http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude
ISSN on-line1984-7513
DOI: 10.4025/ciencuidsaude.v24i1.77234

ORIGINAL ARTICLE

INTEGRATIVE AND COMPLEMENTARY PRACTICES IN THE CONTEXT OF PALLIATIVE CARE

Kamila Rachadel*
Maria Lígia dos Reis Bellaguarda**
Nataniele Kmentt***
Michelle Kuntz Durand****
Bruna Canever*****
Adriana Dutra Tholl******

ABSTRACT

Objective: To understand the use of integrative and complementary practices in the context of palliative care. **Method:** Qualitative research, whose data collection was carried out in June 2021, by application of a semi-structured instrument with 11 health professionals and a spiritual assistant from two public hospitals linked to clinical units and palliative care commission, in Florianópolis, Santa Catarina. Thematic Content Analysis directed to the analytical processes. Study approved by the Research Ethics Committee of the Federal University of Santa Catarina, under opinion 4.079.038. **Results:** Two categories emerged from the analysis, the first: Ways of understanding the process of death and dying and the Integrative and Complementary Practices, in which there is the recognition of the finitude and importance of palliative care and the relationship of these practices as mitigating suffering. The second category: Structure of the assistance by the Integrative and Complementary Practices in palliative care, where they show the decision-making regarding the application of the practices in palliative care. **Final thoughts:** The findings allow to reflect on the importance of integrative practices, through the recognition of professionals as an approach that improves health care.

Keywords: Palliative care. Death. Health personnel. Holistic health. Complementary therapies.

INTRODUCTION

The health care scenario and, consequently, the resources necessary for the team to promote assistance in all phases of life, has evolved gradually and effectively in front of the contributions of researchers and professionals of the assistance practice. In recent years, research and discussions have expanded to cover the entire life cycle - birth, childhood, adolescence, adulthood, aging and the process of dying and death - with special attention to the need for palliative care (PC) according to the profile and individual demands[1,2].

In the meantime, it is worth rescuing the definition proposed by the World Health Organization (WHO), through consensus among experts, in which PC are active care of individuals of all ages with potentially fatal diseases, carried out by a multidisciplinary team based on the prevention and relief of health-related suffering. This suffering may involve physical, social, emotional and spiritual commitment, demonstrating negative impact on people's quality of life, burdening treatments and causing stress to caregivers[3-4].

As a care resource, there are the Integrative and Complementary Practices (ICPs) that can be strategies that meet the quality markers of the PC. They also stimulate the natural mechanisms of defense, prevention, treatment of comorbidities and diseases and recovery of health[5]. By adopting them, it is possible to minimize the suffering and physical, psychological and emotional/spiritual pain, with actions by a multidisciplinary health

*Nursing student. Scientific Initiation Scholarship (CNPQ). Federal University of Santa Catarina (UFSC). Florianópolis, Santa Catarina, Brazil. Email: kamilarachadel@gmail.com. ORCID: https://orcid.org/0009-0003-3435-0092.
**Nurse. Doctor of Nursing. Professor in the Department of Nursing and the Graduate Nursing Program at the UFSC. Florianópolis, Santa Catarina, Brazil. Email: m.bellaguarda@ufsc.br. ORCID: https://orcid.org/0000-0001-9998-3040.
***Nurse. Master's degree in Nursing. PhD candidate in the Graduate Nursing Program at the UFSC. Scholarship recipient through the Academic Excellence Program (PROEX) of the Coordination for the Improvement of Higher Education Personnel (CAPES). Florianópolis, Santa Catarina, Brazil. Email: nataniele.kmentt.enf@gmail.com. ORCID: https://orcid.org/0000-0001-9798-6547.
****Nurse. Doctor of Nursing. Professor in the Department of Nursing and the Graduate Nursing Program at the UFSC. Florianópolis, Santa Catarina, Brazil. Email: michakd@hotmail.com. ORCID iD: https://orcid.org/0000-0003-3660-6859.
*****Nurse. Doctor of Nursing. Professor in the Department and Graduate Program in Nursing at the UFSC. Florianópolis, Santa Catarina, Brazil. Email: bruna.canever@ufsc.br. ORCID: https://orcid.org/0000-0002-3484-0740.
******Nurse. Doctor of Nursing. Professor in the Department of Nursing and the Graduate Nursing Program at the UFSC. Florianópolis, Santa Catarina, Brazil. Email: adriana.dutra.tholl@ufsc.br. ORCID: https://orcid.org/0000-0002-5084-9972.

team, applicable throughout the course of the disease[3].

ICPs were created by the Traditional Medicine Program of the WHO, in the late 1970s, as a set of safe and regulated health promotion strategies. With the creation of the Unified Health System (UHS) in Brazil, in the 1980s, it was established the need to ensure the legitimacy of the ICPs, which was only possible through the implementation of the National Policy of Integrative and Complementary Practices (PNPIC) of the UHS, by the Decree n. 971, of May 3, 2006[6].

Considering that the health professional is the center of all stages of the care process, with the responsibility to restore well-being and provide dignified care, including a death watered by humanity, it becomes crucial to seek strategies, technologies and evidence that subsidize assistance at all stages of life. Given the challenging moments of providing PC, it is essential that these professionals are strengthened and supported by new ways of caring in palliation, a context in which ICPs can be inserted as support tools[7,8].

The sense of transformation of practices in the evolution of human recovery and healing during illness qualifies care with a view to well-being, understanding the process of health and disease[5,9]. It is considered that health production has value when it is developed through care that allows the expression of subjectivity of subjects, giving patients and family members the option to choose their care object, involving the active integrality of their care, promoting quality of life[5,9-10].

In this context of subjectivity, institutionalized care practices - as a science for the promotion, rehabilitation and prevention of health problems - are re-signified, especially in situations involving PC[5,9,11]. This highlights the importance of studies that address the life-death-life continuum, under the paradigms of sensible reason, transdimensionality and spirituality on a scientific basis, signaling the ICPs and the insertion in the hospital environment[12].

ICPs have been very effective in care, especially in the control of pain and anxiety, reduction of drug use and consequent reduction of adverse reactions[5]. Reiki and relaxation techniques, the laying on of hands for the transmission of vital energies and the application of acupuncture are widely used[13]. Furthermore, the importance of these complementary therapies in the oncology scenario should be reinforced, where professionals use the therapies to promote relaxation beyond pain relief, promoting family participation and stimulating contact between health professionals and patients[7].

The use of ICPs facilitates access to services and the performance of professionals with basic and specialized training in PC, at all levels of health care. In addition, its effective use is enhanced by the engagement of universities, welfare institutions, education and research in PC[14-15].

The expansion of the application of ICPs in care practice is gradually growing, but there are still limitations. Among these are the absence of permanent and continuous training, availability in health services, as well as the difficulty of understanding by many professionals the effectiveness of its use in promoting health and relieving pain and suffering[16].

In this context, there is a need for more studies that demonstrate the use of these practices aimed at people during finitude, according to the definition of PC proposed by the WHO. This expansion allows to support health professionals in the assistance and contribute with the proposal of new strategies for health care and the specificity of the hospital environment. It is noteworthy that this study was developed in pandemic time, when Brazil accumulated in October 2020, 4,906,833 confirmed cases of covid-19 and presented itself as the 2nd country with the highest number of deaths (145,987)[17]. The health systems presented themselves in deterioration of care, with overcrowding of hospital beds, lack of resources and administrative difficulties due to health crisis. In addition to being charged from the professionals exhausting work days, new skills, adjustments necessary at all times and dealing with the emotional everyday of working on the front line.

Faced with these arguments, this study aims to understand the use of integrative and complementary practices in the context of PC.

METHOD

For methodological description, we followed the guidelines Consolidated criteria for reporting qualitative research (COREQ)[18]. This is a qualitative research with an exploratory and descriptive approach that was developed with

palliative professionals in two public hospital institutions located in the city of Florianópolis, Santa Catarina (SC).

One institution of the study was a general school hospital and the other institution was a reference hospital in oncological treatment. Both institutions have a Palliative Care Commission and/or Palliative Care Unit and provide care through the UHS. The rationale for choosing the institutions was that they are spaces for development and professional training, because there is a service/school partnership, and one of them being reference in PC in the state of Santa Catarina.

Data were collected in June 2021, after the reduction of the severity of the pandemic. The inclusion criteria were: to be a health professional, effective of the functional framework and member of the PC committee and medical clinic of the institutions. The criteria for non-inclusion were professionals on vacation and/or leave during the period of information collection.

To present the research project, the lead researcher and the study advisor (first and second authors, respectively) sent a video presenting the objectives and the research question to the research management of the institutions and health professionals, in addition to the invitation to participate in the study. This modality was chosen so that the professionals could know about the project and the research interest.

The recruitment was carried out by referrals of nurses from each sector of the institutions (for convenience), which indicated the possible eligible participants, who were contacted being invited to participate and as accepted by them, followed by the collection stage. Subsequently, they were contacted via WhatsApp® and phone and received the Informed Consent Form by the Google® document management platform. Thus, 41 professionals were contacted, of the 30 eligible for participation, but 11 people accepted and effectively participated in the study. The professionals who did not participate was because they did not respond to the call for research and because they were on vacation or away from the work process.

Data collection took place through semi-structured interviews. Only one participant conducted an interview in person, the others requested sending the instrument by e-mail or WhatsApp®. No pilot interview was conducted and these instruments returned answers in an average of ten to 12 days to the researchers.

In the application of the collection instrument using WhatsApp® on mobile phones, participants answered each question via audio. Initially, we collected data on the identification of participants, followed by questions regarding their understanding, such as: What is integrative and complementary practice for health care? ; If it has already been taken care of through integrative practice, which? ; If the integrative practice is considered effective in clinical practice; If the participant has already seen patients with ICPs, which ones? and; The perception of the participants about the assistance from the integrative practices with patients in PC.

Regarding the research team, it should be noted that the interviews were conducted by the first author of this article, a graduate in nursing, a scholarship student guided and supervised by the second and fourth authors, doctors in nursing and teachers from the nursing department. There was training prior to the interviews so that the harvester was properly trained to perform the collections. No field notes were made.

Data saturation resulted from the fact that there were no differentiated and new information that would deepen the theme beyond what is interpreted, within the perspective of this study. Since it is understood that in a research the data bring the new to be interpreted, depending on the researchers' view and analysis through different theoretical dimensionalities[19].

The audios were transcribed manually into a text document by Microsoft Word®, version 7 and subsequently revised by the study supervisor. The feedback to the participants was made through a report sent to the participating institutions of the research.

Regarding the data analysis, the methodological orientation to interpret the findings of the study was the Thematic Content Analysis[20] in the three phases: (1) Pre-analysis - extensive reading of the material following the rules of completeness (all information regarding the object of study must be considered), representativeness (quantity and quality of data sampling), homogeneity (single focus of study) and relevance (refers to the objective of analysis); (2) Content Coding Phase - highlighting the most emerging

issues related to the professional and the patient and family (perception and understanding) and, the ICPs/PC relationship (ways, practices used, results). The significant recording units of the presented content were used, emerging nuclei of meaning that composed the frequency of appearance and significance for the analysis and interpretation of the information; (3) Treatment Phase of the Results - followed with the interpretation and analysis of data corresponding to the Integrative and Complementary Practices, where the professionals, by representativeness, brought the reflection on death and dying, PC, the perception of ICPs and the modes of health care to death. As for the integrative practices with patients and families, we highlight the known practices and performed in PC and chronic condition and the effectiveness evidenced by the ICP in PC to this population.

Before the content analysis, a diagram is presented with the codes that made the categories emerge.

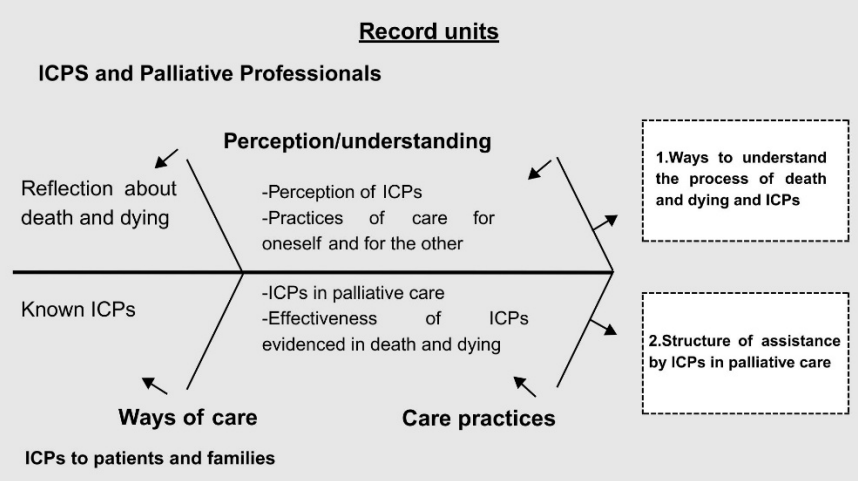

Figure 1. Coding diagram. Florianópolis, SC, Brazil, 2022.
Source: Created by the authors. 2021.

Regarding the ethical considerations, to carry out the study, authorization was requested to the Research Management of the institutions, obtaining their letters of consent. After submission in the system of *Plataforma Brasil*, the research was approved by the Research Ethics Committee of the Federal University of Santa Catarina, under opinion of n. 4.079.038. The invited professionals signed the ICF for participation and ensured the guarantee of the right to secrecy and anonymity respecting Resolution n. 466/12 of the National Health Council for Human Research and its ethical precepts. The identification of participants, in the results of the study, followed the initial letter of the professional/acting area and the numeral corresponding to the interview order and/or the return of the Googledocs® instrument (E1, M1, C1, etc.).

RESULTS

The participants were 11 people, being 10 health professionals - a social worker, five nurses, a psychologist, an occupational therapist and two nursing techniques- and a spiritual/religious assistant - chaplain. The chaplain was the only male participant and the age of the participants ranged from 26 to 59 years.

The average training time was from five to 35 years of work in the health area and only one of the professionals, a nurse, with specific training in PC. It is observed that the specific training in PC is only one professional, it is highlighted that not all professional categories of PC committees participated in the research. This clarifies that PC training covers other categories, which did not participate in this study. The sense and understanding that they present of death and PC is the one that deals with the moment of existential finitude, from a dignified assistance and comfort. About the training in ICPs, a nurse presents specialization in acupuncture.

From the collected data emerged two categories: "Ways of understanding the process of death and dying and ICPs" and "Structure of

assistance by ICPs in palliative care". It should be noted that the structuring of the relationship between ICPs and PC refers to the interlacing of ideas and the junction between care practices and the needs and specificities found in the care process in palliative care.

Ways of understanding the process of death and dying and ICPs

In this category, the participants' conceptions about the process of death and dying are presented, articulated to the understanding of life, the role of the PC and the importance of using ICPs in this path. The talks reveal that the end of life is perceived as a moment that requires integral care, centered on the person and the family, focusing on dignity, comfort and reduction of suffering. This understanding can be observed in the following speeches:

> It is the final stage of life, which focuses on the person and not the disease, neither accelerating nor delaying death, but maintaining serenity so that the last days of life are dignified and of high quality (E2).

> It is when life is nearing its end, palliative care aims to promote comfort for the patient and their family, not accelerating the dying process, but rather facilitating it through comfort (C1).

> It is the end of life. In palliative care, the focus is on the patient, seeking to improve quality of life, offering security to the patient and family (TE1).

> The process that the patient goes through at the end of life, which must involve care, also for family members, to avoid suffering at the end of life, so that it is a painless passage and promotes comfort for the patient and family (TE2).

The reports show that health professionals have an enlightened view on the proposal of PC in the health scenario. It is demonstrated by the speeches the knowledge about the purpose of the PC, directed to the relief of discomfort and offer safety to patients and their families.

Still within this category, it is observed that, by understanding the process of death and dying, participants assign to ICPs a supporting role in end-of-life care. In this context, participants consider the following integrative practices in therapeutic care:

> These are treatments that utilize therapeutic resources based on traditional knowledge, aimed at prevention and also used in palliative care (E1).

> These are practices used to assist in the treatment of patients with diseases of physical, emotional or spiritual origin. Examples: Flower essences, meditation, prayer, Reiki, acupuncture, music therapy, ozone therapy, shiatsu (P1).

ICPs are mentioned not only as techniques, but as care resources capable of relieving physical, emotional and spiritual suffering, favoring comfort and well-being during terminality. Among the most prominent are Acupuncture, Reiki, Massage Therapy, Aromatherapy, prayer and meditation, applied by different professionals, including chaplain, occupational therapist and psychologist, with sessions ranging from 15 minutes to an hour.

The appreciation of traditional knowledge is evidenced in a concrete way in the speeches of participants, noting mention as a resource for prevention and treatment, aligned with PC. There is also an expanded conception of the illness process, taking into account the multidimensionality of the illness, revealing a perspective in line with the principles of the ICPs, which converge with an integral approach to care.

Structure of assistance by ICPs in palliative care

This category reveals how professionals build or weave, the decision-making regarding the use of ICPs in PC assistance. The choices about when, how and for whom to use ICPs emerge from continuous assessments of the physical, emotional and spiritual needs of patients, family members and also of the health team itself.

> I develop ICPs with employees, patients, family members, and caregivers in hospitals, including prayer, Bible reading, and pastoral counseling. People hospitalized in hospital units and healthcare workers are more open to spiritual issues due to high levels of physical, emotional, and spiritual stress (C1).

It is observed that the pandemic required adaptive and contextualized decisions to the scenario, allowing the introduction of ICPs in the management of suffering.

> Now during the pandemic, I used guided meditation and spiritual healing with patients in palliative care (E1).

The decisions to use ICPs involve both the identification of immediate demands, such as pain

and existential suffering, and observation about flexibility for use with patients and families.

> Integrative practices provide better quality of life, inner peace (emotional and spiritual), and enable the development of protective factors in the face of existential suffering or terminal illness (TO1).
>
> It helps control pain, and consequently calms the patient and family (E3).
>
> Essential, as integrative practices help both physiologically and psychologically (P1).
>
> I think integrative practices used in palliative care patients would be important, as it could be a way to reduce medication use and bring well-being (E2).

This acceptance guides the adoption of techniques such as prayer, guided meditation, Reiki, acupuncture, massage therapy, aromatherapy and spiritual counseling, whose need is perceived in the trajectory of illness in which the ICPs are recognized and can be incorporated, as mentioned in the previous category. In this sense, the structure of care reveals that professionals recognize ICPs as tools that enhance well-being and expand the therapeutic possibilities of palliative care.

The integration of these practices with conventional treatments is described as a way to offer comfort, contemplating physical, emotional and spiritual dimensions. In general, it is observed that the ICPs are perceived as fundamental in the decision-making process of the team in the context of palliation. They are not applied in isolation, but constitute a network of actions that interweaves with emerging demands, supporting an assistance that seeks to alleviate suffering and promote dignity in the process of dying.

DISCUSSION

The process of dying and death itself is intrinsically linked to the course of human life[21]. Consonant to literature, in the universe studied, issues related to beliefs, religiosity and spirituality show that participants consider death in the technical and scientific aspect as part of the experiential process. Death is mentioned as another stage of life, marked by physical cessation and it is observed that the participants recognize the process of dying as a living process and as such needs to be carefully cared for.

In this sense, it is reflected that the care offered during the dying process is ressignified, due to palliative care being a differentiator[22]. This type of assistance seeks the promotion of dignity and relief from suffering, allowing multiple focuses of attention, in which well-being and comfort extend to the family[10]. Even with scientific advances on the subject, nowadays, there is still a need for greater understanding of PC by both patients and their families, as well as health professionals.

It is evident that, socially, there is still predominance of care performed by the biomedical and curative model understood as a source of security in times of distress and compassion on the part of health professionals and example of effective care, in which the preference for hospital-level care predominates[8]. This social conception interferes with the care provided during finitude, exacerbating the difficulty of understanding professionals and, consequently, patients and relatives about PC focusing exclusively on physical body care[22].

In this scenario, the ICPs emerge as a complement to conventional care aligning with the principles of the PC[10]. They allow the integration of techniques, technologies and approaches in order to support people and their families during this process. As can be seen from the participants of this study, the ICPs allow the execution of an extended care, shared with the clinical assistance already solidified by science.

The association between PC and ICPs is an emerging issue as both envisage integral, individualized care, optimizing the quality of life and reducing suffering. The application of ICPs, as well as the provision of PC early on, that is, at the beginning of the diagnosis of the disease, allows a more effective control of symptoms and well-being[10]. The use of these strategies demonstrates an understanding of the need to provide PC, positively modifying traditional modes of care during the end of life[24].

In a global context, the participants of this research demonstrated knowledge about the application of ICPs in the context of palliation, especially those that meet care to the spiritual sphere to ease suffering and facilitate the coping with finitude. In this sense, the chaplain, psychology and occupational therapy are identified as integrative categories that understand the need to identify individual needs for the effectiveness of

holistic care.

The literature highlights prayer and meditation as strategies that approach spiritual experiences[25]. Such practices are most often understood as religious practices, as particular meanings for approach to the sacred and religiosity as dogmas, considered organized systems of beliefs and rituals that can bring peace in the process of dying[25].

The Hospital Chaplaincy in interaction with health professionals, characterizes the religious service of institutions and this study shows itself as an active action of support, performed by the chaplain, ensuring emotional harmony to patients and families. The way these practices are presented in daily care is in daily visits, whose weekly meetings have their duration defined according to the need of each person.

In Brazil, since the 2000s, access to religion in hospital environments is regulated by law and points out the exercise of spirituality as an agent of transformation that harmonizes the emotions of patients and families[5]. A literature review showed that chaplains, although not clinical professionals in care, were involved in the preparation of specialized care plan in PC and developed a relationship of care and support to patients and families, in addition to accompanying during mourning[26].

Concerning the performance of occupational therapist is mentioned the application of acupuncture, in which are worked the meridians of relatives and patients in PC, allowing flowing the own energy of individuals, enabling the regulation of some physiological functions such as blood pressure stability, the relief of painful sensation, anxiety, among others[27].

Both acupuncture and auriculotherapy are performed in patients and family members and recognized as therapies that help in the relief of musculoskeletal pain, showing itself as an integrative resource that promotes psychic-organic regulation from the stimulus of energetic points located in the auricle[28]. These findings corroborate the contributions of Traditional Chinese Medicine in reducing pain, treating anxiety, chronic and degenerative diseases, and reducing fasting glycaemia[28].

This study shows that, in the hospital environment and under the perspective of the PC, the ICPs emerge as the care actions applied. However, nurses retain the belief and are adepts to ICPs, but do not yet have intense formal or informal education in the area of natural therapy activities. Even with a growth of studies related to nursing and ICPs, professionals present frailty in teaching about the proposed implementation of ICPs during graduation, and specifically in hospital-level care[27].

This study found that integrative practices are support not only for patients and family members, but also for the professional team involved in the care of these people, since they help in decision-making. The ICPs are internationally recognized and understood, as practices that naturally stimulate the prevention of diseases and illnesses, and the recovery of health by safe means, from natural resources in which there is a search for recovery and assistance away from medicalization practices and the biologist model[28].

In Brazil, the consolidation of the National Policy on Integrative and Complementary Practices (PNPIC) in the UHS brought innovation, autonomy and sharing of responsibilities in health care, being considered an advance in the area[28]. In Primary Health Care (PHC), the ICPs are widely used and there is an acceptance of application by professionals, patients and families, its use in less serious situations and associated with self-care practices and maximized understanding about the process of health and disease, in this scenario[16].

However, this progress needs to be continuously rescued, as it does not yet reflect its consolidation in the hospital scenario, which is still very focused on clinical and biological evidence. There is also evidence of prescribing attitudes of the ICPs in a timid way by professionals, minimizing the supply and availability of accessible, scientific, low-cost and medicalization-reducing care actions[8,28].

Then, some limitations of applicability of the ICPs are emphasized. It is observed that, due to the demand for care during finitude, there is an emerging need for continuing training for professionals, as well as the formulation and standardization of institutional protocols that allow the integration of ICPs with PC. This need arises from the observation that ICPs in integration with conventional health treatments enhance the well-being of patients, families and professionals themselves involved in palliative care, optimizing health care.

Therefore, it is intended to show the importance of this study, to describe the reality of the institutions studied, which present PC committee and are characterized by being reference institutions, one state in oncology and the other a general school hospital, both with educational and training practices in health. Certainly, the clinical practices in interaction with ICPs would determine another scenario to the assistance in PC.

It was possible to observe that the mentioned practices demonstrate comfort, safety and relief of pain and anxiety by promoting well-being to patients and relatives at this stage of life, however they are not effectively consolidated with respect to insertion into care routines in the studied scenarios[7]. Within the scope of health practices, approaches and care strategies are needed that strengthen the health team and promote reception, allowing family involvement in care until the moment of death[3,5].

The limitations of the study concern the restrictions in the development of this article that were directly proportional to the time and dynamics of work in the post-pandemic year, when the services were reorganizing. Limitations in recruitment can be mentioned, given the lack of return from several professionals to participate in the research.

Moreover, there was a limitation regarding the period of the need for adaptation and adoption of different collection techniques (online), the restricted training of professionals in relation to ICPs and PC and the absence of participants from other specialties (medicine, nutrition, physiotherapy, speech therapy, among others) that could enrich the data of this study because they are fundamental in promoting interdisciplinary care recommended by PC.

FINAL THOUGHTS

The study brings to the understanding that the use of ICPs in the context of PC and, in hospital environment is possible and aggregates different strategies for the relief of biopsychospiritual symptoms for care. It is considered that more research is needed between the practice of common sense and scientific advances, aiming to expand the use of ICPs in different contexts and in PC. The study highlights the need for qualification of professional training to improve health care in the care of people and families in PC. There should be new studies including other professional categories involved in health care within the scope of palliative care in integration with ICPs and in the hospital context.

ALCANCES DE APERFEIÇOAMENTO EM SAÚDE MENTAL E ATENÇÃO PSICOSSOCIAL DE ADOLESCENTES PELA ÓTICA DA INTEGRALIDADE

RESUMO

Objetivo: Compreender o uso das práticas integrativas e complementares no contexto dos cuidados paliativos. **Método:** pesquisa qualitativa, cuja coleta de dados foi realizada em junho de 2021, por aplicação de instrumento semiestruturado junto a 11 profissionais de saúde e um assistente espiritual de dois hospitais públicos vinculados a unidades clínicas e comissão de cuidados paliativos, em Florianópolis, Santa Catarina. A Análise de Conteúdo Temática direcionou aos processos analíticos. Estudo aprovado pelo Comitê de Ética em Pesquisa da Universidade Federal de Santa Catarina, sob parecer 4.079.038. **Resultados:** Emergiram da análise duas categorias, a primeira: Modos de entender o processo da morte e do morrer e as Práticas Integrativas e Complementares, em que há o reconhecimento da finitude e da importância dos cuidados paliativos e a relação dessas práticas como atenuantes do sofrimento. A segunda categoria: Tecitura da assistência pelas Práticas Integrativas e Complementares em paliação, onde evidenciam a tomada decisória em relação a aplicação das práticas em cuidados paliativos. **Considerações finais:** os achados permitem refletir sobre a importância das práticas integrativas, por meio do reconhecimento dos profissionais como uma abordagem que aprimora o cuidado em saúde.

Palavras-chave: Cuidados paliativos. Morte. Pessoal de saúde. Saúde holística. Terapias complementares.

PRÁCTICAS INTEGRATIVAS Y COMPLEMENTARIAS EN EL CONTEXTO DE LOS CUIDADOS PALIATIVOS

RESUMEN

Objetivo: comprender el uso de las prácticas integrativas y complementarias en el contexto de los cuidados paliativos. **Método**: investigación cualitativa, cuya recolección de datos se realizó en junio de 2021, por aplicación de instrumento semiestructurado junto a 11 profesionales de la salud y un asistente espiritual de dos

hospitales públicos vinculados a unidades clínicas y comisión de cuidados paliativos, en Florianópolis, Santa Catarina/Brasil. El Análisis de Contenido Temático se dirigió a los procesos analíticos. Estudio aprobado por el Comité de Ética en Investigación de la Universidad Federal de Santa Catarina, bajo dictamen 4.079.038. **Resultados**: surgieron, del análisis, dos categorías, la primera: Modos de entender el proceso de la muerte y de morir y las Prácticas Integrativas y Complementarias, en las que hay el reconocimiento de la finitud y de la importancia de los cuidados paliativos y la relación de estas prácticas como atenuantes del sufrimiento. La segunda categoría: Articulación de la atención a través de las Prácticas Integrativas y Complementarias en cuidados paliativos, donde evidencian la toma de decisiones respecto a la aplicación de las prácticas en cuidados paliativos. **Consideraciones finales**: los hallazgos permiten reflexionar sobre la importancia de las prácticas integrativas, a través del reconocimiento de los profesionales como un enfoque que mejora el cuidado en salud.

Palabras clave: Cuidados paliativos. Muerte. Personal de salud. Salud holística. Terapias complementarias.

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Corresponding author: Nataniele Kmentt. Rua Delfino Conti, S/N - Trindade, Florianópolis - SC, 88040-370, Centro de Ciências da Saúde. Telefone: (53)984261561. Email: nataniele.kmentt.enf@gmail.com.

Submitted: 06/06/2025
Accepted: 14/12/2025