

PALLIATIVE CARE TO CANCER PATIENTS: PERCEPTIONS OF A NURSING TEAM¹

Vivian Fernanda Daronco*

Cleci Lourdes Schmidt Piovesan Rosanelli**

Marli Maria Loro***

Adriane Cristina Bernat Kolankiewicz****

ABSTRACT

Objective: recognizing the perceptions of a nursing team regarding palliative care to cancer patients and identify the care implemented. **Method:** a qualitative, descriptive and exploratory study. The data was collected through open interviews. Fifteen nursing staff workers participated in an oncology unit of a hospital in the northwestern region of Rio Grande do Sul/Brazil. The data were analyzed as recommended by the content analysis and were grouped into two categories, one relating to workers' perceptions about palliative care and other care provided to patients. **Results:** they point to the fragmented view of the concept of palliative care in influencing care, through of nursing techniques, conversations with the patient, listens to the patient, attention to family, emotional support; these care targeted to provide quality of life, comfort, pain control and dignified death. **Conclusion:** it is up to the health care team to develop educational measures for increased awareness of palliative care, resulting in a full comprehensive and humane assistance.

Keywords: Palliative care. Nursing. Neoplasms.

INTRODUCTION

Currently, there is an increased incidence of cancer worldwide, many diagnosed at an advanced stage, which leads to prognostic reserved contributing to the increase of people needing palliative care. Thus, we highlight the importance of effective performance of the nursing staff with knowledge about the health/disease process and prepared to care for, with a view to providing better quality of life (QOL) in the moments before his death, as well as contributing to have a good death.

Cancer is a major public health problem worldwide, since 2003, in that, malignant neoplasms constitute the second cause of death in the population⁽¹⁾. The World Health Organization (WHO) estimates for the year 2030, 27 million new cases of cancer, 17 million deaths from this injury and 75 million people living annually with cancer. Stresses also that this increase will focus on countries with low and medium income⁽²⁾.

Different treatment modalities have aimed to cure, but when this is not possible and the

patient requires treatment and/or palliative care, that aim to relieve symptoms and promote QOL as long as possible.

Due to the large number of individuals with cancer processes without availability of curative treatment, palliative care and knowledge of their purpose are of utmost importance to the management of these patients. According to WHO it is an approach that improves QOL of patients and families facing problems associated with diseases threatening life, through the prevention and relief of suffering by means of early identification, proper assessment and treatment of pain as well as other problems of physical, psychosocial and spiritual order (WHO, 2009)⁽³⁾. However, there are few palliative care services designed to support them, a reality which causes patients without therapeutic conditions are admitted to general hospitals.

Facing this scenario, it is necessary that nurses have knowledge and training about implementation of this modality of care through a multidisciplinary practice with the implementation of an interventionist proposal requiring competence, decision, maturity, ability

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*Nurse, Undergraduated from Regional Northwest University of Rio Grande do Sul (Unijui). E-mail: vividaronco@yahoo.com.br

**Nurse, PhD in Nursing, UNIFESP, Professor at DCVida Unijui. Email: cleci.rosanelli@unijui.edu.br

***Nurse, PhD in Sciences, UNIFESP, Professor at DCVida Unijui. Email: marli@unijui.edu.br

****Nurse, PhD in Sciences, UNIFESP, Professor at DCVida Unijui-RS Unijui. Email: adriane.bernat@unijui.edu.br

to work teamwork and humanitarian engagement⁽⁴⁾. It is understood that the dialogue between the team and are paramount in order to crave positive in regards to the care of patients outside the therapeutic possibilities and their families results.

In this context, this study had the guiding question: "What is the perception of a nursing staff regarding palliative care to cancer patients and how to provide care?" And the objective of ascertaining perceptions of a nursing staff regarding palliative care to cancer patients, as well as identify which care for her.

METHODOLOGY

A qualitative descriptive study was conducted in an Oncology Unit in a hospital in southern Brazil, during the month of May 2009. Participated in the study 15 nursing workers who are with patients undergoing cancer treatment at the unit. Of these, two are nurses, technicians twelve Nursing and Nursing Assistant. Regarding the length of service, they present employment in the unit ranging from three months to one year, with more pronounced prevalence of five to six months. As for length of service in nursing it ranged from four months to twenty-three years.

The criteria for selection of subjects were: work in the nursing staff aged 18 years old and be working in the Oncology Unit. Have the exclusion criteria were: being on vacation and/or sick leave. In order to maintain anonymity, subjects were identified by the letter E, followed by the order of the interview number.

Obtaining information was given through open interviews with the following research questions: What is your perception of palliative care to cancer patients? How you take care of patients in palliative care? The statements were recorded on audio tape transcribed and subsequently analyzed and categorized. The interruption of the interviews took place at the time that there was a saturation of information.

For the analysis of information obtained from the study subjects there were followed the following steps: ordering, classification and analysis of data⁽⁵⁾. All ethical principles of research with people, were observed⁽⁶⁾. The

research project was approved by the Ethics Committee of Unijuí as Opinion No. 085/2009.

RESULTS AND DISCUSSION

From the reading of the interviews and collation of information, two analytical categories emerged: Category I which approaches about perceptions of the nursing staff on the oncology and palliative Category II discusses patient care on the care that the staff implements to these patients.

Category I - palliative care to cancer patients in the design of the nursing team

In the perception of the subjects, palliative care refers to the idea of caring for patients with no possibility of cure. Reports show understanding of the definition of the term, however reductively, not to demonstrate understanding of the extent that "caring" is.

Palliative patients are those patients who we care but that have no more cure. (E3)

Care is what we do for those who do not have a cure. (E10).

Important to emphasize that the care that directs staff to patients, cannot be directed to the cure, but this is not always possible, as death cannot be avoided. Sometimes the success of these goals can be achieved temporarily, but they must be careful before a constant⁽⁴⁾.

The focus of palliative care is the multidisciplinary work with taking attitudes to the reality of human finitude, seeking to meet the human being as a whole to be in the final stages of life⁽⁷⁾.

Care to patients while not having more chance of cure, everyone (staff) is to alleviate their suffering and improve their quality of life. (E15)

The superation of the expectations that palliative care is only morally relevant and used when nothing else can be done to prolong life, occurred in the last decade⁽⁸⁾. In this period, broke the idea that patients should receive care only in their last few days and we started to recognize that there must be a balance between attempts to prolong life when you have real chances of longer survival, palliative symptom management and acceptance that there is no cure. One must consider the possibility that this

patient presents a useful survival or keep the disease under control for a significant time space.

For E2 and E7, palliative care is related to comfort. This can be understood as: humanization, family support, welfare of the sick person, meeting their needs, care and ability to maintain or restore the subjective well-being within their means as well as the balance between its limitations and potential⁽⁹⁾.

(...) It is attention, comfort. (E2)

(...) That's it...make you more comfortable in the last moments that are here with us. (E7)

The knowledge of the needs of care and comfort by the nursing staff, directs the professional reflections on the care environment and changes within the hospital setting, assisting in perceptions about the need for wellness and better QOL of the patient in palliative care⁽⁹⁾.

Pain control is considered by respondents as a definition of palliative care. Pain is considered in various aspects, from physical pain, triggered by a painful sensation; psychic pain generated by fears, sadness, insecurity, despair; pain that embraces social isolation, dependence and rejection; spiritual pain that includes the meaninglessness of life and death⁽¹⁰⁾.

With pain control we seek to improve the QOL of patients and is one of the basic principles of palliative care, according to the statements below:

Palliative care is not to let the patient go pain, suffering pass. (E6)

Palliative for the patient is not feeling pain. There will be more healing, but it is for him to have an end without pain. (E11)

Palliative Care guess is you do not leave the patient feeling pain. (E12)

Pain is present intensively in cancer patients, and in advanced cases of the disease it occurs in 50-75% of them⁽³⁾; the same among one of the most common signs and symptoms in patients with cancer. Study focuses on the role of nurses and the nursing staff is essential in the assessment of pain, as these professionals can track changes, and intervene when necessary⁽¹¹⁾.

The unrelieved physical suffering is one factor constant threat to the feeling of fullness

desired. Try a process of peaceful death without pain is, above all, have the opportunity to fully live his last moment. You must understand that before the terminal patient to adjust to their spiritual needs, it needs to have her relieved and controlled physical discomforts. Providing pain relief is the primary goal of palliative care⁽¹²⁾.

When expressing the concept of palliative care as humanization of care to both the patient and the family, respondents refer us to say Pessini when he says that considering the person not simply as a body, not reducing it to biology, pure and simple, is a big challenge⁽¹²⁾. Thus, holistic, multi-, inter- and transdisciplinary is imperative.

(...) It is the humanization of care as the family... (E2)

For me palliative care is to assist with both procedures we can do to improve their time here, and psychologically for him and his family. (E5)

In palliative care we seek to establish humanized able to offer physical comfort, psychological, social and spiritual support to the patient and his family⁽¹³⁾. The author points out that the humanized care to the patient with cancer and their families should be on a path that allows expressing feelings. In this context, the nursing staff that works with these individuals and their families should help them identify sources of help, inside or outside the family.

However, among the subjects, only one reported that palliative care is beyond the prescribed, performing technical activities, as reported by E14.

I believe that palliative care is care beyond what is prescribed medication, bathing... dressing. (E14)

Caring for a person with no possibility of cure requires technical knowledge and expression of affection. Hence arises the importance of understanding the patient as a whole, offering palliative and compassionate care, and this aspect does not pass the prescriptive actions, it is an intrinsic action of empathy and humanization. Another result that emerges from the statements of the interviewees is the definition of palliative care as care that provides a better QOL for patients. Being defined as the individual's perception regarding

their values and expectations as their position in life⁽¹⁴⁾, which meets the recommended by WHO.

Palliative care is to provide the patient a better quality of life, even though he has no cure. (E12)

(...) improving the quality of their life with this care, even without effecting a cure. (E15)

Promoting patient's QOL is not simply a measure of physical comfort or functional capacity, it is something that can only be defined by the individual patient and that over time can be changed significantly⁽⁸⁾. This points to reflect that in having a knowledge of the subject, there is concern as to watch and care for the person, giving her well-being, comfort and support.

To this end, care is constituted by a complex process in sharing affections of a plurality of vertents⁽¹⁵⁾. Concurrent with this process, the care and integrated care promote humanism, health and QOL.

In palliative care is advocated the care of dieing well, ie, live intensely and dramatically the last phase of life, since this stage that precedes death is understood as the last chance to work on its personal identity⁽¹⁶⁾ according to report of the deponents.

(...) palliative is alleviate his suffering in the final stages of life. (E13)

Palliative care is to alleviate the suffering and death of them, the best possible way to improve his situation... (E15)

Alleviate the suffering of patients in the final stage of life is necessary, because even without therapeutic possibilities there is still much to do for patients in advanced stage of disease, even if it cannot cure them. Many patients who do not benefit from curative treatments available, can receive considerable comfort as well as the improvement in her condition with the institution of comprehensive palliative care, ie, physical, mental, social and spiritual.

Have a dignified death, in peace and without pain requires a comprehensive team care in illness with psychological, social and spiritual comfort. The care of the pain and suffering is essential in order to restore the dignity of the human being in this critical context.

Facing the minds of respondents, it is clear that they refer to palliative care in a partial, fragmented way. Thus, working and improving

the quality of life of patients in palliative care is needed beyond that of technical and scientific knowledge workers in the health field are aware of the principles of palliative care as care that transcends the prescriptive.

Category II – Nursing care to the hospitalized cancer patients, without possibility of cure

Oncologic patients without the possibility of healing, spending most of the time for long treatments, establish greater contact with nursing professionals and become part of their world. In this sense, the relationship between professional and patient shall constitute an inter-relationship, encompassing the technical, scientific and emotional aspects namely determining bonds of personal and affective nature. These aspects may be essential to palliative care when proffer comfort, medicate for pain, provide support to the patient and family, show interest in helping them, they listen and they identify trouble accepting the death of those who care.

Among the care offered to patients in palliative care, comfort stands. The same etymologically originates from confortare Latin, meaning fortification, certify, corroborate, provide, comfort, ease, assist, help and assist⁽⁹⁾.

In the reports of deponents claim that perform care to provide comfort, such as changing positions, bathing, changing diapers, skin care, and pain control.

(...) treating the needs of the patient, such as pain, changing positions, bathrooms, all these precautions we already do (...) not because he is bedridden that you will not take a bath, will not put some talc, deodorant, give the shower and wash the scalp, comb, cut nails and all nursing care. In addition to the nursing care, see this aesthetic part of the patient, change sheets, clothing ... (E4)

The basic thing that we have to do here is to not let the patient feels pain, he is a FPTA patient or not, one cannot help a cancer patient to feel pain (E12)

In addition to the physical comfort measures, medication and other body care, some respondents indicated that they talk with patients, in order to offer them support and attention.

(...) assisting with more attention, be more caring with them. (E3)

Talk extensively with them to not feel alone. (E7)

Alleviate his suffering, paying attention, talking ... I think you give quality care, given the patient well and meeting their needs. (E13)

The actions of care that are inserted into the humanistic aspect and palliative therapy go beyond the performance of certain technical procedures. The touch, expressions of affection and small gestures in care, cause the patient's actions and enjoy time to time providing higher quality of life that has⁽¹⁷⁾. E14 for the care it provides emerge from the desire to meet the needs of the patient, either providing support or getting in your hand to make you feel that, despite being no possibility of cure, is a human being and deserves love, attention and the best care possible.

(...) care comes from the desire to meet their needs, talk, give affection, attention, because they need that kind word or a handshake. Being close, pay attention to him, show him interest ... is enough for them at this time. (E14)

Studies show that patients in his speeches, state that qualified professional is one who looks into the eyes, or watching shows and give importance to the patient speaks. In this sense, eye contact indicates interest and constitutes a facilitator of interaction with patients, as well as portraying emotions, the look has the important function of regulating the flow of the conversation and when there is a disruption of eye contact may denote lack of interest in continuing conversation, so that the interaction is interrupted or impaired. Thus, eye contact is essential for the approach and establishing a bond and trust with patients⁽¹⁸⁾.

The inclusion of the family in care was reported in most statements, which reflects the concern to show the family's team efforts to avoid his being suffers, promoting a dignified death without pain, as well as recognizing the family as an entity that also suffers.

We must pay attention to family because they know that the patient will die, but they do not want us to let him suffer. (E6)

(...) We try our best to comfort, especially the family, no matter what the family does not understand ... (E9)

Conversar com o paciente foi salientado como um cuidado que realizam e, um deles ainda incluiu o escutar como atenção. Conversar

e ouvir são elementos básicos para o cuidado humano, pois a comunicação aberta permite a expressão de pensamentos e sentimentos que podem e devem ser compartilhados durante o cuidar. Entende-se que esses fatores contribuem para uma assistência humanizada aliada ao conhecimento de seus sentimentos e percepções de situações vivenciadas por eles, para melhor cuidar.

Highlights the idea that family members are part of the circle of care and attention, the instance that supports the maintenance of this patient and that is directly involved in the care process, and can not then be relegated in the background.

Talk with the patient was noted as a caution that perform, and one of them still included as listening attention. Talking and listening are basic to human care elements because open communication allows expression of thoughts and feelings that can and should be shared during care. It is understood that these factors contribute to a humanized coupled with the knowledge of their feelings and perceptions of situations experienced by them, to better care.

Some patients, for very difficulty or the impact of diagnosis and prognosis, need to receive information gradually, respecting the time experienced by each. One of the tasks of the team members is to detect and care needs to provide clear guidance, gradual and use of accessible language form, encouraging their participation. In the reports can discern this care.

After drug treatment is what we can do ... cherish, care for, talk, listen. (E2)

(...) Chat, (...) care of that conversation (...) you always have something besides a word to bring to that patient and family to that (...) you only need that kind word (...). (E14)

Communication is an extremely important tool in the care process, especially when it comes to terminal patients, to strengthen the bond between patient/professional, encourage the patient to verbalize anxieties, worries and doubts about the clinical situation, to give opportunity to the patient / family to verbalize preferences in attendance and help them in decision making⁽¹⁹⁾. E8 and E10 the interviewees demonstrated ignore the pleas of hospice care in that state care for terminal patients as others implicitly with or without the possibility of cure.

(...) Just as I take care of others... Does not have any differential care (...) any and all care that we do for all patients are palliative care. (E10)

(...) I take care of them the same way I take care of others. He is already in a terminal phase, has no more to do, the only thing you can do is when you give him pain to go there and make a medication... is pain control. (E8)

When palliative care, we seek to also qualify the finiteness of the patient, in that caregivers need to implement proper care according to the patient's needs. Even being considered low-tech and high-touch, this is not contrary technologies of care related to traditional medicine, however, seeks to ensure care guided by love⁽¹³⁾.

E2 and E3 refer to the difficulties the team faces to make care at the prospect of the death of the patient. Although death is part of the daily lives of these workers, living and build links with patients and family, triggers feelings of loss, as evidenced in the testimonials.

(...) The staff is also quite difficult to care for and work with the losses. We have much loss here on oncology clinic. Here, we have much relationship (...). (E2)

Some employees want to leave, because here you have to be psychologically prepared to take care, take care and miss ... because many people die every day. (E3)

The breakup of the relationship between patient and staff, where the patient's death can raise in the professional negative feelings and suffering due to inadequate coping with the situation. The difficulties of living with the patient's suffering with pain and at death may be a reflection of the professional unpreparedness for, usually, professionals are advised not to show emotions⁽²⁰⁾. Such situations create discomfort and distress which can cause detachment of the patient and family; in this sense, the need to seek ways to minimize suffering, as therapies, meetings and discussions. The statements of the subject reveals the need to humanize care to patients and families, with an emphasis on holistic care, in order to learn, re-learn and understand their needs, including family members, helping them, guiding them and enabling their participation in major decisions of their lives. In this context, means the presence and participation of the family in patient care is vitally important. In short, take

care of the terminally ill or palliative constitutes a constant challenge for health professionals and, in particular, nursing.

FINAL THOUGHTS

The guy in the terminal phase of an oncological disease needs numerous care, guidance and considerations during this process. Therefore, it is necessary that the nursing staff that works with these patients have knowledge about palliative care.

These are in challenge for institutions and health professionals, because they require the implementation of various skills related to care. The technical and cognitive components are important, but the attitude and communication play a crucial role, since it reflects directly on people, families and the team itself.

The understanding of the nursing staff about the study of palliative care is not biased by welcoming the principles of WHO in its fullness. Some unveiled the understanding that palliative care aims to give QOL care to a person with no cure, pain management, other guys have to consider the promotion of comfort and care conceptualized so that does not involve aspects inherent to the principles of palliative care.

Regarding the care they provide to patients without the possibility of cure, the respondents claim that perform nursing procedures (changing position, hygiene, medications, etc.), talk and listen to the patient, provide support, touch. Highlights the predominance of care grounded in the biomedical model, where the execution of techniques prevails in relation to psychological and spiritual care.

It is worth noting that the nursing staff surveyed reveals that values the preservation of life, emphasizing the importance of maintaining the well-being of the patient terminal, watching it in a dignified manner, in order to ensure their comfort and pain control, as well as assisting patients and their families.

It is considered important that the professionals who care for patients beyond therapeutic possibilities receive emotional support to better cope with their anxieties and limitations in care practice. You can get a nuanced and aware of the obligations and duties

of care that health professionals have to patient, and also recognize that the outside chance of cure exceeds the therapeutic range, but will

never exceed the limits of care, their work object.

CUIDADOS PALIATIVOS A PACIENTES ONCOLÓGICOS: PERCEPÇÕES DE UMA EQUIPE DE ENFERMAGEM

RESUMO

Objetivo: conhecer percepções de uma equipe de enfermagem referentes à cuidados paliativos a pacientes oncológicos, bem como identificar os cuidados implementados. Metodologia: Estudo qualitativo, descritivo, exploratório. A coleta de dados ocorreu por meio de entrevista aberta. Participaram quinze trabalhadores de enfermagem que atuam em uma unidade oncológica de um hospital da região noroeste do Rio Grande do Sul/Brasil. Os dados obtidos foram analisados conforme preconiza a análise de conteúdo e foram agrupadas em duas categorias; uma referente à percepção dos trabalhadores sobre cuidados paliativos e a outra aos cuidados prestados aos pacientes. Resultados: apontam para a visão fragmentada acerca do conceito de cuidados paliativos influenciando no cuidado, através de técnicas de enfermagem, conversas com o paciente, escuta do paciente, atenção à família, apoio emocional; cuidados estes direcionados a proporcionar qualidade de vida, conforto, controle da dor e morte digna. Considerações finais: Cabe a equipe de saúde desenvolver medidas educativas para uma maior conscientização do cuidar paliativo, resultando em assistência integral e humanizada.

Palavras-chave: Assistência paliativa. Enfermagem. Câncer.

CUIDADOS PALIATIVOS A PACIENTES ONCOLÓGICOS: PERCEPCIONES DE UN EQUIPO DE ENFERMERÍA

RESUMEN

Objetivo: conocer las percepciones de un equipo de enfermería referentes a los cuidados paliativos a pacientes oncológicos, así como identificar los cuidados implementados. Metodología: Estudio cualitativo, descriptivo, exploratorio. La recolección de datos ocurrió por medio de entrevista abierta. Participaron quince trabajadores de enfermería que actúan en una unidad oncológica de un hospital de la región noroeste de Rio Grande do Sul-Brasil. Los datos obtenidos fueron analizados conforme preconiza el análisis de contenido y fueron agrupados en dos categorías: una referente a la percepción de los trabajadores sobre los cuidados paliativos y la otra a los cuidados prestados a los pacientes. Resultados: señalan para una perspectiva fragmentada sobre el concepto de cuidados paliativos influenciando en el cuidado, a través de técnicas de enfermería, charlas con el paciente, escucha al paciente, atención a la familia, apoyo emocional; estos cuidados son direccionados a proporcionar calidad de vida, confort, control del dolor y muerte digna. Consideraciones finales: Cabe al equipo de salud desarrollar medidas educativas para una mayor concienciación del cuidar paliativo, resultando en una atención integral y humanizada.

Palabras clave: Cuidados Paliativos. Enfermería. Neoplasias.

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Corresponding author: Cleci Lourdes Schmidt Piovesan Rosanelli. Rua São Boaventura, nº 37. Ijuí, Rio Grande do Sul, Brasil. CEP:98700-000. E- mail:cleci.rosanelli@unijui.edu.br.

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