transcribed. The meeting maintained the necessary privacy to protect confidentiality and secrecy, lasting 20 to 40 minutes.

The data was submitted to content analysis¹², going through pre-analysis, material exploration and result processing using Microsoft Excel

software, and then classified into five categories: 1) first contact with patients to talk about PC; 2) professional contact with patients with a guarded prognosis or progressive inability to communicate; 3) ethical dilemmas; 4) losses and gains from using ADs, and 5) AD implementation and adversities.

Results and discussion

First contact

The most noticeable content in this category concerns the misunderstanding of patients or family members/support network about the real severity of the condition (n=6), oscillating between an unrealistic expectation of cure and the idea of imminent death, which leads to resistance to team approach. Concern about communication and inadequate understanding of the notion of PC on the part of patients and health professionals was also evident (n=5).

"Most do not understand what palliative care is, they have no knowledge. There are those who understand it, but end up resisting, even though they know it would be the right thing to do, they hope that death will not happen" (P2).

"The patient does not always understand how serious their condition is. The family understands palliative care as something that arises when the patient is in a serious condition, when there are no medical resources to treat the illness, or they are limited. It's as if one revealed the severity of the situation" (P1).

Professionals' concern is about the emotional response and future perspective of those who receive the information. It can also have repercussions on those who give the information, triggering stress, guilt, and feelings of failure and impotence¹³. Understanding can thus be facilitated or hindered by communication style, informed facts, and expectation adjustment regarding the prognosis.

Two participants noted difficulties in working with the PC advisory team, due to the team's delay in officially requesting the advisory team's services. This is reflected in a perception that they are dealing with PC on their own, compromising the care comprehensiveness.

“When this request does not occur, there are professionals who even say that the patient is already in PC, but they do not ask our help, providing it by themselves when there is a team discussing the case, trying to solve the social, spiritual problems, and the loss of integrality” (P9).

Referring patients to PC was reported as a negative factor, highlighting difficulties faced by some professionals, related to personal suffering, training, patients' and family members' unrealistic expectations, or even institutional issues¹⁴. These difficulties may also be associated with the professional's set of beliefs and stigmas attached to PC, which can prevent early referral and become aspects that influence the care provided in a negative manner¹⁵.

Emotional issues were reported as possible difficulties in contact with the patient (n=3), permeating processes of denial, revolt, and mourning, in addition to the time to assimilate their clinical condition.

“I think we need to take into account the patient's psychological issues when facing the disease and the grieving process. And this means that they can express themselves a lot at some point and not express themselves at all on another occasion. I think it can vary according to the patient's psychological and family situation, as many times there is a conspiracy of silence” (P8).

One of the ways mentioned by participants to deal with the patient's emotional difficulties is to follow guidelines or protocols, so that, despite the emotional issues that hinder, there is welcoming support from the team to ensure therapeutic bonding. The SPIKES protocol was the most cited (n=6), considered by interviewees a guide to the communication process. In the SPIKES protocol, during the first contact, one works on the subject's perception of their illness, the transmission of the necessary information, the empathic response to the patient's emotions, and the discussion about therapeutic planning¹⁶.

These protocols often involve only breaking difficult news. However, the demand for an assessment that beyond the biological dimension, considering the need to deal with the emotions of patient in a terminal situation, makes psychological support a need. This is especially

crucial due to the emotional exhaustion and psychological symptoms¹⁷.

Contact with critically ill patients and clinical limitations

Four types of content prevailed: 1) advanced clinical conditions; 2) strategies in the face of difficulties; 3) human dignity, and 4) alternative means of communication. Regarding the first content, professionals' complaints about the severity condition of some patients were recurrent when the PC team is requested, which implies communication difficulties caused by sedation, cognitive impairment, or use of devices that impede communication (n=3).

One interviewee indicated the delay in requesting the team as a factor that contributes to limitations in approaching and communicating with the patient and their support network. This delay represents potential suffering for the patient, given that assertive and compassionate communication is necessary¹⁸.

“There is great difficulty in signaling palliation to the patient. Then this call for team evaluation is very late, so some patients arrive for PC already in a terminal situation. So, for what else? To hold the patient's hand?” (P3).

Communication difficulties compromise the patient's participation in the health-disease process, making it impossible to understand the risks and benefits of therapeutic approaches¹⁸. Furthermore, this condition prevents the patient's wishes from being guaranteed and illness-related fears from being reduced.

Educational and awareness-raising dialogue with care teams (n=1) was listed as a strategy to deal with this difficulty. At the hospital where the study was carried out, the PC team is consultative, so the sooner the request occurs, the more the patient will benefit, with the guarantee of preserving human dignity. This translates into comprehensive care and subject prioritization (n=5), as the focus on care includes recognizing and responding to the patient's and family's needs through a broad and transdisciplinary vision¹⁹.

“It's important when we bring things from their daily life to the current moment: painting, watching

movies, bringing this to hospitalization can ease the suffering. When we take an anamnesis, it's more focused on what we did, drink, smoke... There's a bit of a lack of the hobby, of the routine, in short, of the person" (P9).

As the interviews show, the patient must be humanized in the face of the care technical aspect, which is one of the ways to ensure human dignity. To ensure the team's knowledge of the patient's history and wishes, the team often turns to family members and/or the support network, and they act as the patient's agent when faced with limited or impossible communication (n=7).

Thus, the family can contribute to care humanization, reaffirming the importance of its inclusion in PC and the indispensability of meeting its needs¹. In the care recommended by PC, the family is an important focus of intervention, as they can face symbolic losses involving social roles, autonomy, identity, and the real loss of the patient²⁰.

In situations where alternative means of communication are necessary, the family was referred to as an ally:

"If the difficulty can be overcome through the communication board, we ask for help from occupational therapy and a speech therapist to use it and learn about their wishes. Alternatively, we can approach the family, check if during their life they have already expressed any wish" (P8).

In certain situations, it is necessary to use alternative communication resources, such as the communication board, which requires the professional to have a theoretical-practical knowledge, using alternative and expanded communication tools (AAC)²¹.

Ethical dilemmas

PC provision is immersed in ethical issues: the team's feeling of impotence; patient autonomy and participation; wishes of the patient and family/support network; conspiracy of silence (understood as an omission regarding the patient's diagnosis or clinical prognosis)²², and decision making.

The team's feeling of impotence was reported regarding the limitations of professional conduct due to the low effectiveness of procedures or even

the risk that a certain conduct may pose to the patient (n=2), in addition to the failure to comply with the patient's wishes (n=2). This feeling is preceded by the physical and emotional availability to care and, when choosing to provide care in the hospital context, there is direct contact with human suffering. This scenario can cause satisfaction and vivacity in the professional, but on the other hand highlights their own vulnerability and impotence²³.

Dilemmas were evidenced regarding the boundaries of a decision shared with the patient and the professional's technical behavior. Understanding the risks and benefits of each therapeutic option should involve the patient's history and values. However, many professionals claim that the patient is not always able to decide on certain clinical actions.

"This question of eating, when will it be necessary? Will it bring comfort or not? Limitation between what the patient wants and their condition. Sometimes they want to eat, but if they eat they will have bronchial aspiration and die. Work practices sometimes limit the patient's choice. And we end up talking to the team, but some behaviors are not seen due to the patient's preference" (P2).

Currently, there is an ongoing discussion and efforts underway to provide "appropriate care," which has been defined as individualized care designed to meet needs and wishes and be clinically effective while being affordable and responsible about allocated resources¹⁹.

Effective communication was also indicated as important in providing the patient greater understanding and a conscious decision. Some interviewees (n=3) highlighted the difference between the patient choosing a certain course of action and their participation in the choice through dialogue with professionals, crediting the former with greater weight for the patient.

The patient's participation in their treatment occurs through shared decisions, that is, through dialogue, decisions are sought to be established based on appropriate treatments for each phase of the illness and associated with the preferences and values expressed by the patient²⁴. The patient's wish compared to that of the family member can represent an ethical dilemma (n=3), as these wishes may not coincide or there may be a critical situation, creating an impasse for the team.

“When it is the family that is responsible for the patient, there are ethical dilemmas. Because what is true for the family is not true for the patient. Not that the family won’t be the agent, because at this point it will be, but what the family says the patient would like may not be the case. We try to believe it because the family knows the patient more deeply” (P6).

Although the patient’s will has priority over the family’s, the situation may be uncertain as to the veracity of what is expressed by the family as the patient’s wish, especially when there is nothing to indicate otherwise. In this sense, there are resolutions that can guide the conduct According to article 2, paragraph 5 of CFM Resolution No. 1,995/2012, if either the patient’s ADs are not known, or no designated representative is defined, or there is disagreement between the family members, the doctor will appeal to the institution’s bioethics committee or, in the absence thereof, to the hospital medical ethics commission, or even to the regional and federal medical councils to support their decision on existing ethical conflicts³.

During illness, there emerge the ways that patients, family members and professionals deal with the illness and its repercussions. Decisions appear as a dilemma due to the influence of several factors, such as communication issues²⁵. Difficulty in decisions can come from patients and their family/support network, or even from the professionals themselves (n=2). In situations in which the family plays a large role, attempts may be made to protect the patient from illness by omitting clinical information (n=3), which characterizes a dilemma from an ethical point of view.

An attempt was reported to circumvent the pact of silence created by the family (n=1) to ensure the individual’s autonomy and choice at the end of life. Difficulties can result in a conspiracy of silence, an implicit or explicit agreement with the family, friends, or professionals hiding the diagnosis or prognosis²².

“Sometimes the patient arrives with a diagnosis of cancer and the family comes in saying: ‘Doctor, he doesn’t know what he has. He thinks it’s chikungunya.’ But in the medical records there is the family decision not to tell. At first, the team respects it, but it start talking to the family about the individual’s autonomy, that they have to

know the [condition] severity, their pathology, and choose their end of life” (P4).

Observed or expected gains and losses

According to research participants, ensuring that the patients will participate actively in their health-disease process and actions to be taken when they are unable to express themselves has gains and losses. The following gain subcategories were revealed: security in decisions (n=4), autonomy (n=3), psychological comfort (n=1), strengthening of care, and quality of life (n=1). Among the losses, the following were listed: cognitive impairment (n=1), hindering contextual aspects (n=1), regrets (n=2), excessive technicality combined with the lack of analytical thinking (n=3), and lack of confidence in the AD (n=1).

Security in decision making was approached by the participants (n=4) as a gain, generating comfort and support for action, since:

“It would resolve some ethical issues for professionals, it would provide more professional support for some who have concerns and fears. AD brings greater comfort to professionals who know it” (P8).

Advance directives, as it expresses the patient’s values and preferences, increases security for the professional, as they can act in a forceful manner, in addition to facilitating consensus and clarity for the multidisciplinary team in relation to care²⁶. The findings of this study point to the exercise of autonomy as a gain provided by the instrument at times when expression is compromised. AD legitimizes the individual’s will, respecting their autonomy, freedom, and dignity²⁷. As reported, the patient, when exercising their autonomy, can benefit from the psychological comfort of knowing that their wishes and values will be respected.

“I think that the directive, the PC come to help and provide a dignified death, quality of life in death. I think the AD comes to strengthen patient care” (P5).

“It is very important to improving a psychological condition [of the patient] even in such an adverse situation, because they realize that certain things will be done as to what they want, the future, the after-death situation, the family members taking some action. This has a very good impact” (P1).

The following were listed as possible obstacles to AD: lack of analytical thinking on the part of the team regarding the directive and the circumstances of its use (n=2), professional's technical language (n=1), patient's cognitive impairment (n=1), and patients' low education level (n=1). The lack of analytical thinking with regard to the directive and the circumstances of its use (n=2) can cause problems in the future, as well as a limited reading, as it can add more technicality to an already very technical process. Furthermore, it can allow healthcare professionals and institutions to exempt themselves from responsibility for and involvement with these issues, taking refuge in a general norm or rule⁵.

In addition, there is the excessively technical language, which can pose difficulties in the ability to communicate, considered one of the pillars of PC and should be continually improved²⁸. Finally, it may also represent the professional's fear of facing the patient's emotional reactions²⁹.

The risk of lack of confidence in the AD on the part of the agent (n=1) was highlighted as a loss, which can be justified by emotional unpreparedness, showing the need for prior conversations with the person who is the patient representative and makes decisions.

"Regarding the AD, there is a person who would be responsible for making decisions for you, and you should have already spoken to them beforehand. But this is in theory, in practice, sometimes, I choose a person who is not ready for these confrontations from an emotional point of view, and then this person ends up saying 'oh, do everything'; it is a big danger" (P8).

The agent's lack of confidence in the AD is an important issue to be considered by the patient who decides to define their ADs, because, when choosing a specific person, their reliability and emotional preparation should be assessed. The professionals are who execute the directives directly and need to respect what the patient would like to be done even if it goes against family members, according to CFM Resolution No. 1,995/2012³.

It is worth highlighting that decisions involving ethical issues in health have to be preceded by the analysis of the principles of bioethics, autonomy

(clarification and participation in the health-disease process), beneficence (maximizing good), non-maleficence (not causing harm), and justice (fair and equitable treatment)¹⁹.

Implementation of advance directives

The professionals' perception of the possibility of implementing AD was reported as positive (n=5), conceived as a close reality, regardless of palliation. However, it was found that there could be variations in receptivity (n=3), depending on the dialogue, the team approach, and technical preparation.

"It can be easy, it can be difficult. What I think is crucial is the team technical conduct: knowing how to approach our patients, because their profile is different from that of a private hospital" (P8).

AD integration into the team and technical/professional adequacy were highlighted (n=3) as necessary in the face of possible implementation, in addition to being justified, in part, by the professionals' training deficit, who arrive at the work context without the appropriate knowledge. Death or finitude were considered taboo (n=2), as shown in this statement:

"We leave the undergraduate course with a deficit. We are trained in curative care, so when it comes to the palliative part, it may not be accepted, but I think they would be interested in talking about it. Health professionals have little training in this, because it involves many dimensions: physical, psychological, social, spiritual, affective, etc. It's a huge challenge. The professional needs to acquire knowledge that the undergraduate degree does not provide" (P7).

Failure in academic training results in the professional's inability to deal with palliation and adjacent topics. Perceiving the topic as a taboo contributes to unpreparedness when faced with life-threatening situations and therefore it increases the suffering of patients, families and the team itself²⁸. It is necessary to democratize the topic and naturalize discussions, at a technical, professional, or personal level.

In practical terms, some professionals mentioned the AD informality (n=2), stating that, during care, the verbalization of the patient's

wishes has an AD value for the team, although they feel more protected by means of a specific document. Nowadays, although there are no sufficient laws to support the instrument, it is essential that its expressions are respected²⁶.

In the current scenario, the processing of Law No. 149/2018 30, which provided for the AD, has ended, which impacts negatively the visibility of the topic in the political sphere and reinforces the legal uncertainty of the instrument. The contribution of the instrument to clinical decisions was evident, in addition to the possibility of strengthening the positive perception of care (n=2). Both aspects indicate gains arising from the expression of the patient's wishes, as they can feel seen and recognized in their uniqueness.

Decisions instill responsibility in those who make them, and having the possibility of sharing the decision-making process with the patient, adapting their clinical needs to the values and wishes expressed, can provide a greater security for the professional. The quality of care provided and its results depend on the level of information and decision-making sharing³¹.

Possible adversities in the AD implementation involved the need for team integration (n=2), lack of technical/professional adequacy (n=1), hindering contextual aspects (n=1), resistance to learning new things (n=1), accumulation of professional duties (n=1), severity of the patient's clinical condition (n=1), and need for a specific legal basis (n=1). Regarding the complicating contextual aspects, the passive stance of some patients in the face of illness stands out, as well as their low level of education, which can lead to little or no adherence. Furthermore, there are also adversities regarding health professionals, who, for being overloaded, may see the instrument as an accumulation of duties (n=1).

"Our patients are simple people. I don't believe they would demand much of this: 'I want to give my opinion first.' It's the low education level, the high degree of vulnerability of the patients who arrive here, more and more people arrive with greater difficulties, unemployed, not literate. There is no such guidance, there is no such thing as questioning doctors, what they want or don't want, they come and say 'whatever you do here is fine, I'm being well looked after, I'm very

grateful.' So, one of the biggest obstacles is the level of vulnerability, of formal education" (P3).

"Some people are resistant to learning new things, they think that 'it's just another task for me, it's just another assignment,' they end up seeing it as an accumulation of work within the functions that each person already has. Some people may see it that way" (P2).

Considering the instrument an accumulation of duties may indicate some level of work overload or occupational stress, elements that can cause harm to the professional's health and the quality of the care provided. In this sense, these professionals should be aware of their physical and mental health, as well as other stressors³².

The following skills and abilities regarding AD were considered important: instrument technical/professional adequacy (n=8), empathy (n=1), good communication (n=1), analytical skill (n=1), and personal preparation (n=3). Such findings highlight that the professional has to undergo technical training to act and make decisions about AD, besides social skills training to deal with patients, which is supported by the literature.

A study³³ also pointed out the following as the main barriers to implementing AD: lack of adequate conduct when dealing with symptomatic control, discomfort in talking about care, and emotional discomfort in addressing issues involving finitude. As for the facilitating factors, the following were listed: training and level of knowledge in the area; communication between professionals, specialized teams, patients and family members, and the need for professionals to get basic training to improve the approach to patients with palliative needs.

Faced with an instrument that highlights human finitude, technical skills and personal preparation are essential. In addition to technical skills, the professional should have psychological resources to be able to deal with human finitude, as well as humanitarian and emotional skills²⁸. It is essential that they understand their own emotions in the face of the demands commonly emanating from the contexts of using AD.

Finally, the professional should have emotional intelligence, understood as the ability to recognize

their psychological state and know what to do to improve it, if necessary. Therefore, the training to be offered should cover both technical and emotional aspects³⁴.

Final considerations

This study allowed us to approach the AD use in the hospital context by investigating how professionals from different academic health backgrounds perceive the instrument. It was noticed that AD is well accepted, as it ensures the exercise of patient autonomy, strengthens the perception of care, facilitates decisions, and provides psychological comfort to the patient. However, there are adversities to be overcome, such as the lack of technical adequacy and

team integration, as well as the accumulation of professional duties, the legal informality of the instrument, human finitude as a taboo, and society's lack of knowledge of AD.

Among the limitations of this study, the sampling of only one institution can be listed, since plural realities can add other cultural and contextual elements to the discussion. Despite progress in discussions, this work identified the persistence of ethical dilemmas experienced by the team: impotence, autonomy versus professional conduct, patient's wishes versus family's wishes, patient's choice versus participation in the decision-making process, insecurity in deciding, and conspiracy of silence. It was also possible to observe a common link between the categories: communication. This reveals its importance for health care, including discussions about AD.


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Anne Karolyne Santos Barbosa – Graduate (specialist) – barbosaannekarolyne@gmail.com

 0000-0003-2917-8112

Walter Lisboa – PhD – walterlisboa@academico.ufs.br

 0000-0001-5798-6737

Anali Póvoas Orico Vilaça – Master – analiorico@gmail.com

 0000-0003-1807-5986

Correspondence

Anne Karolyne Santos Barbosa – Av. Marechal Rondon, s/n, Jardim Rosa Elze CEP 49100-000. São Cristóvão/SE, Brasil.

Participation of the authors

Anne Karolyne Santos Barbosa participated in the conceptualization, methodology, investigation, review, and editing. Walter Lisboa collaborated with the conceptualization, methodology, review, and editing. Anali Póvoas Orico Vilaça participated in the conceptualization, methodology, review, and editing.

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