revista de pesquisa ISSN 2175-5361

CUIDADO É FUNDAMENTAL

Escola de Enfermagem Alfredo Pinto – UNIRIO

RESEARCH DOI: 10.9789/2175-5361.rpcfo.v16.13072

KNOWLEDGE, ATTITUDES AND PRACTICES OF A MULTIDISCIPLINARY TEAM ON PALLIATIVE CARE

Conhecimentos, atitudes e práticas de uma equipe multidisciplinar de residentes sobre cuidados paliativos

Conocimientos, actitudes y prácticas de un equipo multidisciplinar sobre cuidados paliativos

Luana Turra[1]

Daniele Delacanal Lazzari[2]

ABSTRACT

Objective: to analyze knowledge, attitudes and practices of multiprofessional residents related to the palliative care assistance. **Method:** a quantitative study, transversal, evaluative of the type Knowledge, Attitude and Practice, developed in a university hospital from the South of Brazil. 49 residents vinculated to the Multiprofessional Integrated Healthcare Residency Program participated. Data collection was made through *Google Forms*. The analyses were graphically represented and made with IBM SPSS Statistics v.25 software. Level of significance adopted was 0.05. **Results:** young group, with little professional experience, mainly women. The majority affirmed they haven't received sufficient information about palliative care and pain in graduation, 53,1% didn't knew how to identify patients candidates to palliative care. The conceptual aspects of palliative care are recognized by the residents. Nevertheless, the use of scales in palliative care, whether or not to suspend procedures and/or feeding and the use of opiates generated less cohesive answers between members of the group. Only the distribution of the Attitude domain was significant between the professional categories (P=0,008). **Conclusion:** participants have demonstrated comprehension about the thematic, even then, fragilities were evidenciated, especially in the Attitude and Practice domains. Palliative care should be a focus of study in the healthcare permanent education, as well as in the multiprofessional residency programs.

DESCRIPTORS: Health Knowledge, Attitudes, Practice; Hospitals Teaching; Internship and Residency; Palliative Care; Patient Care Team;

[1,2] Universidade Federal de Santa Catarina, Santa Catarina, Florianópolis, Brazil.

Received: 24/01/2024; Accepted: 11/02/2024; Published online: 30/03/2024

Corresponding Author: Luana Turra lu.turra@hotmail.com

How cited: Silva CP, Reis APA. Knowledge, attitudes and practices of a multidisciplinary team on palliative care. *R Pesq Cuid Fundam* [Internet]. 2023 [cited year mouth day];16:e13072. Available from:

https://doi.org/10.9789/2175-5361.rpcfo.v16.13072

RESUMO

Objetivo: analisar conhecimentos, atitudes e práticas de residentes sobre Cuidados Paliativos. **Método:** estudo quantitativo, transversal, avaliativo do tipo Conhecimento, Atitude e Prática, desenvolvido em um hospital universitário da região Sul do Brasil. Participaram 49 residentes vinculados ao Programa de Residência Integrada Multiprofissional em Saúde. A coleta de dados ocorreu por meio do Google Forms. As análises foram realizadas no software Statistical Package for the Social Sciences v.25. Com nível de significância de 0,05. **Resultados:** A maioria afirmou não ter recebido informação suficiente sobre Cuidados Paliativos na graduação, 53,1% não sabem identificar pacientes candidatos a abordagem. Os aspectos conceituais são reconhecidos pelos residentes, no entanto, o uso de escalas, suspensão ou não de procedimentos e o uso de opióides geraram respostas diversas. O domínio Atitude foi significativo entre as categorias profissionais (P=0,008). **Conclusão:** Embora os participantes tenham mostrado compreensão sobre a temática, foram evidenciadas fragilidades, especialmente nos domínios atitude e prática.

DESCRITORES: Conhecimentos, atitudes e prática em Saúde; Cuidados paliativos; Equipe multiprofissional; Hospitais de ensino; Residência hospitalar;

RESUMEN

Objetivos: analizar los conocimientos, actitudes y prácticas de los residentes sobre la asistencia en cuidados paliativos. **Método:** estudio cuantitativo, transversal, evaluativo del tipo Conocimiento, Actitud y Práctica, desarrollado en un hospital universitario de la región sur de Brasil. En el estudio participaron 49 residentes vinculados al Programa Integrado de Salud Multiprofesional La recogida de datos se realizó a través de Google Forms. Los análisis se realizaron utilizando el software Statistical Package for the Social Sciences v.25. El nivel de significancia adoptado fue de 0,05. **Resultados:** La mayoría dijo no haber recibido suficiente información sobre Cuidados Paliativos y manejo del dolor al graduarse, el 53,1% no sabe cómo identificar a los pacientes candidatos al abordaje. Los aspectos conceptuales del tema son reconocidos por los residentes, sin embargo, el uso de balanzas, suspensión o no de procedimientos y / o alimentos y el uso de opioides han generado respuestas diferentes. El dominio Actitud fue significativo entre las categorías profesionales (P = 0,008). **Conclusión:** Aunque los participantes mostraron comprensión sobre el tema, se evidenciaron debilidades, especialmente en los dominios de actitud y práctica.

DESCRIPTORES: Conocimientos, Actitudes y Práctica en Salud; Cuidados Paliativos; Grupo de Atención al Paciente; Hospitales de Enseñanza; Internado y Residencia.

INTRODUCTION

Palliative care (PC) is aimed at improving quality of life through prevention, early identification and relief of physical, psychological, psychosocial and spiritual suffering and encompasses care for patients from diagnosis onwards, considering the multiple needs of these patients and their families.[1] This care includes, but is not limited to, end-of-life care and the growing number of programs aimed at implementing and discussing PC is supported by scientific evidence that shows numerous clinical benefits for patients diagnosed with terminal illness.[2]

In a systematic review[3] which aimed to describe the self--perceived roles of the multi-professional team in PC, the dissemination of bad news, symptom management, psychosocial concerns and the quality of communication are frequent objectives when dealing with the unrealistic expectations of patients and families, the challenge of which was partly due to the lack of advance planning for this care.

In this scenario, according to a survey carried out between 2006 and 2011 by the Worldwide Palliative Care Alliance, Brazil was among the group of countries that offer PC in isolation, i.e. activities whose reach is irregular and the demands for support, medication and follow-up are limited in relation to the size of the population.[4] In this way, strengthening discussions among the multi-professional team through the understanding that comprehensive PC care depends on the integration of existing health systems and the interrelationship between team members through interdisciplinary knowledge, attitudes and practices, should be everyone's concern, through the articulation of knowledge, the horizontalization of relationships, participation in decision-making, among others.[5]

In the context of patient care, hospital residencies, whether uniprofessional or multiprofessional in health, include professionals from different areas in practical scenarios and aim to break with paradigms in relation to training professionals for the Unified Health System (SUS), with a strong interdisciplinary characteristic.[6] When thinking about the insertion of residents in teaching hospitals, the approach to PC is included in the many possibilities of care, without there necessarily being preparation or understanding of the hospital teams on this subject.

The lack of preparation to work with PC was highlighted in a recent study, which pointed to a lack of specialized training for professionals and difficulties in interpersonal relationships between team members[5]. It is essential to have a team aligned within the practices that encompass this approach, and for this team to be multidisciplinary, as effective PC requires a range of different professionals.[7]

A bibliometric study that aimed to analyze dissertations and theses on PC and chronic diseases, completed between 2009 and 2018, showed a greater number of studies by nurses, with a

qualitative approach and in a hospital environment,[8] suggesting the relevance of new studies that include the other professionals who make up the team.

Given the importance of the care provided by the multi-professional team to patients undergoing PC, the question arises as to how professionals in a multi-professional residency program perceive this care. In this context, the objective was to analyze the knowledge, attitudes and practices of multiprofessional residents regarding PC care.

METHOD

This was a quantitative, cross-sectional, descriptive study using a self-assessment questionnaire and a knowledge, attitude and practice (KAP) survey. The CAP survey measures the knowledge, attitude and practice of a population, diagnosing what they feel, know and how they behave in relation to a pre-defined topic.9 Studies that have used CAP as a method have determined different strategies for valuing the variables: a) Knowledge: which seeks to assess a population's understanding of a specific topic. b) Attitudes: refers to individual feelings about the subject, preconceived ideas, opinions, predispositions, beliefs. c) Practices: refers to the ways in which interviewees express their knowledge and attitudes through their actions, reinforcing a social dimension.9 In this study, the CAP Survey was made up of ten statements, where participants could choose between the following answers: Totally Agree (TC), Partially Agree (CP), Neutral, Partially Disagree (PD) and Totally Disagree (DT).

This study was carried out at a university hospital in southern Brazil, which treats clinical and surgical patients in a wide range of specialties, both in outpatient and inpatient settings. This hospital exclusively serves SUS users and, in 2010, started the Integrated Multiprofessional Health Residency (RIMS), with two areas of concentration: Urgency and Emergency Care and High Complexity Care. Later, in 2014, Women's and Children's Health was added to the areas.

According to data provided by the RIMS coordinators, at the time of data collection, the program had 69 residents in the three areas of concentration. All were invited to take part in the study, 49 of whom accepted and constituted a convenience sample. Data was collected online using Google Forms, and the collection instrument was sent via e-mail. Data collection took place between April and August 2020.

In the data analysis, comparisons between the means or distributions of the Knowledge, Attitudes and Practice domains and the answers to the self-knowledge questions were carried out using the t-test for independent samples or the Mann-Whitney test, depending on the distribution and sample size. Categories with a sample size (n) of less than 12 subjects had non-parametric tests carried out without checking the Shapiro-Wilk normality test. In relation to the professional groups, the domains of the CAP questionnaire were compared using the Kruskal-Wallis test and, when significant, compared pairwise using Dunn's post-hoc test. These variables were represented by mean and standard deviation and interquartile range (median [Percentile25; Percentile75]). The analyses were represented graphically using IBM SPSS Statistics v.25 software. The significance level adopted was 0.05.

The study was approved by the Research Ethics Committee of the Federal University of Santa Catarina, in accordance with Resolution 466/2012, under CAAE No. 26199119.1.0000.0121 and approval No. 4.049.824. The participants signed a Free and Informed Consent Form (FICF).

RESULTS

Table 1 shows the characterization of the sample, which was mostly female (93.9%).

Table 1 – Caracterização da amostra quanto ao sexo, profissão, experiência profissional, especialidade. (n=49). Florianópolis, 2020.

Gender	
Feminino	46 (93,9)
Masculino	3 (6,1)
Occupation	
Assistente Social	5 (10,2)
Dentista	4 (8,2)
Enfermeiro	13 (26,5)
Farmacêutico	5 (10,2)
Fisioterapeuta	3 (6,1)
Fonoaudiólogo	3 (6,1)
Nutricionista	6 (12,2)
Psicólogo	10 (20,4)
Professional Experience (in years)	
0	11 (22,4)
1	18 (36,7)
2	11 (22,4)

3	6 (12,2)
4	1 (2,0)
6	1 (2,0)
10	1 (2,0)
média (DP)	1,59 (1,73)
mediana [P25; P75]	1,0 [1,0; 2,0]
Area of concentration	
Alta complexidade	36 (73,5)
Saúde da mulher e da criança	6 (12,2)
Urgência e Emergência	7 (14,3)

Table 2 – Description of the Self-Assessment items. Florianópolis, SC, Brazil, 2020.

	No	Yes
	n (%)	n (%)
Did I receive enough information about PC during my degree?	45 (91,8)	4 (8,2)
Did I receive enough information about managing patients with pain during my undergraduate studies?	45 (91,8)	4 (8,2)
Do I use a pain scale to assess patients?	33 (67,3)	16 (32,7)
Do I feel prepared to manage the most common symptoms in PC patients within the scope of my profession?	24 (49)	25 (51)
Do I feel able to assist patients undergoing PC?	17 (34,7)	32 (65,3)
Do I know how to identify patients who are candidates for PC?	26 (53,1)	23 (46,9)
Do I know the WHO definition of palliative care?	13 (26,5)	36 (73,5)

The group of residents, in terms of their professions, is heterogeneous according to the demand and vacancies offered by the program, but Nursing is the predominant profession in the group (26.5%) and High Complexity, the area of concentration with the most residents (73.5%). With regard to professional experience, 36.7% of the participants indicated one year's experience and 22.4% indicated two years, including time as a resident. Thus, considering the two-year residency period, 81.5% of the participants had no significant previous care experience beyond the residency period.

In Table 2, the number of participants who said they had not received enough information about PC during their undergraduate studies was higher than those who said they had. The same applies to those who said they had not received enough information to manage patients with pain (91.8%). In addition, 67.3% of participants said they did not use a pain scale to assess patients.

However, although there was a predominance of participants who indicated that they had not received enough information about pain and PC, 65.3% considered themselves able to provide care to patients undergoing PC.

Table 3 describes the 10 items that made up the survey, divided into the Knowledge, Attitudes and Practices spectrums, as well as the responses from the group of multiprofessional residents.

In Table 4, only the distribution of the Attitude domain was significant between the professional categories (P=0.008). The difference was found in the Dentist (median=3.2) and Physiotherapist (median=5.0) categories. It is not possible to say that the others differed.

Table 3 – Description of the results of the CAP Survey (Knowledge, Attitude and Practice). Florianópolis, SC, Brazil, 2020.

	DT	**DP**	**Neutral**	**CP**	**CT**
	n (%)	**n (%)**	**n (%)**	**n (%)**	**n (%)**
1. PC is the last resort of care, with an interdisciplinary approach, adopted when there is no other care or technology that can be given to the individual.	10 (20,4)	20 (40,8)	0 (0)	12 (24,5)	7 (14,3)

2. PC aims to improve the quality of life of patients facing life-threatening illnesses, as well as their families, by preventing and alleviating suffering.	1 (2)	1 (2)	0 (0)	10 (20,4)	37 (75,5)
3. Stopping futile treatments does not promote death, it prevents dying from being prolonged at the cost of great suffering. It can even be started at the same time as curative treatment.	0 (0)	3 (6,1)	5 (10,2)	19 (38,8)	22 (44,9)
4. When it becomes palliative, all curative measures are suspended. It is intended exclusively for patients at the end of their lives.	30 (61,2)	7 (14,3)	3 (6,1)	7 (14,3)	2 (4,1)
5. At the end of life in PC, continuous monitoring can be withdrawn, vital signs can be checked at different times and painful procedures can be suspended or minimized.	2 (4,1)	1 (2)	4 (8,2)	12 (24,5)	30 (61,2)
6. Tube feeding can be considered a futile measure for the PC patient and even harmful in some situations.	2 (4,1)	2 (4,1)	9 (18,4)	11 (22,4)	25 (51)
7. The use of opioids for pain relief should be personalized for each patient according to their own threshold, until acceptable levels of analgesia are achieved. There is no pre-established maximum dose.	0 (0)	4 (8,2)	9 (18,4)	19 (38,8)	17 (34,7)
8. I respect the PC patient's will and autonomy regarding visits, procedures, conversations and assessments, even if this goes against the previously established plan.	0 (0)	0 (0)	3 (6,1)	17 (34,7)	29 (59,2)
9. I use pain measurement scales continuously and/or record all information relating to care in depth, analyzing possible alternatives and allowing other professionals to use my records to gain a comprehensive understanding of the patient's clinical situation.	3 (6,1)	5 (10,2)	11 (22,4)	13 (26,5)	17 (34,7)
10. I use data from the Palliative Performance Scale (PPS) and the Edmonton Symptom Assessment Scale (ESAS) to guide my actions and analysis with patients undergoing PC.	17 (34,7)	1 (2)	22 (44,9)	2 (4,1)	7 (14,3)

Table 4 – Comparison of Knowledge, Attitude and Practice score distributions among residents. Florianópolis, SC, Brazil, 2020.

	n	Knowledge		Attitude		Practice	
		mean	median	mean	median	mean	median
		(DP)	[P25; P75]	(DP)	[P25; P75]	(DP)	[P25; P75]
Social Worker	5	4,0 (0,7)	4,0 [3,8; 4,5]	3,7 (0,5)	3,7ab [3,3; 4,0]	3,5 (1,2)	3,7 [2,3; 4,7]
Dentist	4	2,8 (0,4)	2,9 [2,5; 3,0]	3,3 (0,6)	3,2a [2,8; 3,7]	3,8 (0,3)	3,8 [3,5; 4,0]
Nurse	13	3,6 (0,6)	3,5 [3,3; 3,8]	4,5 (0,5)	4,7ab [4,0; 5,0]	3,6 (0,6)	3,3 [3,0; 4,0]
Pharmacist	5	3,2 (0,5)	3,0 [3,0; 3,3]	4,0 (0,6)	4,0ab [4,0; 4,3]	2,7 (0,5)	2,7 [2,3; 3,0]
Physiotherapist	3	3,3 (0,5)	3,3 [2,8; 3,8]	5,0 (0,0)	5,0b [5,0; 5,0]	4,0 (0,9)	3,7 [3,3; 5,0]
Speech therapist	3	3,3 (0,4)	3,0 [3,0; 3,8]	4,6 (0,4)	4,3ab [4,3; 5,0]	3,4 (0,8)	3,0 [3,0; 4,3]
Nutritionist	6	3,3 (0,3)	3,3 [3,0; 3,5]	4,4 (0,2)	4,3ab [4,3; 4,7]	3,9 (0,4)	3,8 [3,7; 4,0]
Psychologist	10	3,2 (0,4)	3,1 [2,8; 3,5]	3,9 (1,0)	4,2ab [2,7; 4,7]	3,9 (0,9)	4,2 [3,0; 4,3]
P			0,062		0,008		0,178

DISCUSSION

Regarding the characterization of the professionals/residents taking part in this study, they are a young group with little experience in care, corroborating other studies involving this group.[10-11]

There was a predominance of professionals belonging to the area of concentration of High Complexity Health Care, which also corresponds to the largest number of vacancies available in the Residency Program. It is important to note that, regardless of the area of concentration, all residents will at some point be able to care for/assist patients who are candidates for or undergoing PC. The institution in which this study was carried out has a Palliative Care and Pain Management Committee (CCPD), founded in 2011, which acts on requests for advice from other medical specialties and also provides outpatient care for patients after discharge from hospital, but approaches to PC are not restricted to an isolated sector or to this specific committee.

In terms of self-assessment, 91.8% of the participants said they had not received enough information about PC and the management of patients with pain during their undergraduate studies. Studies that have tried to assess health professionals' knowledge of PC have found common points, such as: misperceptions about care, gaps in teaching about pain and palliative care in undergraduate courses, difficulties in applying theoretical knowledge in professional practice.[12-14] However, 65.3% of the participants considered themselves able to provide care to patients undergoing PC, suggesting that their training came from sources other than undergraduate courses.

In addition, 53.1% of residents said they did not know how to identify patients who were suitable for CP. This weakness was reinforced in the CAP survey, in the practice variable, in which 34.7% of residents said they did not use the Palliative Performance Scale (PPS) and the Edmonton Symptom Assessment Scale (ESAS). The Palliative Performance Scale (PPS) makes it possible to establish the patient's prognosis and functionality and is widely used to indicate palliative care.[15] In Brazil, Resolution no. 41/2018, instituted by the Ministry of Health, was a major step forward for PC, regulating this practice as a health policy. This resolution establishes that palliative care will be offered to anyone affected by a life-threatening illness, whether acute or chronic, from the diagnosis of this condition.[16] This is in line with what is recommended by the WHO7, as the body emphasizes the early identification of people who would benefit from the approach. It is possible that late approaches could favor the paradigm that PC is an end-of-life practice.

As for the CAP survey findings, in the knowledge variable, despite the fact that, as previously mentioned, this was a group without much professional experience, the answers aligned with the definitions of PC predominated. Among the participants, 61.2% disagreed that PC is the last resort of care. PC can even be offered concomitantly with curative treatment.[5,7,17] A study carried out with resident doctors at another university hospital came up with similar findings.[14] Failure to adopt palliative and curative treatment concomitantly can even result in a late transition of patients to the approach, constituting a barrier.[5]

For 44.9% of the participants, there was total agreement on the need for PC to be started concomitantly with curative treatment, as well as the fact that stopping futile treatments does not promote death. With regard to tube feeding, which can be considered a futile measure for patients undergoing PC, 51% totally agreed, demonstrating an understanding of the issue. Measures such as the decision to suspend artificial nutrition and hydration and dialysis, based on evidence and clinical experience, are widely accepted in many countries. In addition, there has also been an acceptance in recent years of the withdrawal of mechanical ventilation in the Intensive Care Unit (ICU), with palliative extubation.[17-18] However, a recent study in the ICU18 also found a tendency towards therapeutic obstinacy, based on the understanding that a professional duty must be fulfilled. Among the residents interviewed, 61.2% totally agreed that painful procedures could be suspended or minimized. It is important to evaluate the criteria for palliative care to avoid patients with indications for PC occupying ICU beds unnecessarily and suffering from therapeutic obstinacy.[15]

In the "attitude" domain, 59.2% said that they respected the wishes and autonomy of the PC patient with regard to visits, procedures, conversations and assessments. Professional preparation, effective communication with the patient and their family and/or guardian, respect for the autonomy and dignity of the individual, as well as the principles of beneficence and non-maleficence are indispensable for the success of this practice.[12,17,18]

Regarding the use of pain measurement scales continuously and/or recording all the information related to care in depth, 34.7% of the participants agree that they do so. Given the multi-professional nature of PC7, it is essential to exchange information accurately and formally so that the best care is provided to the patient. It is known that the emotional aspect of the patient directly influences their perception of pain and that pain is not always related to a tissue lesion that is evident in histopathological terms.[19] Therefore, the identification of pain and its management, within the scope of each profession, needs to be done, including in order to respect the definition of PC made by the WHO, which emphasizes the impeccable assessment and treatment of pain and physical, social, psychological and spiritual symptoms.

When comparing knowledge, attitude and practice between the professional categories, only the distribution of the "attitude" domain was significant between the professional categories (P=0.008). In the attitude domain, physiotherapists were more likely to agree with the statements, which is very positive, since all the alternatives were true. In a recent study,

20 nursing students presented favorable attitudes towards death and PC, but had a low level of knowledge and self-efficacy in relation to the issues and the study suggested the need to include PC in the nursing curriculum in China. This need is also evident in the present study, as the Multiprofessional Residency Program where the study was carried out does not have a subject in its curriculum that specifically addresses PC. Ademias, dentists and social workers, respectively, were the professions that most opposed the statements in the Attitude domain.

In the Knowledge domain, there were no significant differences between the professions, nor in the Practice domain. It is interesting to note that, with regard to Knowledge, in general, it was possible to observe that the broader conceptual terms about PC are recognized by the residents interviewed, but are not well consolidated, because in the "attitude" domain, where more specific knowledge was required, such as: use of scales in PC, suspension or not of procedures and feeding and the use of opioids, there were less cohesive responses. This theoretical notion of PC was also evidenced in a study carried out with patients and family members/caregivers in the USA.[21]

Competence in PC is determined by various factors, and caring for/assisting patients in PC, in the various phases of the approach, both at diagnosis and at the end of life, can lead to multiple issues for health professionals. A study of 372 nurses[22] found that more than half felt anxious about caring for a dying person and their family. This is in line with another publication on PC[20] which indicates that it is imperative, along with academic training, to prepare students to deal psychologically with the challenges of the dying process.

CONCLUSION

Health professionals are required to provide the best care in relation to the specific moment in the patient's life. Providing timely and quality PC is a challenge. Although the interviewees showed an understanding of the subject, weaknesses were evident, especially in the attitude and practice domains.

One limitation is that the study was carried out in just one university hospital, which makes it difficult to generalize the results. It should also be noted that the questionnaires were administered online due to the SARS-CoV2 pandemic, which may have restricted the information obtained.

The replication of this study in other multiprofessional residency programs could be part of future research to investigate other scenarios in order to discuss Health Knowledge, Attitudes and Practice. But regardless of the number of participating institutions/programs, the analysis carried out in this study shows that it is necessary to discuss PC as a possibility for all patients, according to their clinical conditions. It is essential that PC be a focus within permanent health education, as well as in multi-professional residency programs.

REFERENCES

1. Morrow BM, Barnard C, Luhlaza Z, Naidoo K, Pitt S. Knowledge, attitudes, beliefs and experience of palliative care amongst South African physiotherapists. S Afr J Physiother [online]. 2017 jul; [cited 2020 dez 22];73(1):384. Available from: http://doi.org/10.4102%20/%20sajp.v73i1.384.

2. Huo J, Hong YR, Grewal R, Yadav S, Heller IW, Bian J, Wilkie DJ. Knowledge of Palliative Care Among American Adults: 2018 Health Information National Trends Survey. Journal of Pain and Symptom Management [online]. 2019 mar/jul; [cited 2020 dez 22];58(1):39-47. Available from: https://doi.org/10.1016/j.jpainsymman.2019.03.014

3. Senior H, Grant M, Rhee JJ, Aubin M, McVey P, Johnson C et al. General practice physicians' and nurses' self-reported multidisciplinary end-of-life care: a systematic review. BMJ Supportive & Palliative Care [online]. 2019 ago; [cited 2020 dez 22];001852. Available from: http://dx.doi.org/10.1136/bmjspcare-2019-001852

4. Lynch T, Clark D, Connor S. Mapping levels of palliative care development: a global update. J Pain Symptom Manag [online]. 2013 jun; [cited 2020 dez 22];45(6):1094-106. Available from: http://www.jpsmjournal.com/article/S0885-3924(12)00334-X/pdf

5. Almeida CSL, Marcon SS, Matsuda LM, Kantorski LP, Paiva BSR, Sales CA. Operation of a hospital palliative care service: a fourth-generation evaluation. Rev Bras Enferm. 2019; [cited 2020 dez 22]; 72(2):383-90. Available from: http://dx.doi.org/10.1590/0034-7167-2017-0848.

6. Silva CA da, Dalbello-Araujo M. Programa de Residência Multiprofissional em Saúde: o que mostram as publicações. Saúde em debate [online]. 2019 out/dez; [acesso em 22 de dezembro de 2020];43(123):1240-1258. Disponível em: https://doi.org/10.1590/0103-1104201912320

7. World Health Organization (WHO). Palliative care [online]. 2020; [cited 2020 dez 22]. Available from: https://www.who.int/cancer/palliative/definition/en/

8. Paiva TRS et al. Produção Científica de Dissertações e Teses Sobre Cuidados Paliativos e Doenças Crônicas: Estudo Bibliométrico. Rev Fun Care [online]. 2020 jan./dez.; [acesso em 22 de dezembro de 2020]; 12:723-729.

Disponível em: http://dx.doi.org/10.9789/2175-5361.rpcfo.v12.9461

9. Kaliyaperumal K. Guideline for Conducting a Knowledge, Attitude, and Practice (KAP) Study. Community Ophthalmology [online]. 2004 jan/mar; [cited 2020 dez 22];4(1):7-9. Disponível em: http://v2020eresource.org/content/files/guideline_kap_Jan_mar04.pdf

10. Rotta DS et al. Engagement de residentes multiprofissionais em saúde. Rev. esc. enferm. USP [online]. 2019 jun; [citado 2020 dez 22];53(e03437). Available from: http://dx.doi.org/10.1590/S1980-220X2018003103437

11. Silva DS, Merces MC, Souza MC, Gomes AMT, Lago SB, Beltrame M. Síndrome de Burnout em residentes multiprofissionais em saúde. Rev enferm UERJ [online]. 2019; [acesso em 22 de dezembro de 2020];11(e43737). Disponível em: https://doi.org/10.12957/reuerj.2019.43737

12. Silva HA; Viana GKB; Lima AKG; Lima ALA; Mourão CML. Intervenção em cuidados paliativos: conhecimento e percepção dos enfermeiros. Rev. enferm. UFPE [online]. 2018 mai; [acesso em 22 de dezembro de 2020]; 12(5):1325-1330. Disponível em: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-980775

13. Dalpai D et al. Dor e cuidados paliativos: o conhecimento dos estudantes de medicina e as lacunas da graduação. Rev. Dor [online]. 2017 dez; [acesso em 22 de dezembro de 2020];18(4):307-310. Disponível em: https://doi.org/10.5935/1806-0013.20170120

14. Conceicao MV et al. Conhecimento sobre cuidados paliativos entre médicos residentes de hospital universitário. Rev. Bioét. [online]. 2019 mar; [acesso em 22 de dezembro de 2020];27(1):134-142. Disponível em: https://doi.org/10.1590/1983-80422019271296.

15. Clara MGS et al. Escala Palliative Care Screening Tool como instrumento para indicação de cuidados paliativos em idosos. Rev. bras. geriatr. gerontol. [online]. 2019; [acesso em 22 de dezembro de 2020];22(5):e190143. Disponível em: http://dx.doi.org/10.1590/1981-22562019022.190143.

16. Resolução nº 41, de 31 de outubro de 2018 (BR). Dispõe sobre as diretrizes para a organização dos cuidados paliativos, à luz dos cuidados continuados integrados, no âmbito Sistema Único de Saúde (SUS). Diário Oficial da União, Brasília (DF), 23 nov 2018:Seção 1:276

17. Coelho CBT; Yankaskas JR. Novos conceitos em cuidados paliativos na unidade de terapia intensiva. Rev. bras. ter. intensiva [online]. 2017 abr/jun; [citado 2020 dez 22];29(2):222-230. Disponível em: http://dx.doi.org/10.5935/0103-507x.20170031

18. Maingue PCPM et al. Discussão bioética sobre o paciente em cuidados de fim de vida. Rev. Bioét. [online]. 2020 mar; [acesso em 22 de dezembro de 2020];28(1):135-146. Disponível em: http://dx.doi.org/10.1590/1983-80422020281376

19. Souza JB, Barros CM. Considerações sobre o novo conceito de dor. BrJP [online]. 2020 set; [acesso em 22 de dezembro de 2020];3(3):294-294. Disponível em: http://dx.doi.org/10.5935/2595-0118.20200190

20. Zhou Y, Li Q, Zhang W. Undergraduate nursing students' knowledge, attitudes and self-efficacy regarding palliative care in China: A descriptive correlational study. Nursing Open [online]. 2020 abr/set; [cited 2020 dez 22];8:343–353. Available from: https://onlinelibrary.wiley.com/doi/epdf/10.1002/nop2.635

21. Boakye EA et al. Palliative care knowledge, information sources, and beliefs: Results of a national survey of adults in the USA. Cambridge University Press [online]. 2019 out; [cited 2020 dez 22];18(3)285-292. Available from: https://doi.org/10.1017/S1478951519000786.

22. Etafa W et al. Nurses' knowledge about palliative care and attitude towards end- of-life care in public hospitals in Wollega zones: A multicenter cross-sectional study. Plos One [online]. 2020 out; [cited 2020 dez 22];15(10): e0238357. Available from: https://doi.org/10.1371/journal.pone.0238357.