Chapter 143

Palliative Care Management

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ABSTRACT

Management in palliative care contemplates several important aspects, from its identification, implantation, and reception of the patient with the family, seeking to clarify doubts, expanding attention in care, within the principles of action in palliative care with reinforcement of life, its quality, until the passing of death. The study aims to assist in the applicability of palliative care plans at different levels of medical care, providing a reduction in harm and hospitalizations/interventions, alleviating pain, and suffering to the patient and his support network. Palliative care plans represent great relevance in health care, presented through a narrative bibliographic review, based on scientific data, from UpToDate, PubMed, Scielo, BVS, and Google Scholar, identifying and highlighting some challenges that discourage the collaboration of quality assistance, due to an inefficient public policy, desensitization of health managers, a predominantly paternalistic/curative medicine, the absence in the public health network of multidisciplinary professionals trained to work in palliative care, verifying the need to develop a permanent and social education, implementing patient-centered medicine and its psychosocial aspects.

Keywords: Assistance, Humanized, Identification, Guidance, Finitude.

1 INTRODUCTION

Palliative care is an approach to health care based on technical and scientific knowledge, guided by ethical and philosophical principles, collaborating with the patient's health care, becoming the central object of care, aiming to alleviate suffering in all stages of the process. getting sick and not tending to be limited to end-of-life care (Okon & Christensen, 2022). According to the World Health Organization [WHO] in 2007, it portrays the improvement in the quality of life of patients and their families according to the evolution of their pathology when used in palliative care, being necessary to carry out preventive measures, such as relieving possible suffering by identifying it early, evaluating the treatment of pain and other physical, psychosocial and spiritual problems where they are contemplated in palliative care. However, management in Brazil in palliation has slow applicability, being implemented only in the late 1990s, currently remaining with little coverage in the Unified Health System [SUS]. When analyzing the official data from the National Academy of Palliative Care [ANCP] in 2006, it was detected in the country about 40 active teams and 300 hospital beds destined for this type of care. (Gomes & Othero, 2016)

The challenges in the applicability of palliative care consist in the exaltation of curative medicine after the 20th century, with the advent of new technologies in favor of prolonging life without assessing the quality in which the patient is, contributing to the resistance of accepting human finitude, from the moment of birth. attending physician to the patient, provoking repudiation in discussing palliative care. According to (Okon & Christensen, 2022), patients who have an advanced and/or life-threatening illness are often reluctant to discuss specific issues related to prognosis or anticipatory care planning, while, on the other hand, physicians who do not have a comprehensive and structured assessment approach, run the risk of underdiagnosing distress and failing to discern the patient's real needs or preferences.

The understanding of palliative care as an aid in health care contemplates, in addition to chronic diseases, also the functionality of the patient, being one of the important points to be analyzed to contribute to the improvement of the indices in quality of life and death, not forgetting to recognize the conquests of modern/technological medicine, making a gradual and balanced transition between legitimate attempts to maintain life, when there is a real chance of recovery, and the palliative approach, through symptom control without ever disregarding the dimension of human finitude (Bertachini & Pessini, 2011 as cited in Maiello, Coelho, Messias & D'Alessandro, 2020). In 2018, the SUS published a standardization of palliative care, aiming to clarify the actions of the teams, through guidelines, deepening in a specialized way in care, accompanying health actions, from basic or chronic disease, increasing their proportion in action according to the progression of the getting sick/aging, as well as the expansion of psychological care for all individuals involved in the process and also looking at the psychosocial suffering that the disease can cause. (Costa, Magalhães & Rocha, 2019)

Palliative care is made up of several principles, from pain relief, the exaltation of life, reflection on death, not accelerating or postponing it, highlighting the psychological/spiritual aspects of patients and families, offering health care that makes it possible to live as actively as possible, in addition to coping with grief until the moment of death, with a multidisciplinary approach to focus on the needs of patients and their families, positively influencing the course of the disease, which should be started as early as possible, along with other measures to prolong the life, such as chemotherapy and radiotherapy, and include all necessary investigations to better understand and manage stressful clinical situations (Matsumoto, 2012). Maintaining empathetic communication between professionals, patients, and relatives, always acting as a team, in an interdisciplinary nature, due to its wide scope. (Maciel, 2012)

The importance of alleviating pain and suffering implies, not only providing 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 re-signification of care, as expressed in the oaths taken by medical students in a tradition that dates back to Hippocrates. (Schenker, 2022)

The comparative study by Temel, et al., (2010), exalts the importance of palliative care for the quality of life in patients with chronic diseases, comparing the care provided in the traditional model versus early palliative actions, mainly in groups of oncological diseases. Discussing better self-assessments of quality of life, with lower rates on scales that measure mood disorders, documenting less aggressive end-of-life care, in patients who received palliative care, with an average survival of three months more than compared to care in the model traditional, confirming the need for preventive and early actions at various levels of care.

This work aims to assist in the applicability of palliative care plans, at various levels of care, using a narrative bibliographical review of the planning of palliative care teams from the recognition of the case, its applicability together with the assistant team, until the death. Reaffirming the care provided to the family and the patient, giving a new meaning to life in a circumstance of therapeutic limitation, using scientifically based tools, and providing a reduction in harm through the applicability of adequate care for the clinical, psychosocial condition of the patient, with a reduction in hospitalizations, in addition to alleviating pain and suffering that could be avoided for the patient and his support network.

2 METHODOLOGY

The study is a narrative review on management in palliative care, as it is a non-systematized way of reviewing the literature, seeking updates on the subject, with theoretical support in a short period, in addition to being a more simplified process of literary review, with broader or less specific research, approaching freely, without methodological rigor and therefore subject to biases (Casarin et al., 2020). Using scientific articles, manuals, and guidelines, are available in the databases: Scientific Electronic Library Online [Scielo], Google Scholar, UpToDate, PubMed, and Virtual Health Library [BVS]. Excluding studies that did not present an abstract, and did not address the subject under study, as well as opinion articles that were not supported by a scientific database or that did not support systematic data collection.

3 RESULTS AND DISCUSSION

The present study stems from a narrative bibliographic review addressing the steps for implementing management in palliative care, from its identification and eligibility to its prognosis. Continuing with the patient's assessment, performing efficient communication, and outlining a care plan with family assistance, with illustrations/figures for fixation and realization of knowledge.

3.1 MANAGEMENT AND ELIGIBILITY FOR PALLIATIVE CARE

Palliative care is aimed at people with chronic degenerative conditions that threaten the continuity of life, in all clinical stages of illness, as well as in progressive cases of reduced functionality. Thus, 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 interventions necessary for each case, making care more personalized, affecting 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 clinic, evaluating the patient, and considering some fundamental elements that make it possible to understand the sick person, the chronology of the 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 WHO in 2019, benefiting from adequate health care by contributing to the quality of life, supported by the principles of palliative care, according to estimates, are cardiovascular (38.5%), neoplastic (34.0 %), chronic obstructive pulmonary disease [COPD] (10.3%), AIDS (5.7%) and diabetes mellitus (4.6%) (WHO, 2020).

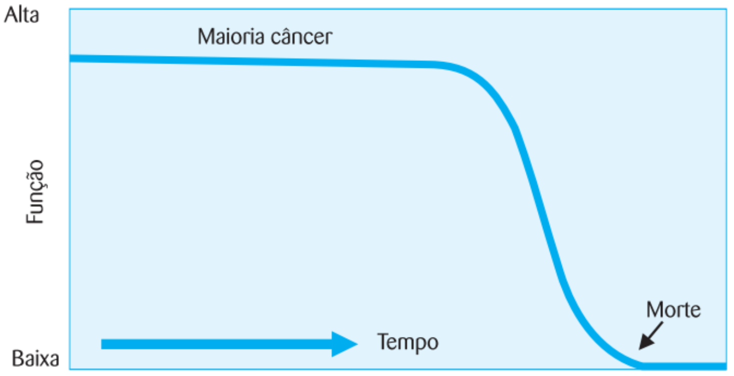
As described by Arantes (2012), when observing the difficulty in assessing and caring for the suffering of patients with chronic diseases, establishing some recommendation criteria for palliative care, considering the indication for those patients who have exhausted all possibilities of maintenance treatment or prolonging life, or who are in the terminal phase of their pathology, even if diagnosed in their first clinical manifestation (example in the Acquired Immunodeficiency Syndrome - AIDS), highlighting the suffering, opting to maintain comfort and dignity in life. One of the relevant criteria includes the assessment of prognosis and life span, with the designation of six months of life expectancy indicating actions in exclusive palliative care.

3.2 PROGNOSIS ASSESSMENT

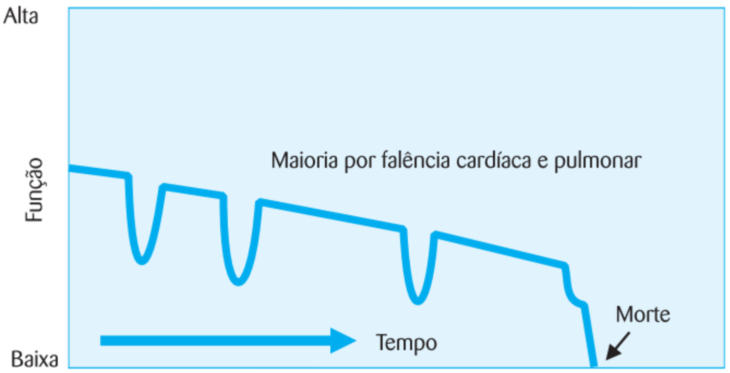
The evaluation of the prognosis represents a broad analysis of the patient from age, which in itself is not a definition, their physical/mental condition and their comorbidities, using some indications such as: heart failure with ejection fraction [EF] less than 20 % or who maintain functional class 4, with optimized medications, and who are not on the transplant list; patient with chronic obstructive pulmonary disease [COPD], with a high Body mass index, airway Obstruction, Dyspnea, and Exercise capacity [BODE] index, and with oxygen dependents who present dyspnea at rest with optimized medications; patients with a diagnosis of chronic liver disease with albumin (< 2.5 g/dl) and any existing complication; patient with creatinine clearance less than or equal to 15ml/min who will not undergo dialysis; and patient with dementia with a more reserved picture, associated with stage 7 or more on the Functional Assessment Staging [FAST] scale, plus the occurrence in the last year of at least one of the complications due to the existing condition. (Maiello et al., 2020)

In some contexts of discussions for palliative care, illustrated in figure 1, it considers the evolution of the disease through changes in functionality according to the pathology presented, with neoplasms having a greater permanence of function over time with a rapid decrease, unlike cardiopulmonary diseases, describing several oscillations representing decompensations/exacerbations with slow progression of decline, however, mental illnesses start with low functionality remaining in continuous regression over time.

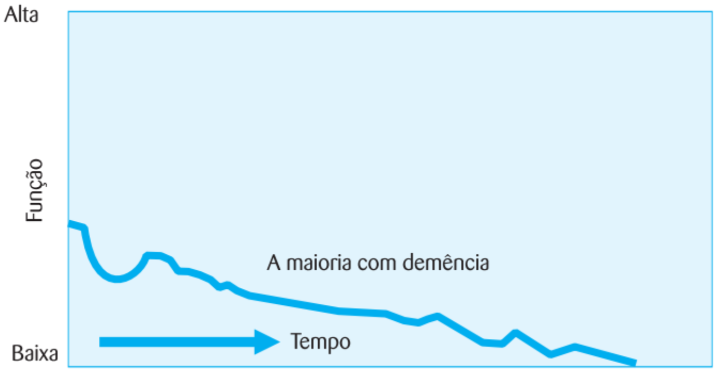
Figure 1. Varied characteristics of evolution according to the disease.



Curto período para declínio evidente



Limitações de longo período com intermitentes episódios sérios

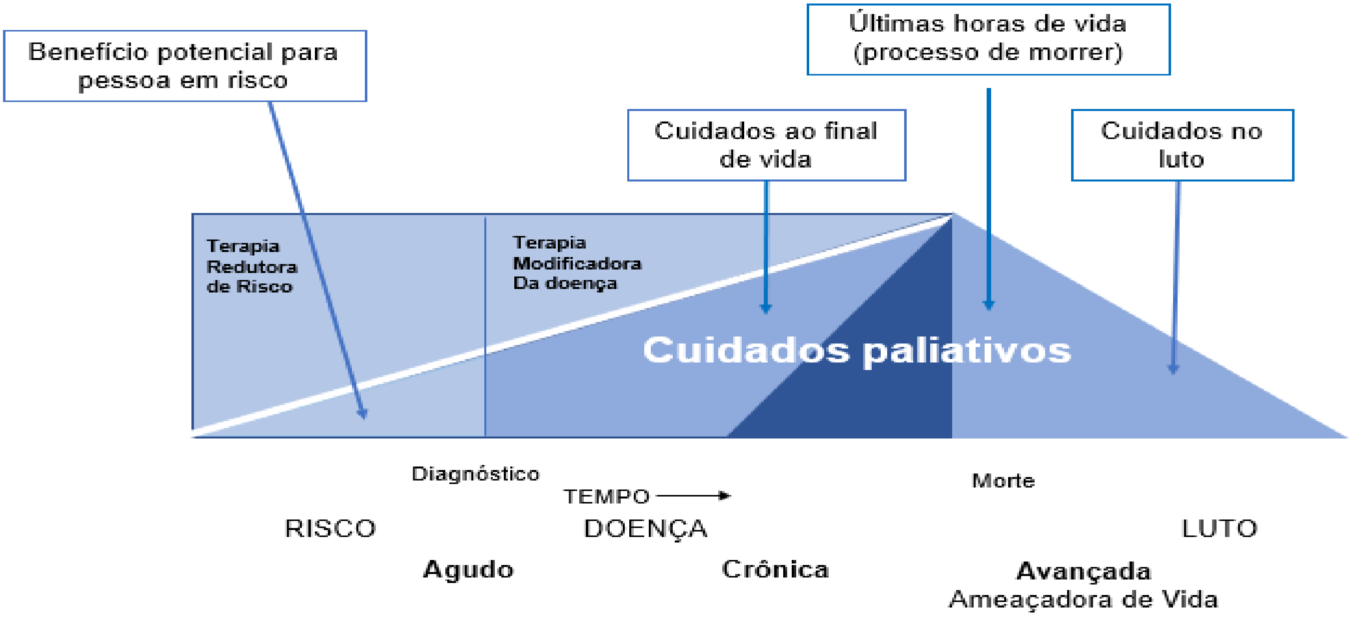


Prolongado decréscimo

Source: Adapted from Cuidado Paliativo. Conselho Regional de Medicina do Estado de São Paulo [CREMESP], 2008.

As the disease progresses, even during treatment with curative intent, the palliative approach tends to be expanded. Figure 2 describes the transition from care with a cure objective to care with palliative intent, which 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)

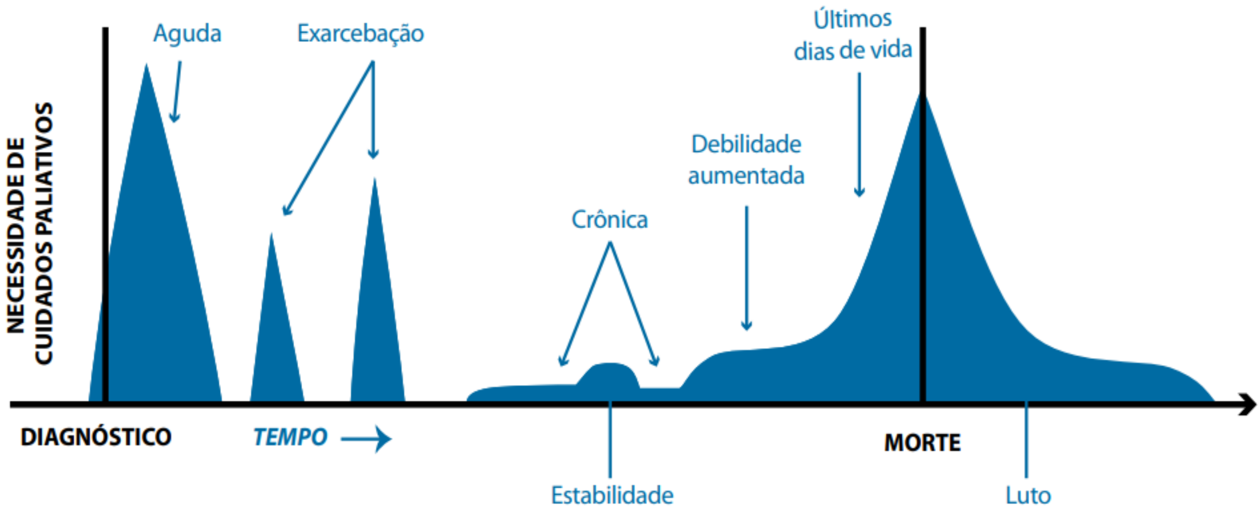
Figure 2. An integrated model of palliative care for progressive chronic diseases.



Source: Adapted from Comissão Permanente de Cuidados Paliativos da Sociedade Brasileira de Geriatria e Gerontologia. (SBGG, 2014)

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

Figure 3. Variability of palliative care needs.



Source: Adapted from Comissão Permanente de Cuidados Paliativos da Sociedade Brasileira de Geriatria e Gerontologia. Vamos falar de Cuidados Paliativos. (SBGG, 2014)

3.3 ASSESSMENT OF THE PATIENT IN PALLIATIVE CARE

Palliative medicine requires technical knowledge, combined with the perception of human beings as agents of their life history, determining their 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 their families when they want to understand. (INCA, 2022)

The instrument for identifying people with advanced and/or terminal chronic diseases in need of palliative care, initially consists of the applicability of the instrument - NECPAL-BR, contemplating some clinical parameters, from functional and nutritional decline, the presence of comorbidities, in addition to the geriatric conditions that need care, as well as general clinical indicators of pathological, clinical (oncological, pulmonary, cardiological or neurological) severity and progression. In addition, the surprise question [PS] is the first parameter of the NECPAL scale, it employs a single question to be asked to the attending physician regarding the estimate of the patient's life expectancy: “Would you be surprised if the patient died in the next 12 months ?” Patients for whom the physician answered “no” are considered positive PS indicating actions in palliation. (Orzechowski, et al., 2019)

The integration of the Karnofsky Performance Scale [KPS] in the evaluation of the patient's functionality as a percentage, classifying him as to the ability to perform active work, maintenance of self-care such as the need for frequent medical care due to the greater evidence of disease. (INCA, 2022)

Adding to the functional assessment, the Palliative Performance Scale [PPS] scale, which is important for monitoring the evolutionary curve of the disease, constitutes a valuable element in decision-making, prediction of prognosis and diagnosis in terminality, and should be used every day for patients hospitalized patients, as well as in outpatient consultations and home visits. The Edmonton Symptom Assessment Scale [ESAS] aims to analyze the patient's symptoms from admission, hospitalization, outpatient consultations, and home visits. (Maciel, 2012)

Complementing decision-making about prognosis with the application of the Palliative Prognostic Index [PPI] is a prognostic tool, validated by researchers, designed to evaluate cancer patients with advanced disease. Consisting of the sum of the value attributed to the PPS, with the values attributed to other clinical variables, namely: oral intake, edema, dyspnea at rest, and delirium. These variables, by themselves, are predictive of poor prognosis, helping to predict whether or not a patient will survive longer than three or longer than six weeks. (INCA, 2022)

Continuing with palliative care management, after obtaining a global view of the patient, allowing the applicability of stratification of a personalized care plan for the case, contributing to efficient communication between the various professionals of the team, guiding the actions planned for the patient according to their evolution. The stratifications of care plans (proportionality of care) are organized into groups, maintaining permanent support for patients and family members, addressing diagnosis, patient conduct, and prognosis, in addition to clinical, psychosocial, and spiritual assistance. (Mauriz, Wirtzbiki & Campos, 2014)

One of the groups labeled as early palliative care includes good functional status (KPS or PPS > 60%), with a care plan in case of acute clinical instability, extended care management such as referral to the intensive care unit [ICU] if indicated, receiving advanced life support in case of cardiorespiratory arrest [CPA], prioritizing curative or restorative treatment and using the principles of beneficence and autonomy. The group of palliative care called complementary, presents with intermediate functional status (KPS or

PPS between 40-60%), at this moment it is unlikely that the patient will be able to respond completely or satisfactorily to the curative treatment. However, one can benefit from invasive procedures or treatments that improve symptoms and quality of life, respecting the wishes of the patient or their legal representatives. In case of acute clinical instability, transfer to the ICU should be considered, taking into account that if potentially reversible conditions are taken into account, a limit of therapeutic effort may be defined. (Mauriz, Wirtzbiki & Campos, 2014)

The low functionality status (KPS or PPS <40%) refers to the predominant palliative care group, identifying irreversibility criteria for the underlying disease, seeking actions for the best possible quality of life, such as controlling uncomfortable symptoms (treatment of infections, correction of hydro electrolytic disorders, analgesia, etc.), respecting the principles of autonomy and non-maleficence, without futile therapies or referral to the ICU, considering the wishes of the patient or their legal representatives. (Mauriz et al., 2014)

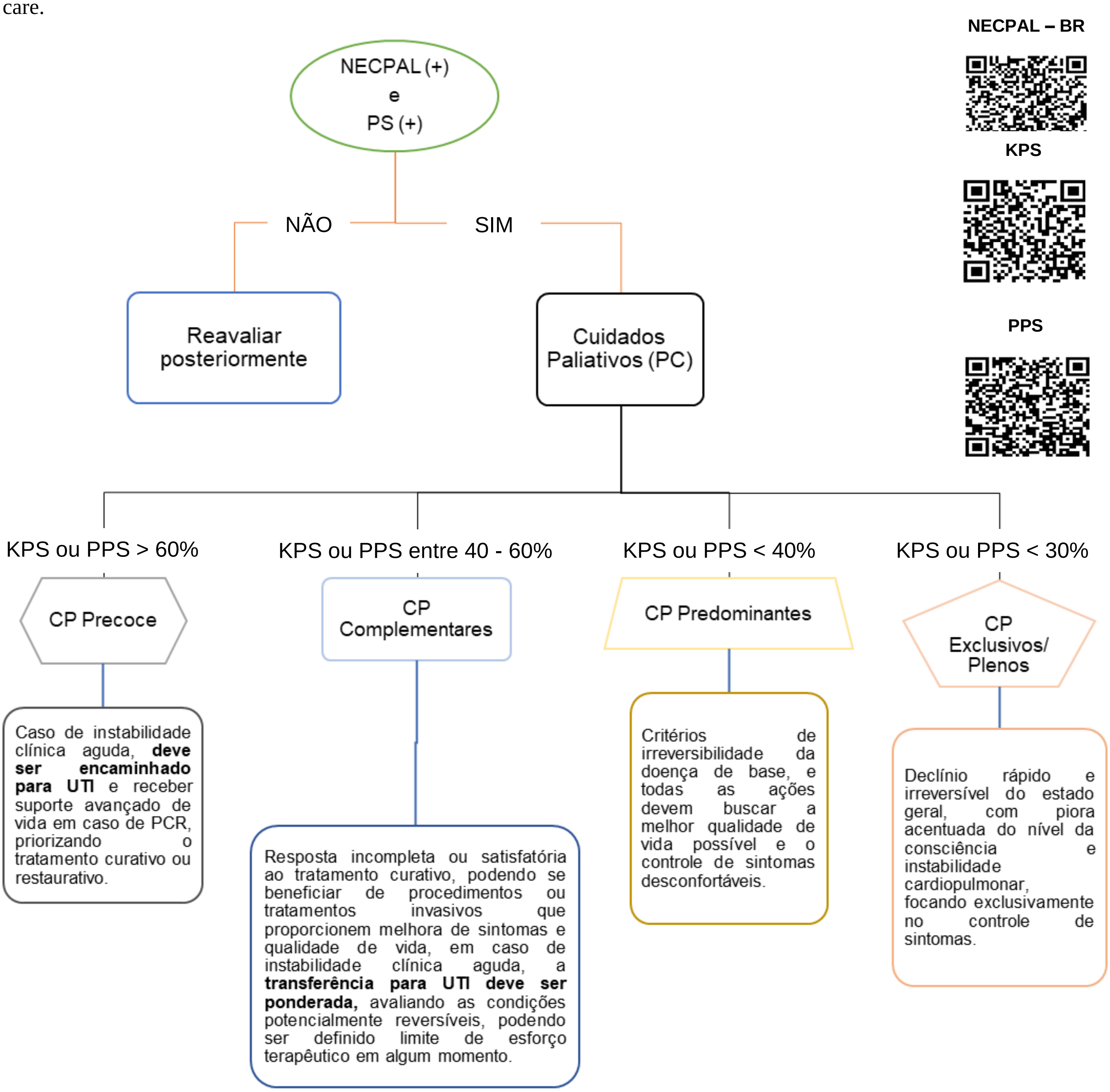
When faced with a purpose-of-life situation, with functional status (KPS or PPS <30%) or solid neoplasm with metastasis, contemplating exclusive/full palliative care, due to the rapid and irreversible decline of the general condition, with a marked worsening that may be evidenced by the impaired level of consciousness and cardiopulmonary instability, focusing exclusively on symptom control. (Mauriz et al., 2014)

3.4 COMMUNICATION IN PALLIATIVE CARE

Satisfactory communication about the finitude of life requires knowledge of pathology, with humanization and empathy to achieve an understanding of the case for the patient and family, and the existing scientific evidence does not support the common belief that communication about end-of-life issues does not increase the patient's distress. However, conversations about treatment goals are often conducted by physicians who do not know the patient, do not routinely address non-medical goals, and often do not provide enough information about prognosis to allow appropriate decisions, compromising care processes. with the patient's chronic illness and its impact on end-of-life processes. (Bernacki & Susan, 2014)

The implementation of management in palliative care illustrated in Figure 4, in principle, requires clear and empathetic communication with the patient and family, reaching an understanding of the diagnosis, and prognosis, such as care planning, adherence to treatment, and obtaining real expectations for the patient and their caregivers, generating a reduction of suffering and harm in the process. (INCA, 2022)

Figure 4. Management in Palliative Care from the identification, functional assessment, and stratification of care at all levels of care.



Caso de instabilidade clínica aguda, **deve ser encaminhado para UTI** e receber suporte avançado de vida em caso de PCR, priorizando o tratamento curativo ou restaurativo.

Resposta incompleta ou satisfatória ao tratamento curativo, podendo se beneficiar de procedimentos ou tratamentos invasivos que proporcionem melhora de sintomas e qualidade de vida, em caso de instabilidade clínica aguda, a **transferência para UTI deve ser ponderada,** avaliando as condições potencialmente reversíveis, podendo ser definido limite de esforço terapêutico em algum momento.

Critérios de irreversibilidade da doença de base, e todas as ações devem buscar a melhor qualidade de vida possível e o controle de sintomas desconfortáveis.

Declínio rápido e irreversível do estado geral, com piora acentuada do nível da consciência e instabilidade cardiopulmonar, focando exclusivamente no controle de sintomas.

Source: Adapted from Manual em Cuidados Paliativos – ANCP, (Arantes, 2012) e Protocolo Cuidados Paliativos na Atenção Básica. (Silva et al., 2021)
Notes: Instrument for identifying people with advanced and/or terminal illness and need for palliative care for use in health and social services in Brazil [NECPAL – BR]; Surprise question [PS]; Karnofsky Performance Scale [KPS]; Palliative performance scale [PPS]; Intensive care unit [ICU].

The patient under palliative care aims to be understood as a human being who suffers physically and psychosocially. For these needs to be met, health professionals need to rescue empathetic and compassionate interpersonal relationships as a basis for their actions and conduct, not only in developing their technical skills with improvement to diagnose, and treat, but seeking information about the patients relationship with their pathology, proposed therapy, situations involving everyday life, aspects of life/death, 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, their wishes being respected. (Silva & Araújo,

2012) Communicating bad news involves preparing the receiver from how much the patient understands about the situation, how much information should be passed on, to the appropriate place to discuss the patient's clinical condition, developing communication in an accessible, objective language, demonstrating empathy and segmented contemplating a summary of the conversation, solving immediate and subsequent doubts, planning 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)

3.5 CARE PLANS

Care plans for critically ill patients are an essential element of high quality, allowing clinicians to align care with what is most important to the patient. These initial discussions containing the goals of care promote a reduction in the use of non-beneficial medical care close to death, improve attributions promoted by planning, resulting positively for family members, and reduce unnecessary costs. (Bernacki & Susan, 2014)

It is considered practically impossible, according to Silva & Araújo (2012), to take complete care of an individual without considering their context, dynamics, and family relationship. Continuous and accessible information for family members is the essential element that will allow for a more serene and peaceful experience of the illness/dying process, without generating expectations that cannot be met. Take care to seek first, if the patient is lucid, the desire to share this information in a meeting or not, such as who he/she wants to be present at that moment (family members). A procedure according to Maiello et al., (2020), usually manifests itself in family members, and emotional security when perceiving the availability of the health team to listen to them, clarify doubts, and recognize them as an important part of the care provided to the patient. Presenting a new meaning of life, easing the suffering for the family, discussing the measures that can be offered to the patient, and understanding the objectives of palliative care and the limitations present in each phase of the disease until the course of death. (Maciel, 2012)

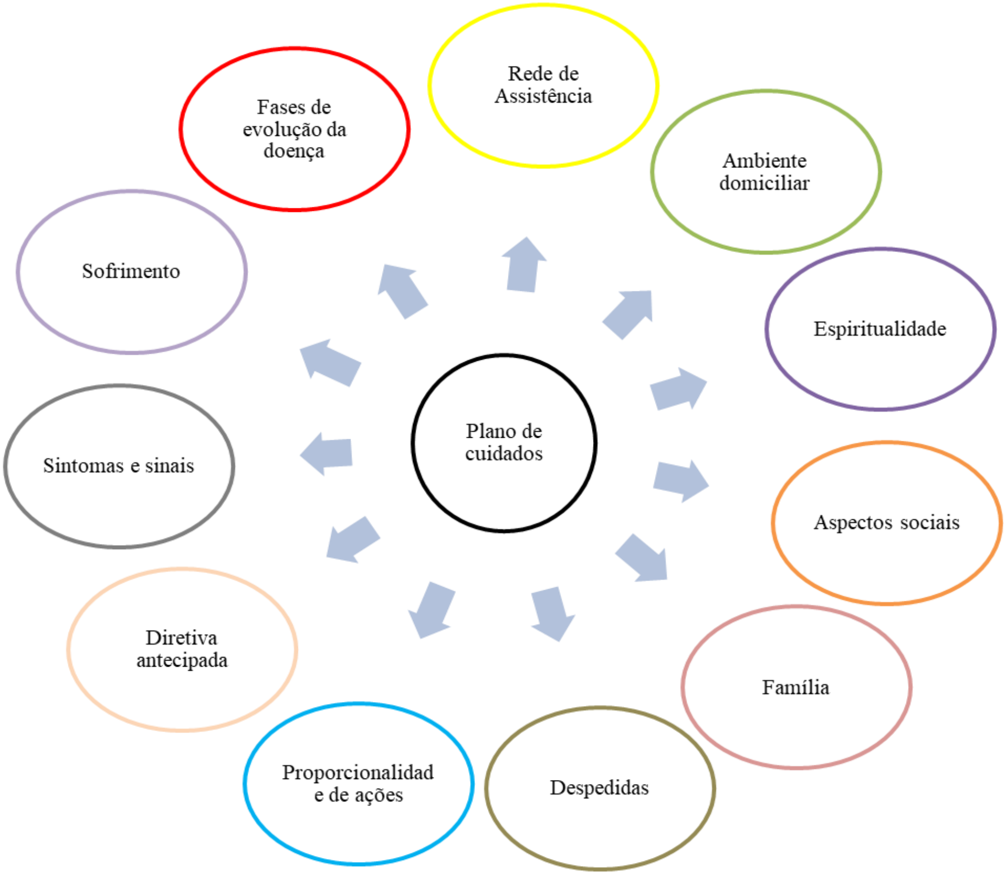
Understanding as a set of tasks and interventions aimed at relieving suffering in situations of life-threatening chronic illnesses, palliative care prioritizes active listening to the person and their family members to identify unique aspects that should support and contribute to the definition of the care plan, involves adequacy of the therapeutic effort, balancing values, risks, and benefits of each instituted measure. (Silva, Peixoto, Mota, Rodrigues & Amaral, 2018)

Palliative care presupposes a multidisciplinary approach so that care takes place in all aspects: physical, psychological, social, and spiritual. Thus, decisions regarding the indication and implementation of the necessary care must involve the participation of all members of the multidisciplinary team, establishing care priorities at all levels. Patient care implies a broad analysis of the case, from the clinical, functional, and autonomous condition, aiming to benefit from the actions/therapies provided, contributing to a better performance according to the existing need in palliative care at all levels of care (Unit of Intensive Care -

ICU, oncology, and especially in the context of long-term hospitalization). (SES-DF, 2018)

The existence of a new reorganization of the aspect of life, such as remodeling planning in an individualized/personalized way, covering the contingencies of each phase or stage of the illness process (diagnosis, recovery, relapses, complete remission or death) demands adaptations for the person, their family group and caregivers. Figure 5 is based on principles and demands related to the sick person, centering on the care actions of the multidisciplinary health team for the planning and implementation of assistance defined in the individualized care plans for each case. (Silva et al., 2018)

Figure 5. Aspects and bases of the singular therapeutic plan



Source: Adapted from Curso de Aperfeiçoamento – Cuidado Paliativo em Atenção Domiciliar: Núcleo de Educação em Saúde Coletiva (Nescon) da Faculdade de Medicina da Universidade Federal de Minas Gerais (FMUFMG). Supervisão: Ministério da Saúde/Universidade Aberta do SUS (UNA-SUS). (Silva et al., 2018)

The continuation of care by the assistant team remains exists in palliative care, through outpatient consultations and/or during hospitalizations due to possible complications/aggravations. Keeping control of the referred symptoms, mainly pain. According to Cardoso (2012), in addition to cancer pain, unlike other pain syndromes, it may be associated in 64% to 93% of patients in palliative care with intense pain, of the “breakthrough” type [DTB]. This prevalence seems to increase with the progression of the disease and with the intensity of baseline pain, using simple analgesia for mild pain, to opioids for moderate to severe pain, evaluating the need to associate it with other drugs as analgesia adjuvants.

Assistance in palliative care at home has been part of the Health Care Network - SUS [RAS-SUS] since 2016, aiming to control pain and suffering, with frequent monitoring, carried out by the multidisciplinary team of the Home Care Service [SAD], according to Ordinance No. 825, of April 25, 2016, of the Ministry of Health. Including interventions in palliative care from preventive actions, which mitigate the effects of expected disabilities, and emphasize patient education, such as the psychosocial reconstruction of the patient, through rehabilitation and support procedures, contributing to teaching patients to accommodate their disabilities, raising their autonomy and minimizing debilitating changes in their progressing disease. (Jorge & Othero, 2012)

The management of other symptoms such as nausea and vomiting has usually prescribed some antiemetics on an ongoing basis. However, dyspnea is another frequent complaint, implying a careful evaluation because it is associated with pain and/or anxiety, requiring evidence of hypoxemia for the indication of oxygen therapy. Other symptoms present such as constipation, hiccups, anxiety, and insomnia, have an important impact on medical care, requiring good communication with the patient and caregivers, to understand the existing needs, and their context, to alleviate suffering, reduce complications and evaluate possible clinical measures, according to the stage of the disease and the patient's clinical condition, contributing to the redefinition of palliative care for health professionals by individualizing the cases, according to the evaluation of the functionality and current situation of the patient. (Silva et al., 2021)

The continuity of palliative care contemplates several aspects, from the spiritual, advance directive of will, end-of-life care options, and legal aspects involving the Resolution of the Federal Council of Medicine [CFM], nº 1.805, published in 2006, which shows in the phase terminal 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 that lead to suffering, in the perspective of comprehensive care, respecting the patient's will or its legal representative. (CFM, 2006)

The multidisciplinary action seeks to encompass most of the situations that may cause suffering, from legal issues such as guidance on financial assistance (health aid), helping in the resolution of emotional and spiritual conflicts, and also contemplating the planning and discussion on the advance directive of will, describing the set of previous desires and expressly manifested by the patient, about care and treatments that he wants or not to receive at the moment he is unable to express, maintaining his autonomy, which can be changed according to the patient's will, as well as again registered and/or annulled, having the ethical support in CFM Resolution nº 1.995, published in 2012. (CFM, 2012)

Due to the frequent changes in the clinical picture, the patient permanently needs care and different therapies, which can be offered in a hospital environment, in hospice units, or at home, recommending that he remain in a place where he can be able to be care, receiving relief and comfort. In general, in the last months of life, the patient is seen at the outpatient clinic, but the consultation is mainly aimed at alleviating pain, abdominal discomfort, insomnia, depression, and fear of dying, among others. (Chino, 2012) Preparation of the home environment for end-of-life care should be carried out if the decision is to die at home. These are moments of farewells, conclusions of negotiations, reconciliations, and evaluation of the pre-existing desire, with the redirection of hope and a spiritual approach (Silva et al., 2018). This consists of one of the fundamental pillars in palliative care, as proposed by the WHO, with the inclusion in the care of patients who are in a situation of life-threatening illness, easing suffering and pain in a situation that can be something transformative, and result in growth, but it can also be desperate and distressing. (Puchalski, Ferrell, Otis-Green & Handzo, 2016). The spiritual need of the patient with a life-threatening illness is considered urgent, as he experiences suffering due to the proximity of death and the multidisciplinary team must help him to face the process of mourning and mourning. (Evangelista et al., 2016)

For the grieving process, some protective factors contribute to the healthy elaboration and some risk factors influence the emergence of a complicated grieving process, in which the characteristics of bereavement can be experienced with greater intensity, making the flow of mourning difficult. process (not in the same way as before) or get stuck. Other manifestations of complications are the absence of feeling (reactions) as if the subject had not experienced any loss, or they are experienced late, with the bereaved having greater difficulty in reestablishing security and adaptation after the loss (Parkes, 2009). The type of loss (death, security, health, routine, financial) experienced does not qualify or quantify grief, it is important to recognize the feelings involved and seek support from the multidisciplinary team, friends, family, and spirituality itself. (Maiello et al., 2020)

Therefore, the preparation of professionals, and their incorporation into programs that integrate public health care, from managers and politicians, in an articulated manner, contribute to expanded palliative care, at all levels of care in the health network, achieving humanized care and integrative, since this incorporation can help to reduce the abandonment and suffering of patients and their families. The training of human resources in palliative care, including emotional preparation to deal with these patients and their families, with the continuity of patient care 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 in caring for people whose life continuity is threatened. (Souza et al., 2015)

4 CONCLUSION

Attention to palliative care in Brazil represents a small portion of the action in public health, when observed worldwide, making evident the enormous evolutionary disparity regarding palliative care, due to the implementation of recent public policies, desensitization of health managers, the predominance of paternalistic and curative medicine, with little availability of actions in palliation in the SUS. The present study on the management of palliative care contributes to its applicability at all levels of care, favoring an increase in the quality of life of the evaluated patients, reducing hospitalizations, improving the administration of public inputs, easing the pain and suffering of the family, performing humane and empathetic assistance in the process of becoming ill and dying, reaffirming the need for multidisciplinary professionals trained for its expansion and dissemination in the health network, collaborating for future work in the implementation of palliative actions, developing permanent and social education, mainly in medical specialties, with the perpetuation of patient-centered medicine and its psychosocial aspects.

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