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ORIGINAL ARTICLE

Perception of healthcare professionals in a teaching hospital about palliative care in pediatrics

Fernanda Queiroz Xavier[1], Juliana Queiroz Xavier[2]

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Abstract

The philosophy of palliative care is about maximizing a persons quality of life. Through physical, social, psychological, spiritual and family support, in a meaningful and effective way, the patient is given the possibility of being themselves in a time of difficulty. This is a quantitative-qualitative research, which used structured and semi-structured interview techniques, carried out in Goiânia, with a sample of 30 health professionals, who were actively working in sectors of the Pediatrics Department of the Hospital das Clínicas de Goiás - EBSERH. The average age of the participants was 30.97 years, with a predominance of females. Approximately 56.7% were single and doctors were the most prevalent in the study. In relation to the questionnaires, the majority stated that they felt insecure when talking about palliative care, in addition to stating that they did not believe in the teams preparation regarding this topic. The results of the semi-structured interview were arranged into topics, the most prevalent of which were training, care and communication. There is a need to expand the discussion about CPP, to better apply its principles.

[1] Universidade de Rio Verde, Medicina - Rio Verde - Goiás - Brazil.
[2] Universidade Federal de Goiás, Departamento de Pediatria do Hospital das Clínicas UFG/EBSERH - Goiânia - Goiás - Brazil.

Correspondence to:
Fernanda Queiroz Xavier
Universidade de Rio Verde. Fazenda Fontes do Saber, s/n, Rio Verde, GO, Brazil. CEP: 75901-970. E-mail: fernandaqx@hotmail.com

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INTRODUCTION

Palliative care (PC) philosophy is about maximizing a person's quality of life. Through meaningful and effective physical, social, psychological, spiritual and family support, patients are allowed to be themselves during difficult times. In this sense, a multidisciplinary team is necessary, from which the skills of various professionals are brought together and used to support this care[1].

The first historical record of palliative care dates back to 1960. At the time, Cicely Saunders, a physician, nurse and social worker from the United Kingdom, started a care movement that included assistance, teaching and research, aiming to bring comfort to patients. Following this line, in 1967 the first inpatient institution was founded with the sole purpose of monitoring, treating and clinically supervising terminally ill patients, St. Christopher's Hospice. In 1970, this trend reached America through Elisabeth Kubler-Ross, a psychiatrist who had contact with the work that Cicely promoted in the United Kingdom[2].

In Brazil, the first palliative care service was opened in 1991, at the National Cancer Institute. Over the years, the service developed, and in 2004, the Cancer Hospital sought a more modern vision. With a set of assistance actions based on the provision of comprehensive and humanized care, the Hospital promoted physical comfort and psychological support with the aim of improving the environment and working conditions of those involved in the care process[3].

Advances in science have also made it possible to increase life expectancy for pediatric patients. As a result, the number of children with life-threatening conditions has increased considerably[4]. When offered at the right time, Pediatric Palliative Care (PPC) can improve quality of life, reduce stress and provide support for everyone to go through the grief of losing a child[5].

Planning for death is a difficult process for the entire medical team. However, the family is the unit most affected by this moment[6]. In this sense, high-quality communication with the family unit opens the door to a calmer environment, associated with feelings of comfort and peace of mind[7].

It is important that the team be trained to adapt their form of communication so that it is in synergy with the needs of patients and their companions. To do this, it is necessary to pay attention not only to verbal language, but also to non-verbal language. By allowing the pediatric patient to feel comfortable expressing their fears, desires and anxieties, palliative care becomes more effective for the entire unit involved in the situation[8].

METHODOLOGY

This is a mixed research project, with qualitative, phenomenological and quantitative, descriptive-exploratory methods. Semi-structured and structured interview techniques were used, respectively, in addition to a survey with epidemiological data.

The institution studied was the Hospital das Clínicas UFG/EBSERH in Goiânia, Goiás - Brazil. The instruments were applied from October 2021 to November 2021.

Three questionnaires composed of direct questions were applied to 30 healthcare professionals from the Pediatrics Service at HC-UFG/EBSERH, in addition to a semi-structured interview with eight participants. After the application, a quantitative and qualitative assessment was carried out to establish the participants' perceptions and level of basic knowledge about palliative care management.

For the qualitative interpretation of the semi-structured interviews, the content analysis method was used, in the thematic analysis modality. The recordings of the interviews were written down in full and interpreted by the researchers.

For the statistical analysis of the quantitative part of the study, the data from the epidemiological questionnaires and structured interviews were used as components. A computerized instrument was developed for the file in the Statistical Package for the Social Sciences software version 22.0 and the data were entered by the researchers. The results were analyzed using the following statistical tests: a) measures of central tendency and variability - mean, median, standard deviation and confidence interval of the mean (95% CI), assessed by descriptive statistics; b) Chi-square test or Fisher's exact test, in the case of qualitative variables. The significance level adopted was 95% ($p<0.05$).

RESULTS

The mean age was 30.97 years, with a predominance of females in 90.0% of cases. Most participants were single (56.7%), Catholic (46.7%) and had higher education (63.3%), with physician being the most prevalent profession in the study (36.7%). Professionals who did not have a fixed work unit were the most prevalent (46.7%), in addition, the median time since training in pediatrics was 1.0 year (Table 1).

The interview on personal impressions (Table 2) revealed that 81.8% of physicians felt insecure when talking about palliative care, while 60.0% of nurses and 100.0% of physical therapists did not. All professionals believed that the practice of palliative care was important and possible, although 4 physicians (36.4%), 1 nutritionist (33.3%) and 1 pharmacist (50.0%) stated that they had difficulty accepting that children may need palliative care.

Sixty-three percent of physicians, 50.0% of nursing technicians, pharmacists and speech therapists stated that they did not feel capable of caring for patients in PPC, and most professionals acknowledged that family acceptance or not interferes with palliative care practice.

There was significant divergence in the participants' opinion regarding the team's preparation to deal with patients in palliative care: 100.0% of physicians, physical therapists

Table 1. Distribution of epidemiological variables of the 30 healthcare professionals included in the study.

Characteristics	n	%
Age in years (mean/SD*)	30.97 (8.43)	
Sex		100%
Males	3	10.0%
Females	27	90.0%
Marital Status		
Single	17	56.7%
Married	12	40.0%
Widow (er)	1	3.3%
Schooling		
Technical	2	6.7%
Higher	19	63.3%
Specialist	6	20.0%
MSc.	3	10.0%
Religion		
Catholic	14	46.7%
Evangelical	10	33.3%
Spiritism	4	13.3%
No religion	2	6.7%
Children		
None	22	73.4%
1	4	13.3%
2	3	10.0%
3	1	3.3%
Profession		
Physician	11	36.7%
Nurse	5	16.7%
Nurse technician	2	6.7%
Psychologist	3	10.0%
Nutritionist	3	10.0%
Physical therapist	2	6.7%
Pharmacist	2	6.7%
Speech therapist/audiologist	2	6.7%
Place of work		
Pediatric ward	5	16.7%
UTIN	1	3.3%
UCIN	4	13.3%
SERUPE	6	20.0%
No fixed unit	14	46.7%
Time in training (years)	6.76 (8.73)	100%
Time in the job – Pediatrics (years)	1**	1-28

UTIN – Neonatal intensive care unit; UCIN – Neonatal intermediate care unit; SERUPE – Pediatric emergency service at HC-UFG-EBSEHR.
*SD – standard deviation of the mean.
** – median – most had one year of experience, but there was a range of 1-28 years.

and pharmacists stated that they believed the team was not prepared, while 60.0% of nurses, 100.0% of nurse technicians and 66.7% of psychologists stated that the team was prepared.

Statistically relevant results were also obtained regarding discussions about palliative care during academic training: 80.0-100.0% of physicians, nurses, nursing technicians and speech therapists received some type of information about PC, in contrast to only 33.3% of psychologists and none of the physical therapists and pharmacists.

Regarding the questionnaire on knowledge of palliative care (Table 3), although healthcare professionals felt the need for more training in the area of palliative care and were uncertain about the topic, they performed well when answering basic and universal questions about palliative care.

Only one professional believed that palliative care indicates the end of life, and another that children in palliative care should not receive curative care. The question that generated the greatest divergence was about whether the family agreed with palliative care, since 81.8% of doctors, 80.0% of nurses and 66.7% of psychologists chose the answer ''false'' and 100.0% of speech therapists answered ''true'' to this question.

Eight healthcare professionals agreed to participate in the semi-structured interview. Through a categorization of subjects (Table 4), it was possible to classify the results into topics.

Concept of palliative care

In this category, some healthcare professionals felt more familiar with the concept of palliative care than others. However, all of them valued palliative care as a way of providing comfort and support to the patient and their family members.

> *"Not intervening in things that are not necessary but not failing to provide comfort to the child and provide care to the parents" (E7).*

Challenges in the practice of PPC

When asked about the challenges that palliative care brings, it is important to highlight family acceptance, but also the integration of the healthcare team and the joint decision on the best path to be taken for the patient.

Thus, in the category of challenges in the practice of pediatric palliative care, 3 subcategories emerged. The first is the difficulty of the family accepting the terminality:

> *"[…] acceptance by the family […]" (E6).*

> *"It is difficult for the family and the professionals to understand the entire process […] it is difficult for them to accept […]" (E2).*

The 2nd subcategory concerns the objections of healthcare professionals:

> *"[…] accepting the child who is heading towards the death process… sometimes they (patient and family) accept it and we (professionals) are resistant […]" (E8).*

This resistance, both from the family and from the professionals themselves, is particularly evident in pediatrics, as was brought up in subcategory 3:

> *"No one is prepared to understand that a child has a very serious disease that has no cure […] that their life will be shortened […]" (E1).*

Table 2. Questionnaire applied to healthcare professionals about personal impressions about palliative care in pediatrics.

Questions	Physician		Nurse		Nurse Tec.		Psychologist		Nutritionist		Physical therapist		Pharmacist		Speech Therapist		p
	yes	no	yes	no	yes	no	yes	No	yes	no	yes	no	yes	no	yes	no	
Q1	9 81.8%	2 18.2%	2 40.0%	3 60.0%	1 50.0%	1 50.0%	2 66.7%	1 33.3%	2 66.7%	1 33.3%	0 0.0%	2 100%	1 50.0%	1 50.0%	2 100%	0 0.0%	0.247
Q2	11 100%	0 0.0%	5 100%	0 0.0%	2 100%	0 0.0%	3 100%	0 0.0%	3 100%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	1.000
Q3	10 90.9%	1 9.1%	4 80%	1 20%	2 100%	0 0.0%	1 33.3%	2 66.7%	2 66.7%	1 33.3%	0 0.0%	2 100%	0 0.0%	2 100%	2 100%	0 0.0%	**0.016**
Q4	4 36.4%	7 63.3%	0 0.0%	5 100%	0 0.0%	2 100%	0 0.0%	3 100%	1 33.3%	2 66.7%	0 0.0%	2 100%	1 50.0%	1 50.0%	0 0.0%	2 100%	0.252
Q5	4 36.4%	7 63.3%	4 80%	1 20%	1 50.0%	1 50.0%	3 100%	0 0.0%	2 66.7%	1 33.3%	2 100%	0 0.0%	1 50.0%	1 50.0%	1 50.0%	1 50.0%	0.266
Q6	10 90.9%	1 9.1%	4 80.0%	1 20.0%	2 100.0%	0 0.0%	3 100.0%	0 0.0%	3 100.0%	0 0.0%	2 100.0%	0 0.0%	2 100.0%	0 0.0%	2 100.0%	0 0.0%	0.886
Q7	10 90.9%	1 9.1%	5 100%	0 0.0%	2 100%	0 0.0%	3 100%	0 0.0%	3 100%	0 0.0%	2 100.0%	0 0.0%	2 100.0%	0 0.0%	1 50.0%	1 50.0%	0.633
Q8	0 0.0%	11 100%	3 60.0%	2 40.0%	2 100%	0 0.0%	1 33.3%	2 66.7%	2 66.7%	1 33.3%	0 0.0%	2 100%	0 0.0%	2 100%	1 50.0%	1 50.0%	**0.007**

* Fisher's exact test

** Chi-Square test

Q1 - Do you feel insecure when talking about palliative care?

Q2 - Do you consider palliative care to be an important and possible practice?

Q3 - Have you had any discussions about palliative care during your academic training?

Q4 - Do you have difficulty accepting that children can receive palliative care?

Q5 - Do you feel capable of providing care to children/adolescents in palliative care?

Q6 - Have you ever been interested in reading about palliative care?

Q7 - Do you realize that the acceptance or not of palliative care by the family and/or patient interferes with your provision of healthcare services?

Q8 - In your opinion, is the multidisciplinary team in the department where you work prepared to care for patients in palliative care?

Table 3. Questionnaire applied to healthcare professionals on knowledge about palliative care in pediatrics.

Questions	Physician		Nurse		Nurse tec.		Psychologist		Nutritionist		Physical therapist		Pharmacist		Speech therapist		p
	T	F	T	F	T	F	T	F	T	F	T	F	T	F	T	F	
P1	0 0.0%	11 100%	0 0.0%	5 100%	0 0.0%	2 100%	0 0.0%	3 100.0%	1 33.3%	2 66.7%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	2 100%	0.666
P2	0 0.0%	11 100%	1 20%	4 80%	0 0.0%	2 100%	0 0.0%	3 100.0%	0 0.0%	3 100.0%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	2 100%	0.806
P3	11 100%	0 0.0%	5 100%	0 0.0%	2 100%	0 0.0%	3 100.0%	0 0.0%	3 100.0%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	1.000
P4	2 18.2%	9 81.8%	1 20%	4 80%	1 50.0%	1 50.0%	1 33.3%	2 66.7%	2 66.7%	1 33.3%	1 50.0%	1 50.0%	1 50.0%	1 50.0%	2 100%	0 0.0%	0.329
P5	0 0.0%	11 100%	0 0.0%	5 100%	0 0.0%	2 100%	0 0.0%	3 100%	0 0.0%	3 100%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	2 100%	1.000
P6	11 100%	0 0.0%	5 100%	0 0.0%	2 100%	0 0.0%	3 100.0%	0 0.0%	3 100.0%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	1.000
P7	11 100%	0 0.0%	5 100%	0 0.0%	2 100%	0 0.0%	3 100.0%	0 0.0%	3 100.0%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	1.000
P8	11 100%	0 0.0%	5 100%	0 0.0%	2 100%	0 0.0%	3 100.0%	0 0.0%	3 100.0%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	1.000
P9	11 100%	0 0.0%	5 100%	0 0.0%	2 100%	0 0.0%	3 100.0%	0 0.0%	3 100.0%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	1.000
P10	0 0.0%	11 100%	0 0.0%	5 100%	0 0.0%	2 100%	0 0.0%	3 100%	0 0.0%	3 100%	0 0.0%	2 100%	0 0.0%	2 100%	0 0.0%	2 100%	1.000

* Fisher's exact test

** Chi-Square test

P1 - Palliative care means end of life

P2 - Children in palliative care should not receive other curative care

P3 - There is nothing more that can be done for children in palliative care

P4 - The family should always agree with palliative care measures

P5 - Palliative care is only applied to children who have cancer

P6 - Palliative care does not end when the child dies; it is advisable for the family to be monitored even after death

P7 - The patient and their family members can experience grief even before death occurs

P8 - It is important for healthcare professionals to know about grief; both to approach the family and to have tools to deal with their own grief

P9 - When talking about the disease and palliative care, professionals should be careful to identify what the patient already knows about the disease and their expectations

P10 - Children and adolescents in palliative care should not know about their disease, in order to minimize their suffering

Table 4. Categories, subcategories and indicators for analyzing the perception of palliative care in pediatrics.

Category	Subcategories	Indicators (Numbering units)
PPC concept	Comfort care protocols	Comfort (6) Peace of mind (2)
	Care for the parents	Care for the Family (5) Relationship between team, user and family (2)
	Ethical values	Humanization (2) Quality of life (2)
Challenges in PPC practice	Family acceptance	Impact (3) Denial (1) Care for family (2)
	Professional acceptance	Resistance (3) Difficulty (2)
	Dealing with the acceptance of death	Different interpretations (1) Lack of preparation (1) Difficulty understanding (5)
Healthcare team's role	Improved care	Performing procedures calmly and safely (2) Care (4) Listening (3) Family involvement (4)
	Recognition of the role of each team member	Identification (2) Working for the benefit of the patient (4) Mutual strengthening (2)
Personal limitations	Emotional attachment	Engagement (3) Empathy (3) Strong bond (1)
	Difficulty recognizing the stages of PPC	When not to intervene (2) When not to invest (3)
Family acceptance	Interference in the PPC conduct	Denial (5) Ease when she accepts (6)
	Influence on decision-making	Understanding behaviors such as giving up (3) Need to invest more (1)
Improvements in PC practice	Continuing education	Programs (3) Training (5) Education (5)
	Teamwork	Interação (2)

Role of the healthcare team

It was reported that the role of the team in pediatric palliative care was to provide the best care for the patient and their family (subcategory 1):

> *"[…] performing the necessary procedures in a calm and safe manner […] welcoming the child and family […] being well and accepting palliative care to accommodate the pain of the family and the patient […]" (E4).*

Another point raised was the importance of professionals recognizing their objective within the work unit and relating it to that of their professional partners (subcategory 2):

> *"[…] it seems obvious, but the role of the team is to work as a team [...] to know the common objectives and work for the patient's benefit [...] favoring a good death [...]" (E5).*

Personal limitations

When asked about the personal challenges encountered in the daily practice of PPC, the interviewees reported emotional attachment to patients and their families:

> *"I'm emotional [...] I have too much empathy [...]" (E2).*

> *"We get too attached [...]" (E3).*

One of the participants mentioned the need for more training in PPC: "[...] we need to have more training [...]" (E8).

Another interviewee raised the difficulty of recognizing the stages of PC: "[...] when to stop intervening in this attempt to cure, knowing what not to invest in so as not to prolong the suffering [...]" (E1).

Family acceptance

For the interviewees, family acceptance directly affects the management of pediatric palliative care:

"[...] it is easier for us to help the family (when they accept) [...]" (E4).

The family's acceptance or not also influences the healthcare team's decision-making:

"[…] the family may understand some behaviors as giving up...building this reasoning with the family is a huge challenge [...] they are experiencing the process of understanding the illness and that death is near [...]" (E5).

Improvements in palliative care practice

When raising the question of improvements in palliative care, the point was raised about the need for continued learning and teaching (subcategory 1)

"[…] I emphasize the need for training [...] since graduation [...]" (E8).

Other interviewees highlighted that the team should be prepared and work in a coordinated manner, to safely pass on information and manage the case to the patient and their family (subcategory 2):

"Through teamwork […] if we had more time for interaction, it might help a little" (E2).

DISCUSSION

The professionals emphasized the importance of implementing palliative care and stated the need to include the entire family unit at this time. Although most interviewees stated an interest in reading about palliative care, some of them associated the implementation of palliative care with the imminent end of the patient's life, mainly citing comfort and analgesia. Research indicates that this is a common tendency, and it is related to the perception of the finiteness of life with the establishment of palliative care, while in fact palliative care should be initiated as soon as it is perceived that a cure is impossible[9].

In this scenario, conceptual confusion is a major obstacle to implementing palliative care in the appropriate manner and at the right time. A Swiss study found that even though the multidisciplinary team knew and understood the concept of PC well, they chose to start palliative care only when curative care was no longer effective[10].

Therefore, it is important to understand that palliative care can and should be started from the moment of diagnosis and not only when there is no longer any prospect of a cure.

Regarding family acceptance, the interviewees stated that if the family does not accept the moment experienced, the process becomes more painful overall. In this sense, it is pointed out that the possibility of death is often an issue avoided between the family and the patient. There is a denial of the finiteness of life, even if subconsciously[11].

Communication is an essential tool for the practice of palliative care. Through it, the patient can clarify doubts and reduce their anxiety and distress, thus improving their quality of life[12].

Dialogue is the key point of palliative care and should never be left in the background. Therapeutic communication allows the development of the relationship between the team and the patient, opening doors to improving the quality of life of both groups. An American study indicated that the lack of family support and understanding, with unrealistic expectations, is the biggest obstacle to quality palliative care. This is in addition to barriers such as a basic PC program and a team with less in-depth knowledge[13].

It is important to emphasize that the first impact when faced with the certainty of death may be rejection. In this sense, the patient and his/her family unit may have barriers when dealing with the subject. This topic was highlighted a lot by the participants in the study. Therefore, it is the role of the multidisciplinary team to handle this situation in the best possible way, showing that accepting palliative care does not mean giving up on life, but learning to live with the real situation, with the highest quality of life that can be achieved.

Another point to be analyzed is the lack of acceptance by the multidisciplinary healthcare team. During the interviews, it was possible to notice that even though it was a common situation in the professionals' lives, they still dealt with feelings of inability when faced with the impossibility of curing their respective patients. The highest percentage was in the medical class, a fact probably associated with the feeling of "leadership" of the multidisciplinary team, which brings with its responsibilities. In this regard, health professionals are trained with an emphasis on the healing process. Therefore, when this objective is not achieved, the professional tends to adopt a posture of denial in the face of the situation. Under these conditions, the possibility of dysthanasia occurring increases considerably, since the team may have difficulty in giving up curative treatments[11].

Furthermore, as a pillar of support for the patient and their family unit, the multidisciplinary team tends not to show their suffering to the detriment of the well-being of the environment in which they are located. In this scenario, these attitudes trigger negative impacts on professionals, including Burnout Syndrome, decreased job satisfaction, anxiety and depression[14].

In the case of healthcare professionals, empathy has been described as an essential quality of more humane care. This skill is defined as an attribute that implies the ability to understand the experiences, concerns and perspectives of patients[15]. However, although empathy is a commendable characteristic, the emotional burden that the multidisciplinary healthcare team carries when accompanying different patients can be harmful both for the patient and their family unit, as well as for the professionals. In this study, it was reported that emotional suffering follows the team even after they finish their work shift, which could have numerous consequences for their health.

A study conducted in Australia defined "Compassionate Care," which consists of an approach that is completely centered on the patient and their family, seeking to understand their fears, anxieties, and concerns. However, this same study states that by worrying so much about others, the multidisciplinary healthcare team ends up neglecting self-care, causing fatigue among professionals[16], a fact that was present in several reports in this study.

One point raised by the interviewees was the need for well-coordinated teamwork. It was evident that the presence of different views on the patient's recovery potential made it difficult to make decisions regarding this process, as it ended up influencing daily practice. Most of the participants in this study believed that the team was not fully prepared to deal with patients in palliative care. This divergence of positions may be related to communication problems and a lack of care protocols. In order to standardize procedures, it is necessary for the multidisciplinary team to work actively on communication, as this is fundamental in PPC and allows better access and approach to the emotional dimension of the process[11]. Furthermore, the lack of auxiliary protocols makes it difficult to decide which is the best path to follow and which therapies should be maintained for patients undergoing palliative care. In this sense, training professionals and establishing protocols in the hospital would provide a better multidisciplinary approach for both the team and the patients and their families[12].

During the interview, most participants mentioned the need to discuss PC in education. For them, education not only technically qualifies the professional, but also helps build relationships with the team and patients. Research indicates that training and education from the beginning of higher education are effective in developing healthcare professionals capable of administering excellent palliative care, in addition to building better relationships with the work team[17].

Considering the failure in this aspect, it was expected that the interviewees would have little knowledge of the basic principles of PPC. Although this was not the trend in this study, 3 questions presented divergent answers. Most interviewees stated that the family should always agree with the palliative care measures.

According to the District Attorney's Office, a physician who insists on continuing treatment or any other procedure, contrary to the wishes of the patient or his/her legal representative, will be committing dysthanasia. Even so, the multidisciplinary team must always respect the wishes of the patient or his/her legal representative and not the other way around, taking due care not to violate the legal aspects of the act of providing care[18].

In summary, the opening of a palliative care protocol for a given patient is a medical decision, but its actual implementation also depends on the wishes of the patient and his/her family.

CONCLUSION

This study emphasizes the need to broaden the discussion on the topic of pediatric palliative care, to improve assistance and application of its precepts, in addition to greater integration of the team in the care of palliative patients. The multidisciplinary team of Pediatrics at the University Hospital demonstrated basic conceptual knowledge about pediatric palliative care.

REFERENCES

1. García-Baquero Merino MT. Palliative Care: Taking the Long View. Front Pharmacol. 2018 Out 16;9(1140).
2. Gomes ALZ, Othero MB. Cuidados paliativos. Estud Avançados. 2016 Dez 1;30(88):155-66.
3. Paiva CF, Santos TCF, Aperibense PGG de S, Martins G da CS, Ennes LD, de Almeida Filho AJ. Historical aspects in pain management in palliative care in an oncological reference unit. Rev Bras Enferm. 2021;74(5):e20200761.
4. De Clercq E, Rost M, Pacurari N, Elger BS, Wangmo T. Aligning guidelines and medical practice: Literature review on pediatric palliative care guidelines. Palliat Support Care. 2017 Jan 9;15(4):474-89.
5. Sreedhar SS, Kraft C, Friebert S. Primary palliative care: Skills for all clinicians. Curr Probl Pediatr Adolesc Health Care. 2020 Jun;50(6):100814.
6. Norris S, Minkowitz S, Scharbach K. Pediatric Palliative Care. Prim Care. 2019 Set;46(3):461-73.
7. Snaman J, McCarthy S, Wiener L, Wolfe J. Pediatric Palliative Care in Oncology. J Clin Oncol. 2020 Mas 20;38(9):954-62.
8. Ranallo L. Improving the Quality of End-of-Life Care in Pediatric Oncology Patients Through the Early Implementation of Palliative Care. J Pediatr Oncol Nurs. 2017 Jun 10;34(6):374-80.
9. Silva EMB, Silva MJM, Silva DM. Perception of health professionals about neonatal palliative care. Rev Bras Enferm. 2019 Dez;72(6):1707-14.
10. De Clercq E, Rost M, Rakic M, Ansari M, Brazzola P, Wangmo T, et al. The conceptual understanding of pediatric palliative care: a Swiss healthcare perspective. BMC Palliat Care. 2019 Jul 11;18(1):55.

11. Santos R da S, Pasklan ANP, Vale IS, Leitão IES, Barros BFM, Santiago FA de O, et al. Percepção de cuidados paliativos dos profissionais de saúde no ambiente hospitalar do município de Pinheir-MA. Rev Bras Ciênc Saúde. 2021 Out 2;19(69).

12. Gulini JEHM de B, Nascimento ERP do, Moritz RD, Rosa LM da, Silveira NR, Vargas MA de O. Intensive care unit team perception of palliative care: the discourse of the collective subject. Rev Esc Enferm USP. 2017;51(0):e03221.

13. Song IG, Kang SH, Kim MS, Kim CH, Moon YJ, Lee J. Differences in perspectives of pediatricians on advance care planning: a cross-sectional survey. BMC Palliat Care. 2020 Set 18;19(1):145.

14. Sarmento WM, Araújo PCB de, Silva BN da, Silva CRDV, Dantas RC de O, Véras GCB. Formação acadêmica e qualificação profissional dos enfermeiros para a prática em Cuidados Paliativos. Enferm em Foco. 2021 Jun 11;12(1):33-9.

15. Marilaf Caro M, San-Martín M, Delgado-Bolton R, Vivanco L. Empatía, soledad, desgaste y satisfacción personal en Enfermeras de cuidados paliativos y atención domiciliaria de Chile. Enferm Clín. 2017 Nov;27(6):379-86.

16. Ferraz SL, O'Connor M, Mazzucchelli TG. Exploring Compassion from the Perspective of Health Care Professionals Working in Palliative Care. J Palliat Med. 2020;23(11):1478-84

17. Parikh PP, White MT, Buckingham L, Tchorz KM. Evaluation of palliative care training and skills retention by medical students. J Surg Res. 2017 May;211:172-7.

19. Maiello APM, Coelho FP, de Almada Messias A, D'Alessandro MPS. Manual de Cuidados Paliativos. Cad Saúde Pública. 2020;1(1):1-172