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## PALLIATIVE CARE: PRINCIPLES AND VALUES

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**ABSTRACT: INTRODUCTION:** In this work, we present a literature review about palliative care, from a perspective of the principles and values that underlie it. Palliative Care (PC) is an approach that promotes the quality of life of patients and family members, who face illnesses that threaten the continuity of life, through prevention and relief of suffering. **METHODOLOGY:** This is a literature review, of a narrative type, which aims to describe palliative care and its principles and values, from a theoretical point of view, through materials that have already been published on the topic in question, through analysis and interpretation of literature. The inclusion criteria were: articles in Portuguese and English; published between 2019 and 2024 and which addressed the themes proposed for this research, review-type studies made available in full. The need to expand services dedicated to palliative care is discussed. **RESULT AND DISCUSSION:** Palliative care requires the early identification, assessment and treatment of pain and other problems of a physical, psychosocial and spiritual nature. This work seeks to identify and address the principles and values of palliative care, contributing to the study, deepening and dissemination of this topic in academia, professionals and society in general. **CONCLUSION:** The propagation of the subject contributes to the debate within the scope of public health policies and assists in the process of training and training professionals to act with competence and respect for human dignity until the last moments of sick people's lives.

**Keywords:** Care; Palliatives; Principles; Values

## INTRODUCTION

PC, according to the World Health Organization (WHO), is defined as an approach that values the quality of life of patients and their families in facing problems caused by life-threatening diseases, through the prevention and relief of suffering, identification early, correct assessment and treatment of pain and other physical, psychosocial and spiritual problems (World Health Organization [WHO], 2002).

PCs are recommended in cases of advanced, progressive and incurable illnesses; in the lack of response to specific treatment; in the presence of numerous intense, multiple, multifactorial and changing symptoms; in the presence of great emotional impact on the patient, the family and the care team, related to the explicit presence or not of death; and life prognosis of less than six months (Pessini and Bertachini (2006),

The importance of alleviating pain and suffering implies not only presenting empathetic care, but collaborating in making informed decisions, which reflect the values/identity of each patient, contributing to the humanization of medical actions with a new meaning of care, as expressed in the oaths taken by medical students in a tradition dating back to Hippocrates. (Schenker, 2022).

Addressing the subject in question, the general objective of this work is to address the principles and values of CP, contributing to the study, deepening and dissemination of this topic in academic, professional circles and society in general. And the specific objectives: to provide knowledge about the history and concepts surrounding CP. Our objective is to expand new discussions and debates that encourage new researchers to build new research; since the topic is dense, broad and full of taboos and prejudices, needing to be disseminated more and more.

## METHOD

This is a literature review, of a narrative type, which aims to describe palliative care and its principles and values, from a theoretical point of view, through materials that have already been published on the topic in question, through analysis and interpretation. of literature. The inclusion criteria were: articles in Portuguese and English; published between 2019 and 2024 and which addressed the themes proposed for this research, review-type studies made available in full. The exclusion criteria were: duplicate articles, available in abstract form, which did not directly address the proposal studied and which did not meet the other inclusion criteria.

The review was carried out from November to January 2024, through searches in the databases Virtual Health Library (VHL), Latin American and Caribbean Literature in Health Sciences (LILACS), *National Institutes of Health's Library of Medicine* (PubMed) and *Scientific Electronic Library Online* (SciELO). The following descriptors were used: "Care", "palliative", "principles", "values" in order to find articles relevant to the subject covered. After the selection criteria, 5 articles remained that were subjected to thorough reading for data collection. The results were presented in a descriptive way, divided into thematic categories addressing: describing the subtitles or points that were mentioned in the discussion.

## RESULT AND DISCUSSION

In principle, the term palliative was not associated with care dedicated to people with life-threatening illnesses. However, the essence of the term reveals signs of care and attention; since "palliative" is derived from the Latin "pallium", which means cloak, cloak and is related to the woolen coat that sheep shepherds use to face the cold and changeable climate (Kovács, 1999).

The humanization policy becomes the main guideline to guide reflection on health actions, seeking to increase respect and the quality of relationships built in the health context. It is the PNH that has contemplated and anchored PC since the beginnings of the PNHAH, through interventions related to the humanization of pain, humanization of care in the hospital environment, humanization of old age, communication as a humanization factor in old age and humanization at the end of life in elderly patients (Archanjo, 2010).

The philosophy of humanizing health practices not only permeates, but is central to palliative care. Several critical situations can be listed to show the extent of the need for humanization of health care in the context of PC: the progressive aging of the population, which is accompanied by a predominance of slowly evolving chronic-degenerative diseases; the increase in cancer cases; HIV infections, and other illnesses that compromise the individual and cause dependence (Carvalho, & Parsons, 2012).

With regard to aging and increasing longevity, we find that longevity is often associated with years of suffering, countless visits to doctors, and prolonged stays in hospitals. Situations that bring physical and mental consternation to the patient, their family members and caregivers.

In this scenario, palliative practices emerge to show professionals that care for people with illnesses that threaten the continuity of life must be comprehensive. This means that he must be considered as a unique, dignified human being, who has his own life story, with experiences lived and shared among family members and caregivers that are reflected, mainly, in moments of pain and anguish, which must be respected until the end. Therefore, “the importance of humanization in palliative care is essential, as this care begins from the understanding that each patient has

their own history, relationships, culture and that they deserve respect, as a unique being” (Melo, 2012).

This way, palliative medicine includes in its main motto of care, helping the patient to enjoy possible personal achievements during coping with the disease and in the last moments of life (Pedreira, 2013).

This search for more humane practices is also ensured by the principles of Bioethics, which constitutes a force combined with the CP approach. One of the principles of bioethics proposes that patient autonomy can be guaranteed through informed consent, which allows them to make their own decisions, complying with the principle of beneficence and non-maleficence (Matsumoto, 2012).

Respect and care for human beings must therefore be ensured at all times of their lives, and it is not because they are in a critical condition of illness, or even beyond the possibility of cure, that essential and special care must be forgotten, on the contrary, these ones must be used so that these patients can live in the best way possible, until the final moments of life (Pedreira, 2013).

## **PALLIATIVE CARE MANAGEMENT**

Palliative care is aimed at people with chronic degenerative conditions that threaten the continuity of life, in all clinical phases of illness, as well as in progressive cases of reduced functionality. Therefore, recognizing the profiles of patients that can be included in this definition and the natural evolution of chronic-degenerative diseases is of great importance, as it allows the early and planned start of the necessary interventions for each case, making care more personalized, providing relief of suffering, crisis management and contributing to the promotion of quality of life (Carvalho & Parsons, 2012).

The beginning of management in palliative care consists of identifying the case,

regardless of the type of care, in the ward/emergency room or outpatient, carrying out the assessment of the patient, and considering some fundamental elements that enable the understanding of the sick person, the chronology of evolution of the disease, the treatments already carried out, the current needs for the case, such as medications and proposed treatments. (Maciel, 2012)

The diseases listed by the WHO in 2019, benefiting from adequate health care due to its contribution to quality of life, supported by the principles of palliative care, according to estimates, are cardiovascular (38.5%), neoplastic diseases (34.0 %), chronic obstructive pulmonary disease [COPD] (10.3%), AIDS (5.7%) and diabetes mellitus (4.6%) (WHO, 2020).

## ASSESSMENT

As the disease progresses, even with treatment with curative intent, the palliative approach tends to be expanded. Care with the aim of healing for care with palliative intent is a continuous process, and its dynamics differ for each patient, making it a priority to guarantee quality of life, comfort and dignity. (INCA, 2022)

During the course of an illness and the grieving process, patients and families have a variable need for palliative care, according to the intensity of the problems that arise dynamically, systematized in Figure 3 of variability of needs. (SBGG, 2014)

Palliative medicine requires technical knowledge, combined with the perception of human beings as agents of their life history, determining their own course of illness and death (Maciel, 2012). The existence of different scientifically validated tools and scales helps to obtain a prognosis, helping in decision-making both by the team and by the patients and families themselves when they want to understand. (INCA, 2022)

The patient under palliative care aims to be understood as a human being who suffers physically and psychosocially. For these needs to be met, it is necessary for health professionals to rescue empathetic and compassionate interpersonal relationships as the basis for their actions and conduct, not only in developing their technical skills with improvement in diagnosing, treating, but seeking information about the patient's relationship. with their pathology, proposed therapy, situations involving everyday life, the life/death aspect, with a relationship based on respect and empathy. Although most patients want to know about their health condition, they also have the right not to receive information, and their wishes are respected. (Silva & Araújo, 2012).

Communicating bad news involves preparing the receiver, from how much the patient understands of the situation, how much information must be passed on, to the appropriate place to discuss the patient's clinical condition, developing communication with accessible, objective language, demonstrating empathy and segmented, covering a summary of the conversation, resolving immediate and subsequent doubts, preparing a plan for the next steps, being able to use various communication tools such as the bad news protocol (S Setting up; P Perception; I Invitation; K Knowledge; E Emotions; S Strategy and Summary) [SPIKES]. (Maiello, Coelho, Messias, & Alessandro, 2020)

The continuity of palliative care includes several aspects, from spiritual aspects, advance directives, end-of-life care options and legal aspects involving the Resolution of the Federal Council of Medicine [CFM], no. terminal illness of serious and incurable illnesses, the doctor is allowed to limit or suspend procedures and treatments that prolong the patient's life, guaranteeing the necessary care to alleviate the symptoms



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### **PALLIATIVE CARE TEAM**

According to Santos (2011), PC must be offered by a multidisciplinary team that contains at least: doctors, nurses, social workers and psychologists, who must ensure in a broad and optimistic way the relief of the suffering that the disease causes. In cases of chronic diseases with a high degree of fatality, the focus is on quality of life. However, all care must be offered as soon as the disease is diagnosed, ensuring the physical, psychosocial and spiritual well-being of the individual.

Professionals who seek to train in PC begin to recognize the limits of medicine, avoiding excess treatment, which is sometimes useless and futile; and they learn to respect the patient's autonomy in wanting or not to continue treatment (Pedreira, 2013). Multidisciplinary monitoring must include the "participation of: anesthesiologists, clinicians, surgeons, psychiatrists, physiotherapists, nurses, social workers and psychologists, and often, religious support is necessary".

The Palliative Care Manual for Cancer Patients also emphasizes the fundamental

importance of a complete team in the practice of this care so that the person is seen and treated from a biopsychosocial perspective. Likewise, the Palliative Care Guide records the importance of a humanized multidisciplinary team in the PC scenario.

The World Health Organization (WHO, 2002) published a list of principles that govern the performance of the multidisciplinary PC team. Therefore, the multidisciplinary team must:

1. Promote relief from pain and other unpleasant symptoms;
2. Affirm life and consider death as a normal process of life;
3. Do not accelerate or postpone death;
4. Integrate psychological and spiritual aspects in patient care;
5. Offer a support system that allows the patient to live as actively as possible until the moment of death;
6. Offer a support system to help family members during the patient's illness and cope with grief;
7. Take a multidisciplinary approach to focus on the needs of patients and their families, including grief support;
8. Improve quality of life and positively influence the course of the disease;
9. It must be started as early as possible, together with other life-prolonging measures such as chemotherapy and radiotherapy and include all necessary investigations to better understand and manage stressful clinical situations.

People outside the curative therapeutic reach generally wish to be accompanied by family members. That is why, within the principles of PC, the family must also be assisted by the multidisciplinary team, since family caregivers are highly involved in the illness of their relative who begins to live with a physical, emotional, social, material, financial and existential, especially when the

course of the disease is advanced (Floriani, & Schramm, 2006).

Accepting death as part of life still causes conflicting feelings in health professionals. Direct contact with human beings, in a state of health or illness, puts the health professional face to face with their own lives, their own conflicts and frustrations. This can sometimes lead professionals to use detachment as a defense mechanism, due to tensions arising from frequent contact with pain and suffering, fear of making mistakes and relationships with difficult patients (Mota and Martins, 2006)

Therefore, the preparation of professionals, and their incorporation into programs that integrate public health assistance, from managers and politicians, in an articulated manner, contribute to expanded palliative care, at all levels of care in the health network, achieving humanized assistance and integrative, as this incorporation can help reduce abandonment and suffering among patients and their families. The training of human resources in palliative care, including emotional preparation to deal with these patients and their families, with continuity of care for the patient in the transition from curative to palliative treatment are factors that favor humanization, comprehensiveness and the achievement of more appropriate responses to the ethical challenges experienced by teams when caring for people whose continuity of life is threatened. (Souza et al., 2015)

## CONCLUSION

CP-related activities still need to be regularized by law. We still have a huge prevalence of lack of knowledge and a lot of prejudice related to this care, especially among health professionals, hospital managers and the judiciary. CP is confused with euthanasia and the prejudice regarding the use of opioids for pain relief is enormous.

However, knowledge about PC is

increasingly necessary for the good exercise of health practices. Training at a secondary and higher technical level, as well as the training of professionals already in practice, must be the most effective way of making these professionals more prepared and multipliers of palliative practices, strengthening public policies and humanization programs of the end-of-life care.

However, competent training in palliative practices becomes even more urgent when the phenomenon of population growth in Brazil and the world is observed, in which life expectancy is increasing and medical technologies are modernizing, in order to increase longevity human.

The word death and dying in their relationship with palliative practices need to be discussed more critically and reflectively, aiming to contribute to their demystification and their taboo nature. Living with the death of patients with terminal illnesses is constant in hospitals, but most health professionals rarely discuss the issue with patients, and even less with their families, as they have difficulty dealing with the issue. The process of death and dying needs to be demystified, unraveled, studied and reflected on, so that people are better prepared for this moment, since it is an inevitable and natural phenomenon of life.

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