

Medical performance in palliative care for terminally ill patients admitted to an intensive care unit

Actuación médica en cuidados paliativos del paciente terminal ingresado en una unidad de cuidados intensivos

A atuação médica nos cuidados paliativos de pacientes terminais internados em unidade de terapia intensiva

Isabela Rodrigues de Oliveira^{1*}

ORCID: 0000-0001-9972-3222

Anne Christina Faria

Mascarenhas¹

ORCID: 0000-0002-6244-8850

Albervania Reis Paulino²

ORCID: 0000-0003-1909-8063

Bruno Alves Anselmo¹

ORCID: 0000-0003-2048-7912

João Salviano Rosa Neto¹

ORCID: 0000-0003-2646-5415

Natã Cordeiro Amorim¹

ORCID: 0000-0001-8833-5283

Rubenhaone Alberto Paulino¹

ORCID: 0000-0002-1934-6947

Stela Carolline de Oliveira Melo¹

ORCID: 0000-0002-3860-2600

Simone Mendonça Reis³

ORCID: 0000-0001-8185-8348

Dayane Quintino Vasconcelos¹

ORCID: 0000-0002-3761-8862

¹Centro Universitário Atenas.
Minas Gerais, Brazil.

²Centro Universitário Serra dos
Órgãos. Rio de Janeiro, Brazil.

³Universidade Nove de Julho. São
Paulo, Brazil.

How to cite this article:

Oliveira IR, Mascarenhas ACF, Paulino AR, Anselmo AR, Rosa Neto JS, Amorim NC, Paulino RA, Melo SCO, Reis SM, Vasconcelos DQ. Medical performance in palliative care for terminally ill patients admitted to an intensive care unit. Glob Acad Nurs. 2023;4(Spe.1):e375. <https://dx.doi.org/10.5935/2675-5602.20200375>

*Corresponding author:

bebela_oliveira@hotmail.com

Submission: 07-08-2022

Approval: 04-02-2023

Abstract

The aim was to discuss medical performance in palliative care in the Intensive Unit environment. This is a bibliographical review prepared and written in an integrative manner. Palliative care is not new to medical practice. In the intensive environment, this care is routinely ignored or poorly implemented. The intensive care doctor must be prepared to face practical, ethical, and cultural dilemmas. In addition to indicating the interruption of treatments and providing clear and precise information to patients and family members. The professional must also be able to recommend palliative extubation, and interruption of dialysis and manage the main symptoms presented by terminal patients, such as pain, dyspnea, nausea, and vomiting. However, what is clear is that most professionals are not capable of performing palliative care in an intensive environment. In this sense, this study seeks to discuss palliative practices in the care of terminally ill patients admitted to an Intensive Care Unit based on evidence and experiences from large centers.

Descriptors: Palliative Care; Terminally Ill; Critical Care; Teaching; Intensive Therapy Unit.

Resumen

El objetivo fue discutir la actuación médica en cuidados paliativos en el ambiente de Unidad Intensiva. Se trata de una revisión bibliográfica elaborada y escrita de manera integradora. Los cuidados paliativos no son nuevos en la práctica médica. En el entorno intensivo, esta atención se ignora o se implementa mal de manera rutinaria. El médico de cuidados intensivos debe estar preparado para afrontar dilemas prácticos, éticos y culturales. Además de poder indicar la interrupción de tratamientos y poder brindar información clara y precisa a pacientes y familiares. El profesional también debe poder recomendar la extubación paliativa, la interrupción de la diálisis y manejar los principales síntomas que presentan los pacientes terminales, como dolor, disnea, náuseas y vómitos. Sin embargo, lo que está claro es que la mayoría de los profesionales no son capaces de realizar cuidados paliativos en el entorno intensivo. En este sentido, este estudio busca discutir prácticas paliativas en el cuidado de pacientes terminales ingresados en una Unidad de Cuidados Intensivos a partir de evidencias y experiencias de grandes centros.

Descriptores: Cuidados Paliativos; Enfermo Terminal; Cuidado Crítico; Enseñando; Unidad de Terapia Intensiva.

Resumo

Objetivou-se dissertar sobre a atuação médica nos cuidados paliativos no ambiente de Unidade Intensiva. Trata-se de uma revisão bibliográfica elaborada e redigida de maneira integrativa. Os cuidados paliativos não são uma novidade na prática médica. No ambiente intensivo, esses cuidados são rotineiramente ignorados ou implantados de forma deficitária. O médico no cuidado intensivo deve estar preparado para encarar dilemas práticos, éticos e culturais. Além de ser apto a indicar a interrupção de tratamentos e ser capaz de passar informações claras e precisas aos pacientes e familiares. O profissional deve também estar apto a indicar extubação paliativa, interrupção da diálise e a manejar os principais sintomas apresentados por pacientes terminais, como a dor, a dispnéia, a náusea e o vômito. Porém, o que se percebe é que a maioria dos profissionais não são capazes de realizar cuidados paliativos no ambiente intensivo. Neste sentido, este estudo busca discutir práticas paliativas no cuidado do paciente terminal internado em Unidade de Terapia Intensiva a partir de evidências e experiências de grandes centros.

Descriptores: Cuidados Paliativos; Doente Terminal; Cuidados Críticos; Ensino; Unidade de Terapia Intensiva.



Introduction

The 1960s brought an important evolution to health care. Concern about cancer patients dying in suffering and in charitable homes with precarious conditions led health professionals to realize the existence of a large gap in health services in the care provided to terminally ill patients. There were, among several deficient aspects, obstacles in communication, adequate care for patients, and psychosocial aspects of health that were ignored¹.

Palliative care emerges in this context as a quest to guarantee dignity to terminally ill patients. The word palliative, which comes from the Latin term "pallium" which means to camouflage, translates to the search to alleviate symptoms when the illness can no longer be cured. It is a quest to care for the person and empower them in their care, while death approaches. It aims to maximize quality of life through symptom control, and psychological and spiritual support, ensuring that the patient has autonomy in the most difficult moment of human life².

For the World Health Organization (WHO), palliative care is an approach that improves not only the patient's quality of life, but also that of their family members, when facing problems associated with life-threatening illnesses, through prevention, relief of suffering, early identification, and accurate assessment of the treatment of pain and other physical, psychosocial, and spiritual problems³.

Although the concept of palliative care is widely adopted, there are major barriers to implementing this assistance. Palliative care is currently not part of routine clinical care and there are limitations in understanding the ways to provide this essential care. Intensive Care Units (ICU) represent a place of care with high mortality rates, ranging from 20% to 35%, depending on the geographic region, and with an increase in hospitalizations in recent years. In the absence of a response to treatment and care objectives, ICUS must have adequate support to guarantee a dignified death. However, what is observed is the lack of understanding among most professionals about the suspension/withdrawal of interventions and the support that should be offered at the end of life^{2,4}.

Therefore, this article aims to present the importance of palliative care for terminally ill patients in the ICU. Furthermore, critically demonstrates how doctors should behave in the face of adversity, both with the patients themselves and with their families in times of conflict.

Methodology

This study is a bibliographical research, research methodology defined⁵ as the search for material prepared and endorsed by peers, such as books and scientific articles. It is also characterized by research that seeks to guarantee a broad view of phenomena that direct investigation cannot cover all aspects of. Complementarily, a study⁶ presents as a study that performs analysis and synthesis of information relevant to the topic of the study, its function being to summarize existing knowledge about a research problem.

To carry out this study, a critical review of the literature, the terms intensive care, palliative care, intensive care unit, palliative care, medical communication, and terminal patient were researched in the Virtual Health Library (VHL) databases and its different banks database, Scientific Electronic Library Online (SciELO), Medical Literature Online Analysis and Retrieval System (MedLine).

The inclusion criteria were original articles, revisions, and experience reports, written in Portuguese, English, or Spanish, published between 2011 and 2021, available in full online, and relevant to the topic sought. Furthermore, a Thematic Content Analysis was carried out⁷.

Results and Discussion

Medical communication in the ICU environment

The ICU environment involves several uncertainties and ethical issues, which is why communication suffers from barriers within the team itself, between the team and patients and family members. The doctor in the ICU environment must deal with the unpredictability of results, which affects decisions, increases the stress involved, and ethical dilemmas, such as the dilemma of when to suspend life-sustaining treatments, which must involve family members and which, Therefore, good communication⁴.

In the current scenario, it is observed that the ICU environment represents a place of conflict, causing animosity, mistrust, and poor communication. Conflicts are related to disagreements about prognosis and treatment plans, almost always occurring within the team itself, transmitting insecurity to the patient and family members⁴.

A cross-sectional study was carried out with 103 patients admitted to the ICU, seeking to assess the quality of communication. Patients reported communication failures the small amount of information passed on, and although there was a desire to know more, they also communicated the need for greater sensitivity from doctors, confidence in reporting pain and discomfort, and felt the need for more attention time. Although overall communication was good on the scale, end-of-life communication was considered poor by patients. Even those who considered it good, in this study, pointed out the need for more time available to clarify the clinical condition, treatment, and prognosis of the clinical condition. It is pointed out that providing frequent information about the diagnosis, length of stay, talking about common aspects of everyday life, and instigating the desire to return to normal life, as well as addressing spirituality and sharing decisions are elements of communication that cause greater patient comfort in intensive care⁸.

In the ICU environment, it is also necessary to pay attention to unconscious and sedated patients who cannot express an opinion. Communication with the family is a great challenge and a source of various conflicts, which arise, mainly, when the family does not agree with the team's conduct, when they feel excluded from the decision-making process, or when the team disagrees with conduct that the family wants. are adopted. Therefore, it is necessary in this process to guarantee access to clear, direct, and honest information about the risks and benefits of treatments and



prognosis. Communication difficulties include the use of medical jargon, lack of team training in communication, and rotation of professionals with different communication skills^{9,10}.

Researchers¹¹ highlighted how current communication is inefficient and problematic. In the study involving 75 family members of patients in a neurosurgical ICU, they observed that more than 70% of the family members evaluated did not understand, at some point, the diagnosis, prognosis, or treatment. Less than 30% of patients understood the three items assessed. Understanding was lower among elderly patients and those with a worse prognosis. This study presents as a problem the inability of a family member who does not understand the information to determine what is best for the patient.

Among the causes of poor communication are the inadequate training of doctors in communication skills, the complexity of ICU environments, the high time that doctors spend within the ICU environment, using their language and

interacting with technological equipment, such as mechanical ventilators and vital signs monitors^{9,10}.

For effective communication, it is important to note that:

"The doctor must start from topics that are relevant to each family and be aware that family members' ideas about the disease and perspectives may be very different from their own. The doctor also must receive information and understand the latest information about the patient's expectations, things that families probably know best. Doctors must verify that the exchange of information occurred and that it was given and received correctly, especially when delicate and irreversible decisions must be made based on that same exchange"^{9:382}.

It is also pointed out that feedback is necessary for effective communication. That is, ask the family and the patient about the information they received. What did they understand and what doubts remained about the patient's condition^{9,10}.

Chart 1 brings together the main elements to ensure effective communication.

Chart 1. Elements necessary for efficient communication. Paracatu, MG, Brazil, 2022

Efficient communication in the ICU environment

- Clear, accurate, jargon-free communication about condition and prognosis
- Guarantee of privacy and comfort when making communications
- Consistent communication, avoiding contradictions
- Communicate risks and prognoses in quantitative terms
- Check whether the information given was understood by the receiver
- Associate written information about diagnosis, prognosis, and treatment
- Allow family members to participate in medical rounds
- Provide security to family members when making decisions, not giving the impression that they are fully responsible for the decisions
- Discuss the benefits and limitations of continuing treatment before making decisions
- Scheduled meetings with family members, especially after the medical visit

Source: Briggs¹².

Study¹² points out that it is necessary to clarify to family members the reason why the patient was admitted to the ICU and the evolution since then, the acute medical problems, treatments given and intended to be given, what the doctor believes could happen, what the treatment options are available and decisions that need to be made. Family members should also seek to clarify their concerns and fears if there is any advance directive of will or desire verbally expressed by the patient. At the end of any conversation, it is necessary to check whether the questions have been answered, asking family members to summarize the information received. In turn, researchers¹³ point out that it is necessary to identify team members, their responsibilities, and family members, identify who will be responsible for decisions, establish regular meeting times, analyze, and identify patient preferences and main problems, evaluate expectations, and plan meetings.

Palliative extubation

Palliative extubation consists of a stage in the care of patients whose terminal condition has been established. It is a measure that aims to ensure patient comfort, and relief

from suffering and avoid unnecessary prolongation of life. It is a stage in which one must seek to ensure the best comfort of the patient, requiring effective communication to dispel the feeling of abandonment that may be faced by patients and their families¹⁴.

The family must receive sufficient information about the risks and benefits. Inadequate and incomplete information can cause resistance and cause anxiety and depression in family members. Furthermore, inadequate dialogue can lead to the development of feelings of guilt regarding the death of a loved one. Furthermore, it is necessary to guarantee psychological support to family members and ensure that they can carry out social and farewell rituals¹⁵.

This procedure presents risks such as the possibility of causing dyspnea, anxiety, and discomfort in the patient. Benefits include improved communication between the patient and family, a greater sense of comfort, compassion, and sensitivity, and fewer symptoms of depression among family members^{13,16}.

It is noteworthy, however, that despite the benefits, ICU professionals, even those who adopt a



palliative approach, still show resistance to palliative extubation, relating the withdrawal of mechanical ventilation to the concept of euthanasia. They only consider mechanical ventilation for dyspneic patients as legitimate¹⁷.

To carry out this procedure properly, it must be ensured that all actions seek dignity and benefit to the patient, review with the patient in detail the procedures to be adopted, greater flexibility must also be ensured in family visits to patients, discontinue monitoring, treatments, and unnecessary medications, ensure that there is pain relief, and the patient remains calm¹³. These are practical procedures for palliative extubation:

- “Remove enteral feeding 12 hours before extubation.*
- Withdraw neuromuscular blockers for at least 2 hours (note: in cases of multiple organ failure, neuromuscular blockers may act for up to 18 hours). Do not use neuromuscular blockers.*
- The entire team taking part in the procedure must be close to the patient.*
- Ensure that intravenous medications are used to control symptoms before and during extubation. The goal should be to alleviate symptoms, such as difficulty breathing and agitation.*
- Maintain venous access to administer medications for patient comfort.*
- Maintain suction equipment for any oral secretions after extubation.*
- Raise the head of the bed to 35 - 45°.*
- Reduce the fraction of inspired oxygen to that of ambient air and reduce the parameters by 50%. If the patient remains comfortable, reduce pressure support and positive end-expiratory pressure to assess whether discomfort-free ventilation occurs. If the patient remains comfortable, extubate.*
- Use an oxygen mask with humidification after extubation.*
- Observe symptoms of anxiety, dyspnea, and agitation, and treat them if necessary [...], a bolus dose of opioid and a benzodiazepine can be administered”^{13,227}.*

Among the medications available to control palliative extubation symptoms are morphine with midazolam (bolus of 2 to 10 mg of morphine, with 1 to 2 mg of midazolam, with morphine maintenance at 50% of the bolus dose/h and 1 mg of midazolam/hour) or propofol, preferable for awake patients with severe respiratory distress, at a dose of 20 to 50 mg bolus and maintenance of 10 to 100 mg/h. During the extubation process, it is expected that the family will ask about the possibility and survival time of patients, which is an element investigated in several studies. A study with 148 patients undergoing the procedure, with an average age of 78 years, followed until death or discharge, had a mortality rate of 77%, with an average time until death of 8.9 hours, ranging from 4 minutes to 7 days. About half of the patients died within 24 hours¹⁸. Another survey divided patients into three groups: A – terminal cancer patients, B – patients with out-of-hospital cardiac arrest, and C – patients with non-oncological organ failure, it was observed that the time until death was, respectively, 97 hours, 0.3 hours, and 6.1 hours^{3,19}.

In a cohort with 322 patients, of which 159 patients were palliatively removed from mechanical ventilation, the average time between extubation and death was 0.9 hours, with a range of 0 to 165 hours, with the time being shorter for patients using vasopressors, dialysates, and with high ventilation settings²⁰.

Palliative interruption of dialysis

The presence of renal failure in the intensive care setting is common. It is estimated that the incidence of acute kidney injury in the critical environment is between 20% and 50%, with increasing trends²¹. A large population-based survey demonstrated that between 1996 and 2010, in Canada, the incidence of acute kidney injury requiring dialysis in critically ill patients increased from 0.8% to 3.0%²².

One of the aspects discussed in palliative care for critically ill patients is dialysis, whether its introduction or maintenance. When managing dialysis, it is important to guarantee the patient an approach that focuses on their comfort and is combined with their preferences, as it is a treatment associated with a high prevalence of debilitating symptoms, associated with multifactorial causes such as uremia. There must be a discussion of goals, prognoses, and encouraged communication between family members and the patient. Furthermore, it is necessary to consider that dialysis does not always represent a benefit for the patient – a topic that still seems to represent a taboo. Patients over 75 years of age, with comorbidities or ischemic heart disease and poor response to treatment, do not have better survival when a dialysis regimen is instituted, on the contrary, they have exacerbated symptoms of suffering²³⁻²⁵.

However, despite several recent studies on palliative care, there are no clear guidelines on which patients should stop or withdraw from dialysis. Authors¹³ recommend that it not be carried out or suspended in patients with maintained decision-making capacity, fully informed, who decide so, patients who have previously indicated oral or written refusal or who have expressed their legal representative, and patients with irreversible and profound neurological impairment, patients with kidney damage acute, chronic kidney disease or end-stage kidney disease with a very poor prognosis. They also recommend that this procedure be discussed for patients over 75 years of age, with stage 5 renal impairment who have a high probability of death within 6 months, a high comorbidity coefficient, significantly compromised functionality, and a state of severe malnutrition.

It is also necessary to be aware that patients with end-stage renal disease may experience pain with great frequency, respiratory secretion, anxiety, mental confusion, dyspnea, and nausea, requiring adequate management of these symptoms. Currently, however, these symptoms are generally inadequately managed by health services²⁶.

Management of symptoms of terminally ill patients

It is expected that the terminal patient will face various symptoms and discomfort related to the disease itself, the environment in which they are placed, and the impact of knowing how to end. Among the symptoms, pain is the most frequently reported symptom, followed by dyspnea, agitation, and nausea. Psychological and psychiatric symptoms, such as symptoms of delirium and suicidal ideation, are also expected. Family members are also exposed to these symptoms, presenting insomnia and depressed mood²⁷.



Pain

Within palliative care, symptoms that cause discomfort need to be controlled, especially pain. Currently, pain must be managed continuously, with fast-acting and sustained analgesics. A consistent level of medication should be maintained throughout the day. Morphine is considered one of the preferred options for treating patients in palliative care. It is a cheaper medicine and is available through various routes of administration. Opioids considered weak, such as codeine, tramadol, and meperidine, are not recommended. Fentanyl can be used for very severe pain. As an adjuvant, non-steroidal anti-inflammatory drugs and corticosteroids can be used. Gabapentin can also be used for patients who have neuropathic pain^{28,29}.

A study showed that around 35% of patients do not receive adequate pain management and around 45% feel the need for an increase in the dose of analgesics or additional treatment, demonstrating that there are still flaws in this management³⁰.

Dyspnea

Various clinical conditions of terminally ill patients can trigger dyspnea, which is often poorly understood and even ignored by clinicians. Palliation of this symptom is still little discussed and is generally performed ineffectively^{13,31}.

Various medications can be used to alleviate this symptom. Opioids can be used to relieve dyspnea. By acting on central receptors in the right posterior region of the cingulate gyrus, they act to depress the spontaneous respiratory impulse and modulate cortical activity. Furthermore, low doses do not increase the risk of death or admission to the hospital. One way to use it is to use 1 to 2 mg of morphine IV, every 15 minutes, until the desired effect is obtained, or more quickly for severe dyspnea. The symptom must be controllable without the adverse effects of the medication being intolerable^{13,31}.

Benzodiazepines can treat patients' anxiety and panic, being useful in controlling dyspnea that has this origin. However, studies on the topic are still scarce and this conclusion is controversial. Furthermore, benzodiazepines can cause adverse effects, particularly drowsiness. It is common for them to be used in combination with opioids, as a second or third line of treatment^{31,32}.

In addition to the medications mentioned above. Corticosteroids are used to reduce airway inflammation and edema, although their ability to achieve the desired palliative treatment is controversial. IV loop diuretics are used for patients with congestive heart failure and patients with obstructed thoracic lymphatics. Oxygen therapy is also adopted, even though its effects on relieving dyspnea are still controversial. It is believed to stimulate upper airway receptors and reduce respiratory drive, in addition to reducing hypoxemia, serum lactic acid, and pulmonary artery pressure. Finally, non-invasive ventilation can be adopted for tachypneic patients, who use accessory muscles and experience uncontrolled dyspnea even when undergoing other therapeutic measures^{13,31,32}.

It is also necessary to consider non-pharmacological treatments, such as positioning and breathing techniques,

mobility aids, and muscle strengthening, which are normally neglected²⁸.

Nausea and vomiting

Nausea and vomiting are noticed by most terminally ill patients, they are derived both from the disease and can also be a result of the adverse effects of medications used, such as opioids. The origin is usually multifactorial^{33,34}.

When managing this symptom, it is necessary to explain its probable origin and the proposed treatment to the family. Traditionally, antiemetics seek to block the main emetogenic pathways, highlighting that determining the pathway is not relevant in palliative care, due to its multifactorial origin and the action of medications on different pathways. For vomiting of chemical origin, haloperidol is recommended as a first line. For delayed gastric emptying, metoclopramide. For head injuries and radiotherapy, histamine antiemetics, such as cyclizine, are the first line. For vomiting that is caused by anxiety and pain, benzodiazepines are indicated. In case of intracranial hypertension or cerebral edema, dexamethasone is recommended^{28,33,34}.

Levomepromazine is suggested as a second or third-line therapy for refractory vomiting. This analgesic medication must, however, be used carefully, due to the sedative effect and great potential to cause postural hypotension. It should be noted that there are limited studies on the management of nausea and vomiting in palliative patients and the evidence for some medications, such as haloperidol, is considered weak³³⁻³⁵.

Grief and depression

The terminal diagnosis is traumatic, leading the patient to experience some type of loss, such as loss of health, property, self-image, and sense of control, leading to the development of grief, an expected and natural adaptive response to the diagnosis, and depression, which it differs from the first because it can worsen physical symptoms, such as pain, interfere with the relationship between the patient and their family members and cause suffering in companions³⁶.

The grieving patient must be offered support. The patient should be encouraged to seek external support, such as family, friends, and even religious communities. Active listening must be exercised and the patient's communication with their family members must be facilitated³⁶.

Depression, in turn, is mistakenly seen as a universal symptom but manifests itself as a depressed mood along with sleep disturbances, feelings of guilt or worthlessness, anhedonia, loss of concentration, difficulty making decisions, agitation or retardation psychomotor, suicidal ideation, must be promptly identified, and treated. Different strategies can be adopted in these patients depending on the prognosis and the profile of adverse events and the costs of each medication. Psychostimulants are a good option, as they reduce symptoms in a few days, and are therefore more suitable for patients whose prognosis is restricted to days or weeks³⁶.



Other care for terminally ill patients

Nutrition and hydration

Artificial hydration and nutrition need to be seen as medical interventions and, therefore, can cause discomfort to the patient without, in return, improving the patient's prognosis. The effects of this therapy include nausea and an increased risk of aspiration^{37,38}.

A study with Italian doctors and nurses demonstrated the difficulty of considering these interventions based on evidence. Cultural, ethical, and psychological issues were a major point of support in decision-making about this therapy, so only 25% of participants in this study followed the recommendations of not adopting hydration and artificial nutrition in terminally ill patients with advanced dementia. On the other hand, the patient's family also makes this perception difficult. When noticing a reduction in oral intake, weight loss or manifestation of asthenia, family members, the patient, and health professionals tend to have great anxiety about the condition. This is also pointed out as a reason, together with the lack of information, for the adoption of these erroneous measures^{38,39}.

Within palliative care, therefore, it is necessary to emphasize to family members and patients that most terminally ill patients do not benefit from this measure. However, it is necessary to consider that interruption can cause suffering to family members and the patient himself, therefore it is a delicate decision that will depend on factors beyond the evidence³⁷.

Spirituality

Traditionally, the intensive environment suppresses expressions of spirituality, that is, the expression of meaning, purpose, and connection, of the patient and their family members. However, most patients and their families tend to view death as a transition or a spiritual journey, so spiritual support, even in an intensive environment, should be one of the areas of ICU care⁴⁰.

Both family members and patients feel the need to have their values and beliefs respected and incorporated into the discussion and decision-making process. They also benefit from questioning their desires, recognizing their life history, and reconnecting. The participation of spiritual caregivers also appears to be beneficial when it involves practices of discussing spiritual and religious needs, family feelings, patients' values, and memories about the patient's life. The greater the number of activities carried out, the greater the satisfaction that family members obtain about intensive care^{40,41}.

Final Considerations

This study demonstrates that there are no contradictions between palliative care and the ICU environment. Although, at first glance, it may seem that there is a restriction on palliative care, due to the complexity of the environment and the care adopted, it is fully possible to guarantee dignity to intensive care patients in their final moments. It is necessary for doctors who work in this environment to reinforce their communicative skills, the basis of all palliative care, and know how to correctly indicate the suspension of treatments and manage the symptoms that may arise from this interruption. Currently, the management of the suffering of patients and their families is still deficient, demonstrating the need to discuss current medical education on palliative care. Doctors responsible for intensive care must know the ethical and practical aspects of caring for terminally ill patients, and specific training is required for these professionals.

Despite all the bibliographical review carried out, this study has limitations, as it is necessary to develop more current studies with medical updates and management techniques in ICU and palliative care, so that new research can be carried out with even more criteria on how it should be carried out. be the way doctors should act in palliative care for terminally ill patients in Intensive Care Units.

References

1. Saunders C. The evolution of palliative care. *J R Soc Med.* 2001;94(4):430-432. doi: 10.1177/014107680109400904
2. Merino MTGB. Palliative Care: Taking the Long View. *Front Pharmacol.* 2018;9:1140. doi: 10.3389/fphar.2018.01140
3. Organização Mundial da Saúde (OMS). Palliative Care [Internet]. OMS; 2018 [acesso em 10 nov 2023]. Disponível em: <http://www.who.int/news-room/fact-sheets/detail/palliative-care>
4. Mercadante S, Gregoretti C, Cortegiani A. Palliative care in intensive care units: why, where, what, who, when, how. *BMC Anesthesiol.* 2018;18(1):106. doi: 10.1186/s12871-018-0574-9
5. Gil AC. Métodos e técnicas de pesquisa social. 6. ed. São Paulo: Atlas; 2008.
6. Mancini MC, Sampaio RF. Quando o objeto de estudo é a literatura: estudos de revisão. *Braz. J. Phys. Ther.* 2006;10(4). <https://doi.org/10.1590/S1413-35552006000400001>
7. Bardin L. Análise temática de conteúdo. Lisboa: Edições 70; 2011.
8. Corrêa M, Castanhel FD, Grosseman S. Patients' perception of medical communication and their needs during the stay in the intensive care unit. *Rev Bras Ter Intensiva.* 2021;3(33):401-11.
9. Wallin V, Mattsson E, Omerov P, Klarare A. Caring for patients with eating deficiencies in palliative care-Registered nurses' experiences: A qualitative study. *J Clin Nurs.* 2022 Nov;31(21-22):3165-3177. doi: 10.1111/jocn.16149
10. Kobewka D, Ronksley P, Mclsaac D, Mulpuru S, Forster A. Prevalence of symptoms at the end of life in an acute care hospital: a retrospective cohort study. *CMAJ Open.* 2017 Mar 9;5(1):E222-E228. doi: 10.9778/cmajo.20160123
11. Mathew JE, Azariah J, George SE, Grewal SS. Do they hear what we speak? Assessing the effectiveness of communication to families of critically ill neurosurgical patients. *Journal of anaesthesiology, clinical pharmacology.* 2015;31(1):49-53. doi: 10.4103/0970-9185.150540
12. Briggs D. Improving communication with families in the intensive care unit. *Nurs Stand.* 2017;32(2):41-48. doi: 10.7748/ns.2017.e10812



13. Coelho CB, Yankaskas JR. New concepts in palliative care in the intensive care unit. *Rev Bras Ter Intensiva*. 2017;29(2):222-230. doi: 10.5935/0103-507X.20170031
14. Cardoso MN. Extubação paliativa: revisão da literatura. (Tese) – Doutorado. Universidade Santo Amaro, São Paulo, 2020.
15. Natividade TSS, Coelho PYC, Aguiar DR, Silva GL, Silva RB, Soeiro ACV. Extubação paliativa: reflexões bioéticas sobre cuidados em fim de vida. *Rev. Bioét.* 2021;29(3). <https://doi.org/10.1590/1983-80422021293491>
16. Peixoto MF, Nascimento FBS, Silva BPA, Silveira DSP. Os benefícios da extubação paliativa na qualidade de morte. *Revista Família, Ciclos de Vida e Saúde no Contexto Social [Internet]*. 2020 [acesso em 10 nov 2023];8(2). Disponível em: <https://www.redalyc.org/journal/4979/497963611001/497963611001.pdf>
17. Rebellato G. Análise descritiva dos pacientes submetidos à extubação paliativa. (Tese) – Doutorado. Universidade de Santa Catarina de Florianópolis, Florianópolis, 2015.
18. Pan CX, Platis D, Maw MM, Pollack S, Kawai F. How Long Does (S)He Have? Retrospective Analysis of Outcomes After Palliative Extubation in Elderly, Chronically Critically Ill Patients. *Crit Care Med*. 2016;44(6):1138-1144. doi: 10.1097/CCM.0000000000001642
19. Kok VC. Compassionate extubation for a peaceful death in the setting of a community hospital: a case-series study. *Clin Interv Aging*. 2015;10:679-685. doi: 10.2147/CIA.S82760
20. Huynh TN, Walling AM, Le TX, Kleerup EC, Liu H, Wenger NS. Factors associated with palliative withdrawal of mechanical ventilation and time to death after withdrawal. *J Palliat Med*. 2013;16(11):1366-1374. doi: 10.1089/jpm.2013.0142
21. Case J, Khan S, Khalid R, Khan A. Epidemiology of acute kidney injury in the intensive care unit. *Crit Care Res Pract*. 2013;2013:479730. doi: 10.1155/2013/479730
22. Wald R, McArthur E, Adhikari NKJ, Bagshaw SM, Burns KEA, Garg AX, Harel Z, Kitchlu A, Mazer CD, Nash DM, Scales DC, Silver SA, Ray JG, Friedrich JO. Changing incidence and outcomes following dialysis-requiring acute kidney injury among critically ill adults: a population-based cohort study. *Am J Kidney Dis*. 2015;65(6):870-877. doi: 10.1053/j.ajkd.2014.10.017
23. Grubbs V, Moss AH, Cohen LM, Fischer MJ, Germain MJ, Jassal SV, Perl J, Weiner DE, Mehrotra R. A palliative approach to dialysis care: a patient-centered transition to the end of life. *Clin J Am Soc Nephrol*. 2014;9(12):2203-2209. doi: 10.2215/CJN.00650114.
24. Combs SA, Davison SN. Palliative and end-of-life care issues in chronic kidney disease. *Curr Opin Support Palliat Care*. 2015;9(1):14-19. doi: 10.1097/SPC.0000000000000110
25. Douglas CA. Palliative care for patients with advanced chronic kidney disease. *J R Coll Physicians Edinb*. 2014;44(3):224-31. doi: 10.4997/JRCPE.2014.309
26. Axelsson L, Alvariza A, Lindberg J, Öhlén J, Håkanson C, Reimertz H, Fürst CJ, Årestedt K. Unmet palliative care needs among patients with end-stage kidney disease: a national registry study about the last week of life. *J Pain Symptom Manage*. 2018;55(2):236-244. doi: 10.1016/j.jpainsymman.2017.09.015
27. Kobayakawa M, Ogawa A, Konno M, Kurata A, Hamano J, Morita T, Kizawa Y, Tsuneto S, Shima Y, Aoyama M, Miyashita M. Psychological and psychiatric symptoms of terminally ill patients with cancer and their family caregivers in the home-care setting: A nation-wide survey from the perspective of bereaved family members in Japan. *J Psychosom Res*. 2017;103:127-132. doi: 10.1016/j.jpsychores.2017.10.012
28. Henson LA, Maddocks M, Evans C, Davidson M, Hicks S, Higginson IJ. Palliative care and the management of common distressing symptoms in advanced cancer: pain, breathlessness, nausea and vomiting, and fatigue. *J Clin Oncol*. 2020;38(9):905-14. doi: 10.1200/JCO.19.00470
29. Lowey SE. Manejo da dor severa em pacientes terminais em casa. *Cuidados de saúde domiciliares*. 2020;38(1):8-15.
30. Mallah H, Mousa R, Fadl NB, Musmar S, Ball S, Nugent K. Pain Severity and Adequacy of Pain Management in Terminally Ill Patients with Cancer: An Experience from North Palestine. *Indian J Palliat Care*. 2019;25(4):494-500. doi: 10.1016/j.chest.2018.04.003
31. Shreves A, Pour TR. Emergency department management of dyspnea in the dying patient. *Emerg Med Pract [Internet]*. 2018 [acesso em 10 nov 2023];20(7):1-20. Disponível em: <https://pubmed.ncbi.nlm.nih.gov/29949707/>
32. Glare P, Miller J, Nikolova T, Tickoo R. Treating nausea and vomiting in palliative care: a review. *Clin Interv Aging*. 2011;6:243-59. doi: 10.2147/CIA.S13109
33. Leach C. Nausea and vomiting in palliative care. *Clin Med (Lond)*. 2019 Jul;19(4):299-301. doi: 10.7861/clinmedicine.19-4-299
34. Murray-Brown F, Dorman S. Haloperidol for the treatment of nausea and vomiting in palliative care patients. *Cochrane Database Syst Rev*. 2015 Nov 2;2015(11):CD006271. doi: 10.1002/14651858.CD006271.pub3
35. Widera EW, Block SD. Managing grief and depression at the end of life. *Am Fam Physician [Internet]*. 2012 Aug 1 [acesso em 10 nov 2023];86(3):259-64. Disponível em: <https://pubmed.ncbi.nlm.nih.gov/22962989/>
36. Dev R, Dalal S, Bruera E. Is there a role for parenteral nutrition or hydration at the end of life? *Curr Opin Support Palliat Care*. 2012 Sep;6(3):365-70. doi: 10.1097/SPC.0b013e328356ab4a
37. Valentini E, Giantin V, Voci A, Iasevoli M, Zurlo A, Pengo V, Maggi S, Pegoraro R, Catarini M, Andriago M, Storti M, Manzato E. Artificial nutrition and hydration in terminally ill patients with advanced dementia: opinions and correlates among Italian physicians and nurses. *J Palliat Med*. 2014 Oct;17(10):1143-9. doi: 10.1089/jpm.2013.0616
38. Del Río MI, Shand B, Bonati P, Palma A, Maldonado A, Taboada P, Nervi F. Hydration and nutrition at the end of life: a systematic review of emotional impact, perceptions, and decision-making among patients, family, and health care staff. *Psychooncology*. 2012 Sep;21(9):913-21. doi: 10.1002/pon.2099
39. Gulini JEHMB, Nascimento ERPD, Moritz RD, Rosa LMD, Silveira NR, Vargas MAO. Intensive care unit team perception of palliative care: the discourse of the collective subject. *Rev Esc Enferm USP*. 2017 May 25;51:e03221. doi: 10.1590/S1980-220X2016041703221
40. Swinton M, Giacomini M, Toledo F, Rose T, Hand-Breckenridge T, Boyle A, Woods A, Clarke F, Shears M, Sheppard R, Cook D. Experiences and Expressions of Spirituality at the End of Life in the Intensive Care Unit. *Am J Respir Crit Care Med*. 2017 Jan 15;195(2):198-204. doi: 10.1164/rccm.201606-1102OC
41. Johnson JR, Engelberg RA, Nielsen EL, Kross EK, Smith NL, Hanada JC, O'Mahoney SKD, Curtis JR. The association of spiritual care providers' activities with family members' satisfaction with care after a death in the ICU. *Crit Care Med*. 2014;42(9):1991-2000. doi: 10.1097/CCM.0000000000000412

