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REFLECTION ARTICLE

Nurse communication in palliative care in oncology

Comunicación de enfermería en cuidados paliativos en oncología

Comunicação do enfermeiro nos cuidados paliativos em oncologia

Renata Marli Costa Miranda[1*]
ORCID: 0000-0002-8208-6914
Italo Frizo[1]
ORCID: 0000-0002-9736-3785
Cláudia Rosana Trevisani Corrêa[2]
ORCID: 0000-0002-3458-8666
Anelvira de Oliveira Florentino[1]
ORCID: 0000-0001-8628-0565
Jéssica Alessandra Pereira[1]
ORCID: 0000-0002-6307-0343
Samoel Mariano[1]
ORCID: 0000-0002-8395-2685
Kayo Augusto Salandin Pacher[1]
ORCID: 0000-0002-0623-6669
Natália Stevanato Silva[1]
ORCID: 0009-0007-6719-0725
Tereza Raquel Schorr Calixto[2]
ORCID: 0000-0001-5708-5082
Márcia Regina de Oliveira Nicola[1]
ORCID: 0009-0001-5733-9350

[1]Faculdade de Ensino Superior Santa Bárbara. São Paulo, Brazil.
[2]Universidade Estadual Paulista. São Paulo, Brazil.

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***Corresponding author:**
renatamcmiranda@gmail.com

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Abstract

This study aimed to analyze the different approaches to communication and care for people with life-threatening diseases in cancer patients, promoted by employees and multidisciplinary work groups that expand as the disease progresses. Since communication is essential in palliative care, accompanied by the triad of care, pain control, teamwork, family, and patient. This is a reflection study, to gather the scientific knowledge already produced on the subject investigated, and to obtain a better understanding of the theme based on previous studies. It was found that communication is the basis of the nursing team's care in palliative care. There is a great need to implement models that generate standardization for humanized care with efficiency and quality. It is concluded that to carry out the practice of palliative care, communication is essential for health professionals. However, it is necessary to improve knowledge through continuing education in the profession and always be aware of everything that involves the area and the patient's life.

Descriptors: Palliative Care; Oncology Patients; Oncology Nursing; Communication; Humanization.

Resumén

El objetivo de este estudio fue analizar los diferentes enfoques de comunicación y atención a personas con enfermedades potencialmente mortales en pacientes oncológicos, promovidos por empleados y grupos de trabajo multidisciplinarios que se expanden a medida que la enfermedad progresa. Dado que la comunicación es esencial en cuidados paliativos, acompañada de la tríada de atención, control del dolor, trabajo en equipo, familia y paciente, este estudio de reflexión busca recopilar el conocimiento científico ya generado sobre el tema investigado, para una mejor comprensión del mismo con base en estudios previos. Se encontró que la comunicación es la base de la atención del equipo de enfermería en cuidados paliativos. Existe una gran necesidad de implementar modelos que generen estandarización para una atención humanizada con eficiencia y calidad. Se concluye que, para ejercer los cuidados paliativos, la comunicación es esencial para los profesionales de la salud. Sin embargo, es necesario mejorar el conocimiento mediante la formación continua en la profesión y estar siempre al tanto de todo lo que involucra el área y la vida del paciente.

Descriptores: Cuidados Paliativos; Pacientes Oncológicos; Enfermería Oncológica; Comunicación; Humanización.

Resumo

Objetivou-se analisar as diferentes abordagens na comunicação e no atendimento e cuidados às pessoas com doença que ameaça a continuidade a vida em pacientes oncológicos promovido por funcionários e grupos de trabalho multidisciplinar que se amplia à medida que a doença avança. Uma vez que a comunicação é fundamental nos cuidados paliativos, acompanhado da tríade do cuidado, controle da dor, trabalho em equipe, família e paciente. Trata-se de um estudo de reflexão, com finalidade de reunir o conhecimento científico já produzido sobre o tema investigado, a fim de obter-se um melhor entendimento sobre a temática baseando-se em estudos anteriores. Verificou-se que a comunicação é à base do atendimento da equipe de enfermagem nos cuidados paliativos. Há uma grande necessidade de implantação de modelos que gerem a padronização para um atendimento humanizado com eficiência e qualidade. Conclui-se que para efetivar a prática do cuidado paliativo, a comunicação é indispensável para os profissionais da saúde. Contudo, é preciso aprimorar os conhecimentos através da educação permanente na profissão e sempre estar atento a tudo que envolve a área e a vida do paciente.

Descritores: Cuidados Paliativos; Pacientes Oncológicos; Enfermagem Oncológica; Comunicação; Humanização.

Introduction

The term palliative comes from “pallium”, which means cape, cloak, or something that protects. It was used to define the cape of medieval knights. It is something that protects against the cold, the elements, and difficulties. Some researchers believe that palliative care dates to ancient times, and in the Middle Ages, monasteries commonly provided support and shelter, as well as protection and comfort, to alleviate human suffering. It was also common to find hospices (inns) during this period (the period of the Crusades), and so monasteries welcomed those in need, not only for healing, but also for protection and relief from suffering[1].

The Order of the Sisters of Charity of Paris, founded by the priest Saint Vincent de Paul, opened numerous homes for the sick, beggars, orphans, and the dying. Not satisfied, in 1902, they founded St. Joseph’s Hospice to shelter the poor at the end of their lives. Cicely Saunders, a nurse, dedicated herself unconditionally to the comfort and relief of all human afflictions. The first service dedicated to the complete care of the patient was founded in 1967, St. Christopher’s Hospice, offering relief from pain and psychological suffering to terminally ill patients[1].

Palliative care is active and comprehensive health care provided to people with serious, progressive, and life-threatening illnesses and should be initiated as soon as possible. According to the National Cancer Institute (INCA), it always aims to improve quality of life, helping to manage difficult-to-control symptoms to improve the patient's clinical condition[2].

It is common knowledge that for highly competent and skilled care, fundamental elements are necessary, including the development of communication and interpersonal skills. Through communication mechanisms, such as listening, instructing, accepting, and learning, nurses ensure an increase in interpersonal relationships with their patients and family members[3].

Study[3] highlights that when understanding the development of the disease, interventions, and prognoses, the patient experiences numerous feelings during the illness process. Therefore, communicating bad news is one of the most complex responsibilities faced by nurses, doctors, and other team members. Since this is the beginning of the patient's journey in the process of understanding the disease, symptoms, and treatment, any unnecessary trauma generated at this beginning may affect the patient's entire survival in palliative care.

According to the World Health Organization (WHO), in a concept defined in 1990 and updated in 2002, “Palliative Care consists of assistance provided by a multidisciplinary team, which aims to improve the quality of life of the patient and their family members, faced with a life-threatening illness, through prevention and relief of suffering, through early identification, impeccable assessment and treatment of pain and other physical, social, psychological and spiritual symptoms”[4].

Palliative care is provided by a multidisciplinary team and is expanded as the disease progresses. It takes care not only of the patient, but also of their psychological, social, and spiritual aspects. This multidisciplinary team strengthens support for the family so that they can go through the process of dying, providing relief from pain and other symptoms related to treatment, and supporting their anguish and fears. Furthermore, coping with death naturally, without delaying or prolonging it, is the basis of palliative care for the patient. This multidisciplinary and multiprofessional team is made up of doctors, nurses, physiotherapists, nutritionists, social workers, psychologists, speech therapists and pharmacists, and caregivers, who accompany family members and the team in favor of the well-being of the patient and the family[2,5]. Furthermore:

> *“Palliative care should include the necessary investigations to better understand and manage complications and stressful symptoms related to both treatment and disease progression. Despite the negative or passive connotation of the term, the palliative approach and treatment should be eminently active, especially in patients with advanced cancer, where some types of surgical and radiotherapy treatment are essential to achieve symptom control. Considering the devastating burden of physical, emotional, and psychological symptoms that increase in patients with terminal illness, it is necessary to adopt early dynamic and active therapeutic approaches, respecting the patient's own limits in the face of their incurable situation”*[4].

Palliative care is based on principles, not protocols as many people think. The proposal is to guide the care priorities for critically ill adult patients admitted to Intensive Care Units through the principles of palliative care, by: raising awareness among professionals who care for critically ill patients, especially in Intensive Care settings, about the importance of Palliative Care; establishing actions and criteria to guide the identification, assessment and care of critically ill patients, especially those admitted to Intensive Care; creating an environment conducive to shared decisions about treatment for patients at the end of their lives; respecting patient autonomy and, when available, Advance Directives of Will; the possibility of suspending or not introducing futile measures for patients at the end of their lives, aiming at the practice of orthotanasia[6].

According to the National Academy of Palliative Care (ANCP)[1], there is no longer talk of terminality, but of a life-threatening illness. For the first time, there is talk of spirituality, and the family is remembered and assisted after the patient's death and the period of mourning. In this sense, it is worth noting that palliative studies view the possibility of death as a natural event in life in the face of a certain illness, always focusing on the person and the life that can still be lived. The study proposes assertive communication with the team, both nursing and the multidisciplinary team, thus avoiding misunderstandings. Since communication is fundamental in palliative care, accompanied by the triad of care, pain control, teamwork, family, and patient. This involves an approach to all dimensions that involve the human being facing a life-threatening illness.

In view of the increase in life expectancy of the Brazilian population, palliative care is extremely important for public health. It is essential to raise awareness among health professionals so that the Brazilian health system can remodel the treatment of patients who have life-threatening diseases[1].

Effective communication serves as an essential therapeutic resource. It is noteworthy that health professionals, at various levels of seniority, still face difficulties when it is necessary to communicate bad news and in the terminal phase of human life. It is not about having an attitude against medicine and life, but rather reflecting on how to deal with death. It is important to seek a balance between scientific and human conduct, restoring dignity and the possibility of dying in peace[7].

Cancer is the world's leading public health problem, ranking as one of the leading causes of death and, consequently, one of the main barriers to increasing life expectancy. In most countries, it is the leading or second leading cause of premature death before the age of 70[8].

The incidence and mortality rates from cancer are increasing rapidly worldwide. This increase is mainly due to the demographic and epidemiological transitions that the world is undergoing. Aging, changes in behavior and the environment, including structural changes that impact mobility, recreation, diet, and exposure to environmental pollutants, are all contributing to an increase in the incidence and mortality rate from cancer. The cancers that cause the most deaths in Brazil are trachea, bronchus, and lung; colon and rectum, and breast[8].

Palliative care phases are the care directed at people with serious illnesses that threaten the continuity of life. According to palliative care guidelines, care is not based on protocols, but rather on principles, as mentioned above. The following principles can be cited: affirming life and considering death as a normal process of life; neither accelerating nor postponing death; integrating psychological and spiritual aspects into patient care; offering a support system that enables the patient to live as actively as possible until the moment of death; offering a support system to assist family members during the patient's illness and in coping with grief; ensuring a multidisciplinary approach to focus on the needs of patients and their families, including support during grief; improving quality of life and positively influencing the course of the disease; and starting as early as possible, together with other therapeutic measures[6].

It is also worth highlighting principles that clarify the concept: death should be understood as a natural process, part of life, and quality of life is the main clinical objective; palliative care does not hasten death, nor prolong the dying process; the family should be cared for with as much commitment as the patient. The patient and family members form the so-called care unit; symptom control is a fundamental objective of care. Symptoms should be routinely assessed and effectively managed; decisions about medical treatments should be made ethically. Patients and family members have the right to accurate information about their condition and treatment options; decisions should be made in a shared manner, respecting ethnic and cultural values; palliative care is necessarily provided by an interdisciplinary team; the fragmentation of health has been a consequence of the sophistication of modern medicine[9].

In contrast, palliative care also encompasses the coordination of care and provides continuity of care; the experience of illness must be understood globally and, therefore, spiritual aspects are also incorporated into the promotion of care; and care does not end with the death of the patient, but extends to support the family in mourning for as long as necessary. Thus, it is possible to list the following as the main guiding principles of palliative care: prevention and control of symptoms; psychosocial and spiritual intervention; patient and family as a unit of care; autonomy and independence; communication and multidisciplinary teamwork. The nurse in palliative care has a fundamental role, as it is his or her job to act in pain relief (or reduction) to support the patient while maintaining his or her dignity. In addition, the nurse administers medication and ensures that there are no other symptoms that cause stress to the patient[10].

Nurses work under the Nursing Process, providing health education, guidance, and emotional and social support to patients and their families. First, the nurse conducts a consultation, which involves assessing and identifying the problem. After this initial contact, the professional establishes a diagnosis that will outline the most appropriate care plans for each patient. Through palliative care, a differentiated view of the patient is applied, focusing on alleviating suffering, providing comfort, and ensuring human dignity[11].

According to a study[10], unfortunately, palliative care training is rarely included in the educational curriculum of health professionals. Furthermore, the availability of pain medications – the most basic topic when it comes to minimizing patient suffering – is woefully inadequate in much of the world, often due to concerns about their illicit use and drug trafficking.

This study aims to demonstrate the benefits of clear and objective communication, seek engagement among individuals, stimulate nursing professionals' knowledge and assertiveness in communication with the team, thus avoiding misunderstandings, and respect the diverse opinions and choices of patients. Thus, the objective was to reflect, verify, and analyze the different approaches in communication in palliative care for cancer patients. In addition, it seeks to answer the following question: "How important is good communication by nurses in palliative care in oncology?".

Methodology

This study, based on a critical reflection of the literature, sought to analyze and interpret the scientific knowledge already produced on the topic investigated, promoting an in-depth analysis that goes beyond the simple synthesis of information. The methodological approach adopted involved a systematic process, starting with the delimitation of the topic and formulation of the guiding question, followed by the definition of selection and exclusion criteria, and culminating in the critical interpretation of the data, to articulate the evidence to the theoretical-practical context of the research.

The sources consulted included the Latin American and Caribbean Literature on Health Sciences (LILACS), the Nursing Database (BDENF), the Scientific Electronic Library Online (SciELO), the National Cancer Institute (INCA), Oncoguia, all accessible through the Virtual Health Library (BVS), in addition to the Nursing Journal of the State University of Rio de Janeiro (UERJ). The descriptors used included terms such as: “Oncology”, “Cancer”, “Nurse”, “Palliative Care”, and “Nursing Communication”, among others. The documentary corpus consisted of complete scientific articles in Portuguese, published between 2016 and 2024, excluding works not aligned with the scope of the research or that did not contribute to the proposed critical reflection.

After the initial survey, the titles and abstracts were carefully analyzed, selecting studies that offered relevant contributions for a qualified discussion. This methodological approach allowed not only mapping the existing production, but also identifying paradoxes, trends, and gaps in knowledge, encouraging a critical assessment of the current stage of the subject. By favoring a reflective analysis over a passive compilation of data, this study sought to enrich the academic dialogue, demonstrating the relevance of approaches that transcend traditional reviews and favor a more dynamic and interpretative understanding of the object of study.

Results and Discussion

It was found that communication is the basis of the nursing team's care in palliative care. The literature points to a lack of preparation, with a lack of knowledge of communication strategies and care related to the topic, due to a lack of academic training and qualifications of professionals.

In 1970, Brazil was considered a young country, but with changes in the demographic profile, this statistic changed radically. This change, due to advances in medicine and the reduction in mortality and birth rates, meant that the country now has more elderly people and fewer young people[12].

The WHO lists four types of diseases that cause the most deaths each year and account for 70% of deaths worldwide. They are diabetes, cancer, respiratory, and circulatory diseases. Chronic Non-Communicable Diseases (NCDs) usually require palliative care, as they have no cure, which does not seek to postpone death, but to allow the patient to live a better life. The WHO also believes that all these diseases require a continued public policy strategy focused on health, regarding prevention and control. All efforts to develop these strategies have not yet been effective, given that the number of patients with NCDs has increased significantly in the last decade[13,14].

Peplau's theory of interpersonal relationships guides the practice of care, focusing on communication between healthcare professionals and family members for humanized care and effective and efficient multidisciplinary palliative care work. The study shows that to effectively practice palliative care, communication strategies are essential for healthcare professionals, since they are characterized by the ability to help people face adverse situations, deal with others, reduce anxiety, promote comfort, and thus provide holistic, quality, and humanized care[14,15].

Communication has two axes: verbal and nonverbal. Verbal communication occurs through spoken and written expression, through which the professional can use several strategies to create an interpersonal relationship with the patient and their family. For example, establishing goals and action plans with the patient and their family, using colloquial language with simple vocabulary, valuing all information provided by the patient and family member, encouraging the verbalization of fears, concerns and anxieties, offering time, verbalizing a willingness to provide attention and care, establishing options and indicating different points of view[16].

The path to visibility that palliative care found was through public humanization policies. The Ministry of Health, seeking to improve the quality of care practices in the SUS, initiated a health humanization program through the National Program for Humanization of Hospital Care (PNHAH). The initiative was triggered by a survey conducted by the Ministry of Health that revealed user dissatisfaction with health services. They found a lack of attention and lack of understanding from some professionals, long waits for care, and a lack of medicine and supplies, confirming an inhumane relationship in what would be constitutional. The National Humanization Policy (PNH) exists to implement the principles of the SUS and has become the main guideline for palliative actions, acting in humanized interventions, environmental care, humanization of old age, and communication, aiming at respect and offering dignity[17].

Healthcare professionals report many difficulties in building communication with patients due to a lack of in-depth knowledge about PC practices, since these only apply to patients who are terminally ill. Due to this lack of knowledge, many professionals tend to confuse communication strategies with the patient's feelings. When a communication strategy is proposed appropriately, it provides many benefits[16].

Therapeutic music is one of the strategies, for example, that can be used to calm the soul and bring back good memories and good feelings. However, to do this, it is necessary to improve knowledge through continuing education/ professional development and always be aware of everything that involves the area and the patient's life[18].

These phases are interconnected mainly by communication strategies in interpersonal relationships: a) Guidance - this is the beginning of the interpersonal relationship. It occurs when the patient seeks help from a professional. It is from the first contact that the degree of partnership between them will be determined – which demonstrates the clarifying communication of the topics discussed. This phase is extremely important for better adherence to treatment. b) Identification - it is important to know the entire medical team; that is, empathy must be shown, and bonds of trust must be established. Effective interpersonal communication can meet needs when affinity is established by the patient. The patient must be given space and an active voice for full and comprehensive understanding based on a solid and trusting relationship. c) Exploration - after establishing a relationship of trust, the patient uses coping strategies that can respond to his/her concerns and needs[16].

Through behavioral and cognitive strategies, the individual seeks to solve problems or balance emotions, control dangerous actions, avoid problems, and seek support. The strategies are designed so that the patient finds the strength to fight against the disease and adversities. d) Resolution - the last phase of the interpersonal process, the identification phase, and the dependency problems were worked on to make the patient stronger and independent of ties with the professional. The paths of this binomial must be separated, and from this moment on, new goals must be outlined. All professionals involved in PC must support and contribute so that the patient enhances his/her strengths and minimizes his/her weaknesses with self-awareness and resilient resolutions[19,20].

The result of the analysis demonstrates the need to implement services that provide palliative care. Regarding the proposal to improve nursing care, it can be inferred that in-service education must be a continuous and permanent process, because the nurses themselves recognize their lack of preparation for the demands and their lack of knowledge in palliative care[21].

Final Considerations

It was possible to understand the complexity and importance of communication in palliative care in oncology, showing that, despite advances in the area, significant challenges persist in clinical practice. Effective communication has proven to be a fundamental pillar for humanized care, not only as a tool for transmitting information but as a therapeutic instrument capable of alleviating suffering, strengthening bonds, and preserving the dignity of the patient and their family members.

However, it was identified that academic training and professional qualifications are still insufficient to prepare nurses and other health professionals to deal with the emotional, cultural and spiritual nuances inherent to this approach. The lack of adequate communication strategies, combined with the scarce integration of palliative care in undergraduate and postgraduate curricula, contributes to fragmented and, at times, dehumanized care.

The results point to the urgent need for public and institutional policies that promote continuing education, raise awareness among professionals, and implement evidence-based protocols, but always aligned with the principles of individuality and respect for patient choices. Therapeutic music, active listening, and the interpersonal approach proposed by Peplau emerged as promising strategies, highlighting that palliative care goes beyond the control of physical symptoms, requiring a holistic view that encompasses psychological, social, and spiritual dimensions. In addition, the humanization of care, as recommended by the National Humanization Program (PNH), must be consolidated as a daily practice, breaking with paradigms that associate palliative care exclusively with terminality and reinforcing its role in quality of life from the moment of diagnosis.

Finally, this study reinforces that nursing, as a protagonist in the continuous monitoring of patients, needs to be strengthened through investments in research, training, and emotional support for professionals. Death, still taboo in our society, should be understood as an intrinsic part of the life cycle, and palliative care as an opportunity to give new meaning to life in its finitude. The transformation of this scenario depends not only on structural changes in the health system but on a collective reflection on the value of empathetic communication, qualified listening, and interdisciplinary work – essential elements to ensure that, even when a cure is impossible, comfort, respect, and human dignity prevail.

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