revista de pesquisa ISSN 2175-5361

CUIDADO É FUNDAMENTAL

Escola de Enfermagem Alfredo Pinto – UNIRIO

INTEGRATIVE LITERATURE REVIEW *DOI: 10.9789/2175-5361.rpcfo.v17.13718*

DIGNITY AND RESPECT AS PRINCIPLES OF CARE FOR PEOPLE IN PALLIATIVE CARE: AN INTEGRATIVE REVIEW

Dignidade e respeito enquanto princípios da assistência à pessoa em cuidados paliativos: uma revisão integrativa

Dignidad y respeto como principios de atención a las personas en cuidados paliativos: una revisión integradora

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RESUMO

Objetivo: mapear o estado da arte acerca dos princípios de dignidade e respeito da pessoa assistida no contexto dos cuidados paliativos, divulgada na literatura científica. **Método:** estudo bibliográfico, tipo revisão integrativa da literatura, realizada nas bases de dados: Medline, via *PubMed*, *Scopus*, *Web of Science*, *Embase*, LILACS e BDEnf, em setembro de 2024. **Resultados:** dos 1.244 estudos encontrados, 12 publicações versavam sobre a temática. O estudo identificou duas categorias temáticas centrais que permeiam a literatura revisada: 1) A dignidade enquanto princípio fundamental à assistência da pessoa em cuidados paliativos e 2) Desafios contemporâneos para uma assistência em cuidados paliativos amparada nos preceitos de dignidade e respeito. A dignidade foi identificada como um princípio multifacetado, que envolve muito além do aspecto físico do cuidado. Conclusão: trabalhos que discorram sobre a associação conceitual de dignidade e respeito como princípios dos CP ainda é muito incipiente.

DESCRITORES: Cuidados paliativos; Dignidade; Respeito; Doente terminal.

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Received: 2024/12/23. **Accepted:** 2025/04/24

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How to cite this article: Rodrigues LF, Nepomuceno AMT, Moreira MASP, Freire MEM. Dignity and respect as principles of care for people in palliative care: an integrative review. R Pesq Cuid Fundam (Online). [Internet]. 2025 [cited year month day];14:e13718. Available from: https://doi.org/10.9789/2175-5361.rpcfo.v14.13718.

ABSTRACT

Objective: to map the state of the art regarding the principles of dignity and respect of the person assisted in the context of palliative care, published in the scientific literature**. Method:** bibliographic study, integrative literature review type, carried out in the databases: Medline, via PubMed, Scopus, Web of Science, Embase, LILACS and BDEnf, in September 2024. **Results:** of the 1,244 studies found, 12 publications dealt with the theme. The study identified two central thematic categories that permeate the reviewed literature: 1) Dignity as a fundamental principle for the care of people in palliative care and 2) Contemporary challenges for palliative care based on the precepts of dignity and respect. Dignity was identified as a multifaceted principle, which involves much more than the physical aspect of care. **Conclusion:** studies that discuss the conceptual association of dignity and respect as principles of PC are still very incipient.

DESCRIPTORS: Palliative care; Dignity; Respect; Terminally Ill.

RESUMEN

Objetivo: mapear el estado del arte sobre los principios de dignidad y respeto de la persona asistida en el contexto de los cuidados paliativos, publicado en la literatura científica. **Método:** estudio bibliográfico, tipo revisión integradora de la literatura, realizado en las bases de datos: Medline, vía PubMed, Scopus, Web of Science, Embase, LILACS y BDEnf, en septiembre de 2024. **Resultados:** de los 1.244 estudios encontrados, 12 publicaciones trataron el tema. El estudio identificó dos categorías temáticas centrales que permean la literatura revisada: 1) La dignidad como principio fundamental para el cuidado de las personas en cuidados paliativos y 2) Los desafíos contemporáneos de los cuidados paliativos basados en los preceptos de dignidad y respeto. Se identificó la dignidad como un principio multifacético, que implica mucho más que el aspecto físico de la atención. **Conclusión:** los estudios que discuten la asociación conceptual de la dignidad y el respeto como principios de la CP son aún muy incipientes.

DESCRIPTORES: Cuidados paliativos; Dignidad; Respeto; Enfermos terminales.

INTRODUCTION

Patients and family members at the end of their lives experience painful moments permeated by declining physiological functions and emotional fragility. Providing health care that is concerned with offering humane and comprehensive care to patients at the end of their lives has been a major challenge, especially in the face of the growing technological apparatus in the health field.[1] Palliative Care (PC) is based on this welcoming, humane and sensitive logic, with the aim of alleviating the real suffering of patients with life-threatening illnesses at an advanced stage and a bleak prognosis.[1-2]

The care offered to people with life-threatening illnesses, under the principles of PC, has shown great effectiveness in improving the quality of life of these patients in declining health.[1-3] More than just a medical specialty, PC represents a multi-professional approach focused on relieving physical, emotional, social and spiritual suffering, where care focuses on the integrality of the human being and their family context[3], permeated by fundamental principles, such as dignity and respect.

Dying with dignity has been one of PC's contemporary struggles. Ending the process of becoming ill with a suffering, agonizing and gloomy death is still the reality in many countries, especially those characterized, from a socio-economic point of view, as poor or developing. Knowing that there is such a thing as the end of life for cancer patients, for example, a survey showed that Brazil ranks third among the forty worst countries in which to "die", when analyzing the quality of death.[4-5]

It is essential that patients who do not achieve a cure receive continuous care in their final phase of life, with autonomy, dignity and respect.[1-6] The remaining life of this patient needs to be considered on a daily basis by health professionals and the family. It is essential that the patient's voice is not silenced and that their wishes are expressed through effective communication, based on the principles of PC. In this context, the principle of dignity stands out, understood as the intrinsic value of every human being, regardless of their physical, mental or social condition.[4] In palliative care, this means treating the patient not just as a carrier of a disease, but as an individual with a history, desires, values and emotions. Respecting dignity means listening to the patient, understanding their needs and accepting their preferences, whether in relation to pain control, decisions about treatments or the way they wish to be cared for in the final moments of life.[1,3]

Respect, in turn, is the concrete practice of valuing the patient's autonomy and individuality.[7] In moments of extreme vulnerability, as occurs in PC, guaranteeing the right to choose and preserving autonomy are ways of reaffirming respect for the person. This involves clear communication, empathy and sensitivity on the part of the healthcare team, promoting an environment where the patient feels comfortable expressing their fears, anxieties and hopes.[1,3,7] The value that should be given to the process of the end of life is the same as that given to birth. People at the end of life need care and a voice, and to be the protagonists of their own care.[7-9]

The literature on palliative care still has gaps, especially in relation to the applicability of the principles of dignity and respect, which are often neglected by the multi-professional team[5-6], although they are fundamental to the quality of care for these patients. Furthermore, the scarcity of research focused on the implementation of these principles reflects an opportunity for the development of the field, and it is essential to

further investigate how the multi-professional team can be better trained to recognize and promote these values.

Given the research problem, it is imperative to understand the principles of dignity and respect as basic human values, especially in situations of fragility, psycho-emotional vulnerability and threats to people's lives. In this sense, this study will help to bring health professionals closer to these concepts, prompting reflections on their practice and the search for strategies that guarantee more autonomy and meet the basic needs and wishes of people under palliative care, promoting a dignified and respectful death. To this end, it seeks to answer the following question: What is the state of the art on the principles of dignity and respect in the context of people in palliative care?

The aim of this study was to map the state of the art in scientific literature on the principles of dignity and respect for the person being assisted in the context of palliative care.

METHOD

In order to achieve the proposed objectives, an integrative literature review was carried out, which allows for a comprehensive and in-depth analysis of the knowledge accumulated and disseminated in previous research on a given phenomenon, with the aim of synthesizing the available evidence and promoting new knowledge. The review followed six stages.[10] Definition of the research question, establishment of inclusion and exclusion criteria for searching the databases, extraction of the data of interest, categorization of the studies, analysis, interpretation and presentation of the synthesis of knowledge.

The guiding question was formulated using the acronym PICo[11], with "P" representing the population (person with a life-threatening illness), "I" for the phenomenon of interest (dignity and respect) and "Co" for the context (palliative care). Based on this structure, the question was defined: What is the state of the art on the principles of dignity and respect for the human person with a life-threatening illness, applicable in the practical context of palliative care?

Next, a broad electronic survey of studies available in the databases of the Regional Portal of the Virtual Health Library was carried out using terms such as "Terminal Illness", "Respect", "Dignity", "Palliative Care", as well as pertinent synonyms, defining the descriptors of the research. These were extracted from the Health Sciences Descriptors Portal (DeCS) and the Medical Subject Headings (Mesh Terms).

The search was carried out in the following databases: Medical Literature Analysis and Retrieval System Online (Medline) via PubMed, Scopus, Web of Science, Embase, Latin American and Caribbean Health Sciences Literature (LILACS) and Nursing Database (BDEnf). Access to these sources was via the Portal de Periódicos of the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior, using authentication by the Federated Academic Community to standardize collection.

The following strategy was used in Medline: ("Terminally Ill"[MeSH Terms] OR "Terminally Ill"[All Fields]) AND ("Respect" [MeSH Terms] OR "Respect" [All Fields] OR "Dignity" [All Fields] OR "Personal Respect" [All Fields]) AND ("Palliative Care" [MeSH Terms] OR "Palliative Care" [All Fields] OR "Palliative Supportive Care" [All Fields] OR "Palliative Surgery" [All Fields] OR "Palliative Therapy" [All Fields] OR "Palliative Treatment" [All Fields] OR "Surgery, Palliative" [All Fields] OR "Therapy, Palliative" [All Fields]). This search strategy was adapted according to the particularities of each database, using the Boolean operators AND to group the references and OR to intersect the terms, while maintaining the similarities in the descriptor combinations.

The sample included articles with no restrictions in terms of methodological design, country of origin or time frame. We considered texts in Portuguese, English and Spanish, available in full, accessible online and free of charge, as well as addressing the principles of respect and dignity for people in palliative care. Editorials, reviews, letters, notes, guidelines, protocols, conference papers, reviews, case studies, book chapters, term papers, dissertations, theses and gray literature were excluded. The articles were selected from the databases by two independent researchers in September 2024.

The studies were then imported into the Rayyan® software, which made it possible to blind the collaboration between the two reviewers, remove duplicates and pre-select articles by reading the titles and abstracts, based on the guiding question and the previously established inclusion and exclusion criteria[12]. It should be noted that if there were any doubts between the two reviewers about the inclusion of the study, a third reviewer was called in to clear up any doubts and decide on inclusion or exclusion.

The studies were classified into levels of scientific evidence13: Level 1: evidence derived from meta-analysis of multiple randomized controlled clinical studies; Level 2: evidence obtained from individual experimental studies; Level 3: evidence from quasi-experimental studies; Level 4: evidence from descriptive studies (non-experimental) or with a qualitative approach; Level 5: evidence resulting from case reports or experiences; Level 6: evidence based on expert opinions.

The final sample was determined after thoroughly reading the selected materials. To extract the data, the reviewers developed a specific instrument based on a validated model[14], containing the following items: identification; year of publication; country; language; database; objective; methodological design; professional involved; main results and classification of the level of evidence as cited.[13] The flowchart for selecting the studies is illustrated in Figure 1. Authors of studies unavailable in full were contacted by e-mail, but there was no response.

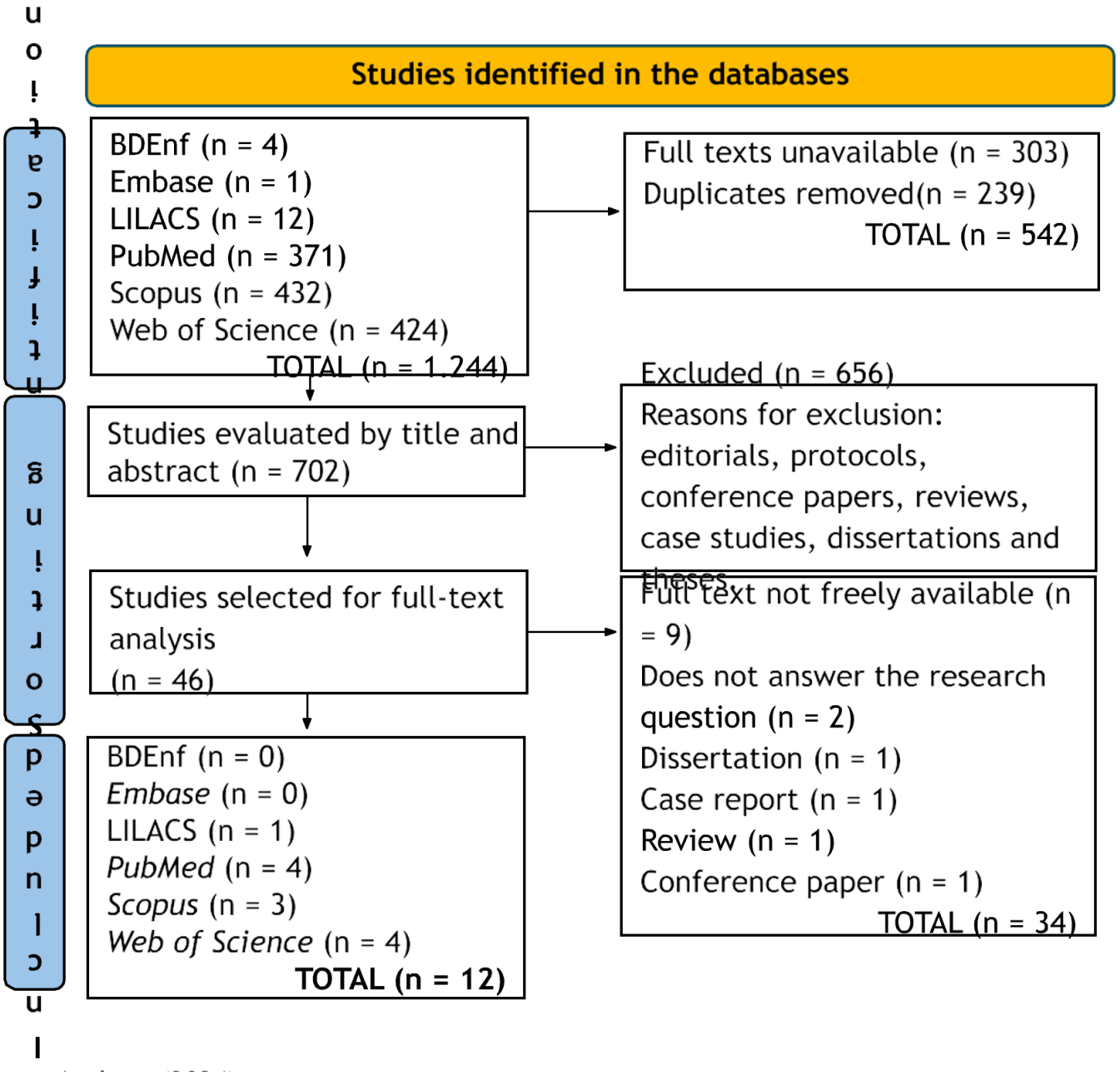
RESULTS

The bibliographic survey resulted in the identification of 1,244 relevant articles. After removing duplicates and applying the inclusion criteria, 702 articles were identified, the abstracts of which were read. After exclusions, 46 scientific productions remained to be analyzed in full, following the same exclusion criteria described above.

In the final sample, made up of 12 publications on the subject, the central elements of each article were assessed, enabling categorization by similarity of themes. These categories were presented in a narrative synthesis.

The process of searching for and selecting studies was recorded in detail, enabling all the decisions made to be identified, and reported by filling in the flowchart adapted from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR), shown in Figure 1.

Figure 1 - PRISMA-ScR ® flowchart of the literature search and selection process. João Pessoa, PB, Brazil, 2024

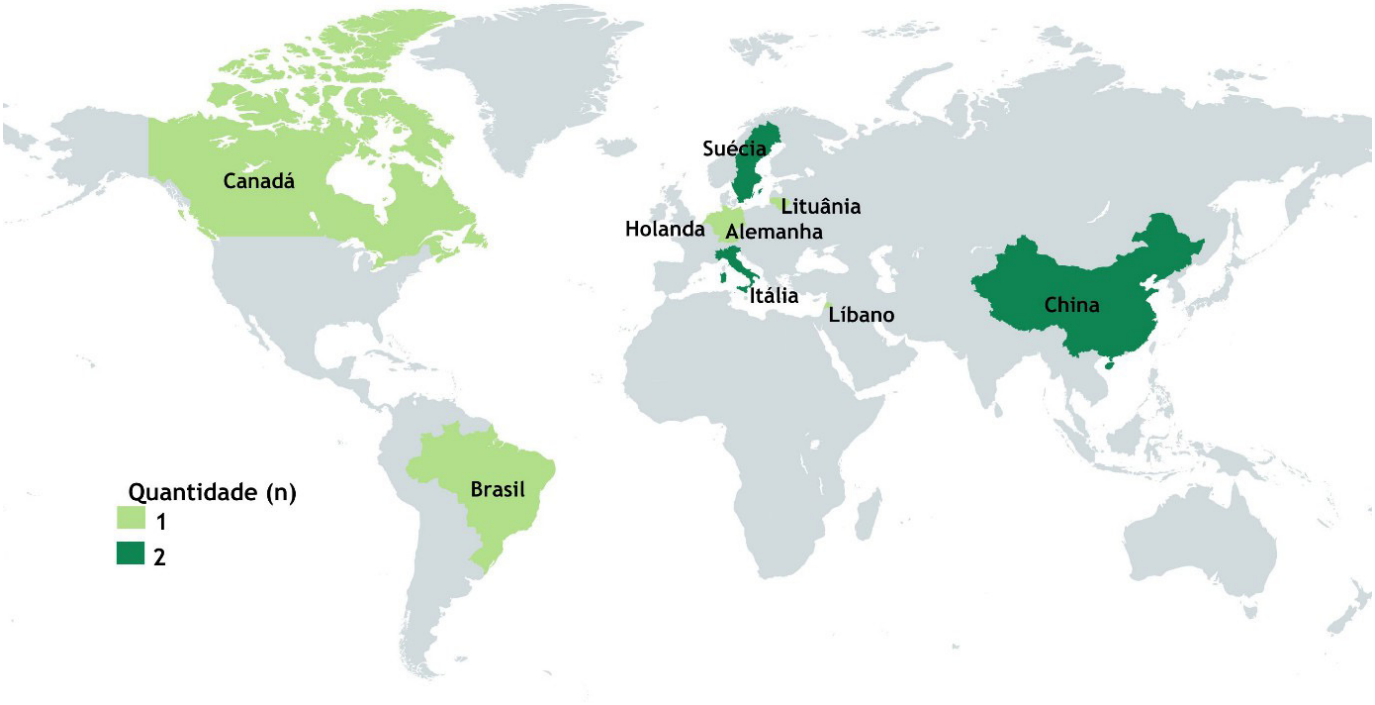


Source: Authors (2024).

Four articles were found in the PubMed[17,19,21-22] and Web of Science[15-16,18,20] databases; three in Scopus[23-25]; and one in LILACS.[8] As far as the time dimension is concerned, the

articles were published between 2002 and 2024, with three in 2021. The articles were written predominantly in English (n=11).[15-25] The thematic map (Figure 2) provides a proportional choropleth representation of the geographical distribution of the articles, with China, Italy and Sweden standing out, with two studies each.

Figure 2 - Thematic map of the geographical distribution of articles. João Pessoa, PB, Brazil, 2024



Note: Germany[23], Brazil[8], Canada[25], China[19-20], Netherlands[21], Italy[16-17], Lebanon[15], Lithuania[18] and Sweden[22,24]. Source: survey data, 2024.

The studies addressed different target groups, including cancer patients undergoing PC[19-20,23,25]; palliative care patients with other pathologies[15] and their family caregivers[16]; as well as patients undergoing PC and nurses[21] and multi-professional teams (nurses and doctors).[22] Also included were studies with people training in the health area, such as medical students[23], as well as studies with health professionals, such as nurses exclusively[8] and multi-professional teams[17-18], made up of nurses, doctors, nursing assistants, psychologists and social workers. The methodological design of the studies varied between qualitative approaches[8,15,17-19,21-22,24-25] and quantitative cross-sectional models.[16,20,23]

After exhaustive reading of the selected studies, two thematic categories emerged: 1) Dignity as a fundamental principle in the care of people in palliative care[8,15,17-19,21] and 2) Contemporary challenges for care in palliative care based on the precepts of dignity and respect.[16,20,22-25] The main evidence is summarized in Charts 1 and 2, organized into their respective thematic categories.

Chart 1 - Summary of integrative review studies, according to thematic category 01. João Pessoa, PB, Brazil, 2024 (n=12)

Thematic Category 01 - Dignity as a fundamental principle in the care of people in palliative care			
ID† - Year	**GOAL**	**NE‡**	**OUTCOMES OF INTEREST**
15 - 2024	Exploring the understanding of dignity in adult patients with PC needs from a Lebanese perspective	IV	Faith in God and strong family ties, as well as relational connection, are dominant elements in maintaining dignity in the Lebanese context.

Thematic Category 01 - Dignity as a fundamental principle in the care of people in palliative care			
ID† - Year	**GOAL**	**NE‡**	**OUTCOMES OF INTEREST**
17 - 2022	To explore the perspectives of health professionals on the dignity of patients at the end of life, collecting a variety of testimonies on what dignity involves and the strategies adopted by health professionals to preserve it throughout the process.	IV	Dignity is a complex concept, encompassing attitudes, behaviors and reflections by health professionals
18 - 2021	Understand professionals' attitudes, experiences and suggestions about dignity at the end of life to provide knowledge on which efforts to improve end-of-life care can be based.		Being heard included elements of the main themes and was identified as a key component or essence of dignity.
19 - 2021	To explore the meaning of patient dignity at the end of life in traditional Chinese culture, from the perspective of patients with advanced cancer and their families.	IV	The patient's dignity must be supported by joint work between the family and health professionals, also taking into account the patient's cultural context, wishes and personal values.
8 - 2020	Investigating the contributions of the Pacific End of Life Theory to nursing care for patients in PC§	IV	Spirituality in promoting peace in the final moments; and attending to the wishes of the terminally ill as an attitude of respect for their dignity.
21 - 2020	Understand how health professionals can preserve and strengthen the dignity of patients.	IV	Dependence on others and the distressing prospect of continued loss of autonomy and deterioration are difficult challenges for all patients.

Note: †ID: identification with numbering of the source cited in the list of references; ‡PC: palliative care; §NE: level of evidenceSource: Information extracted by the authors from the publications included in this review, 2024.

Chart 2 - Summary of integrative review studies, according to thematic category 02. João Pessoa, PB, Brazil, 2024 (n=12)

Thematic Category 02: Contemporary challenges for palliative care based on the precepts of dignity and respect			
ID† - Year	**OBJECTIVE**	**NE‡**	**OUTCOMES OF INTEREST**
16 - 2023	To explore the relationship between the dignity-related suffering of cancer patients at the end of life and the suffering of their caregivers.	III	Caregivers' suffering can directly impact patients' dignity by affecting the interpersonal aspects of their autonomy. Alleviating this suffering is fundamental to promoting patients' autonomy and reducing their fear of becoming a burden.
20 - 2021	To analyze how several sociodemographic and clinical variables are related to personal dignity in a sample of Chinese patients with advanced cancer receiving ‡PC.	III	Self-perceived dignity is significantly negatively associated with meaning in life, age, hospitalization status and performance status.
22 - 2019	To suggest care actions to preserve dignity in PC from the perspectives of patients and health professionals in Sweden.	IV	Care that preserves dignity involves both concrete actions and attitudes that respect the patient, guaranteeing their dignity at all stages of care.
23 - 2014	To examine whether the association between the number of physical problems and demoralization is mediated by loss of dignity.	III	Preliminary evidence suggests that loss of dignity contributes to demoralization in cancer patients, highlighting the need for psychosocial interventions to preserve dignity.

Thematic Category 02: Contemporary challenges for palliative care based on the precepts of dignity and respect			
ID† - Year	**OBJECTIVE**	**NE‡**	**OUTCOMES OF INTEREST**
24 - 2006	To explore medical students' definition of a dignified death.	IV	The students recognize that the medical system is over-treating patients and sometimes causing harm to terminally ill patients.
25 - 2002	To determine how dying patients understand and define the term dignity, in order to develop a model of dignity in terminally ill patients.	IV	The concept and model of dignity provides an approach to understanding how patients deal with the progression of terminal illness, contributing to the promotion of dignity and quality of life for those approaching the end of life.

Note: †ID: identification with numbering of the source cited in the list of references; ‡PC: palliative care; §NE: level of evidenceSource: Information extracted by the authors from the publications included in this review, 2024.

DISCUSSION

There is growing scientific production on palliative care and dignity and respect in the care of patients with an illness beyond the possibility of curative treatment. Although the studies were predominantly in English, the geographical diversity, with articles from countries such as China, Italy and Sweden, points to a growing global interest. However, the cultural and contextual differences in these countries may influence perceptions and practices around PC, impacting the applicability of these findings. There is also a notable scarcity of studies in Latin America, indicating the need for more research to understand the regional demands and challenges faced by patients.

The studies in the first category argue that dignity must be a crucial element in truly effective and sensitive palliative care. Being the bearer of a disease that cannot be cured, as is the case,

The literature highlights that respect for dignity refers not only to what is done, but also to how the patient is treated by health professionals. This reflects the need for a collaborative approach, involving family and professionals, taking into account the patient's personal wishes and values.[15,19] Preserving autonomy, despite the loss of physical and mental abilities, also emerges as an important challenge.

A Dutch study revealed that dependence and the prospect of loss of autonomy and deterioration are difficult for all patients.[21] In this sense, health professionals should encourage the autonomy of their patients with planned health actions that allow them to carry out self-care in order to minimize dependence on care and become key players in the context of improving patients' quality of life.[26]

A study by the Medical University in Beijing/China pointed out that dignity should be supported by the collaborative efforts

The categorization of the articles revealed a predominance of studies with a low level of evidence (level III and IV), suggesting the need for more research with greater methodological rigour to provide more robust evidence. The variety of methodological designs, with a predominance of qualitative studies, allows for a deeper understanding of the experiences of patients, caregivers and professionals, but also highlights the need for quantitative approaches that can evaluate the effectiveness of proposed interventions.

The study identified two central thematic categories that permeate the literature reviewed: 1) Dignity as a fundamental principle for the care of people in palliative care and 2) Contemporary challenges for care in palliative care based on the precepts of dignity and respect. Dignity was identified as a multifaceted principle, involving not only the physical aspect, but also emotional, social and spiritual factors. for example, with patients diagnosed with advanced cancer, causes them to experience feelings of fear, hopelessness and sadness, which add to the fragile physical state they are already in.[16,19-20,23]

Italian research has shown that dignity is a multifaceted concept which involves the attitudes, behaviors and reflections of health professionals. It highlighted various strategies that health professionals use to maintain patients' dignity, such as: care skills, privacy, empathic skills, professional strategies and respect for the whole person.[17]

Promoting care based on valuing life and committed to dignity and respect goes beyond the implementation of hard health technologies. "Being heard" has been identified as a key component or essence of dignity in PC.[18] PC patients, when facing the loss of dignity, deserve to be heard in their complaints, anguish, pain, joys and achievements. Finitude, emotional pain and unfulfilled wishes are constant thoughts for terminally ill patients. Attending to these patients' wishes should be a daily action to respect their dignity.[8]
of family and professionals, taking into account the cultural context and personal values of the patient.[19] Each culture

perceives finitude differently, and for the Chinese culture, dependence on family members is a crucial element in the loss of dignity since their autonomy and functionality are affected.

Respecting patients' dignity also involves valuing their spiritual contexts and family relationships. A recent study of PC patients in Lebanon highlighted the importance of faith and family ties in maintaining dignity.[15] Promoting meetings with spiritual leaders, making visiting times and the number of family members in the hospital context more flexible should also be understood as caring actions and considered as human sensitivity towards this profile of patients who are already so worn down by the painful process of physical and emotional illness.[9,27]

PC care must be centered on the principles of dignity and respect for the patient. Health professionals must use their technical and human skills to provide welcoming, humane and sensitive care. Knowing how to listen, promote comfort and facilitate meetings with family and/or loved ones are fundamental actions that promote extraordinary experiences for patients and their families, who will face the painful process of death.[15]

In relation to contemporary challenges, portrayed in the second category, building PC care based on dignity and respect has been a major challenge, especially in a context where technicist biomedical care still predominates. Caring for PC patients requires skills and abilities that transcend technical knowledge, recognizing the limitations of modern medicine in curing the patient.[25]

Avoiding painful and fruitless procedures is also a form of care for patients whose physiological functions are declining. In a Swedish survey, medical students realized that the medical system is over-treating patients and sometimes causing harm, which raises the need for a more humanized and patient-centered approach.[23] It is understood that these challenges are not exclusive to developing countries, as modern healthcare systems also face obstacles.[24-25]

The multi-professional PC healthcare team must be attentive to patients' needs in order to identify early risk factors for loss of dignity. This improves the meaning of the patient's life, promoting dignity and quality of life.[20,25] The suffering of families who also experience the painful context of illness must be considered, as it can affect patients' dignity.

Giving due attention to patients' families in this context of suffering is still a major challenge for PC care, given that in many contexts care is focused solely on the patient and their health problems, leaving their entire family environment as something secondary and of no real significance.[28] An Italian study showed that the suffering of caregivers and family members impacts on patients' autonomy and, consequently, their dignity, suggesting that alleviating this suffering is essential to promote autonomy and minimize the fear of being a burden.[16]

A team specializing in PC should identify psychological and social problems early on, in addition to physical pain. German research provides evidence that loss of dignity partially explains the positive association between the number of physical problems and demoralization in patients with oncological diseases.[23] These findings emphasize the importance of psychosocial interventions to support dignity. Contemplating and caring for a patient and their family in the context of PC means welcoming a person with dignity into the healthcare system, which involves supporting their ability to uphold standards and values and thus avoid situations of humiliation and shame.[23,28]

Caring for a life that is frailly ill and in finitude involves significant ethical challenges, especially when patients express simple but emotionally valuable wishes. These requests generate dilemmas about how to respect the patient's autonomy within clinical and ethical limits. Although respect for dignity is a fundamental principle in PC, the practice of fulfilling these wishes still faces barriers, such as a lack of ethical training.[26]

The literature reveals that although professionals recognize the importance of respecting patients' wishes, effective implementation still faces obstacles, such as a lack of adequate ethical training and the difficulty of balancing the patient's wishes with the limitations of medical treatment.[16,20,23,24] Thus, ethical training and a humanized approach are essential for the quality of palliative care, aimed at preserving the dignity and well-being of the patient at the end of life.[29]

That said, there are numerous challenges to implementing PC that is truly based on the principles of respect for human dignity. Dying with autonomy and wishes respected is still an uncommon scenario in the reality of patients at the end of their lives. The guarantee of dignity must be understood as a key precept for those professionals who focus on "caring" in PC.[16,22-23]

An important consideration that emerges from this review is the need to include both health professionals and medical students in training on dignity and palliative care. The involvement of students in the research highlights the importance of including these topics in training curricula in order to sensitize future generations of doctors and nurses to the specific needs of end-of-life patients. Continuous training for healthcare professionals is also essential to ensure that care practices are aligned with the precepts of dignity and respect for the patient.[23,29,30]

Future research should focus on conducting studies with a higher level of evidence, such as randomized clinical trials, to evaluate the effectiveness of interventions that promote dignity and respect. In addition, there is an urgent need to explore the feasibility and effectiveness of psychosocial interventions that alleviate the suffering of caregivers, considering their fundamental role. Finally, more studies in diverse cultural contexts are needed to ensure that PC practices are sensitive to local needs and values.

The limitations of this review include the lack of longitudinal studies and greater methodological rigor, as well as the predominant inclusion of articles in English, which may have excluded relevant research published in other languages. Finally, recognizing the unavailability of some studies in full, some important references may have been excluded, affecting the comprehensiveness and representativeness of the results.

CONCLUSION

The synthesis of knowledge resulting from this study points out that, although the number of studies on PC has grown both nationally and worldwide, studies that address the conceptual association of dignity and respect as principles of PC are still incipient. The theme of dignity is multifaceted and is often addressed peripherally in many studies on PC, which explains the scarcity of research in the final sample. Nevertheless, the studies report relevant results when discussing this topic in a central way, highlighting patients and their families as key players in preserving these principles. These studies show that supporting autonomy, respecting the patient's wishes, reducing dependence on others, being listened to, relieving physical symptoms, as well as healthy and balanced social and family relationships, are essential elements in guaranteeing the dignity and respect of PC patients.

REFERENCES

1. Ministério da Saúde (BR). Manual de cuidados paliativos. São Paulo: Ministério da Saúde; 2023 [acesso em 21 de outubro 2024]. 421p. Disponível em: https://biblioteca.cofen.gov.br/wp-content/uploads/2023/10/manual-de-cuidados-paliativ os-2a-edicao.pdf.
2. Agência Nacional de Cuidados Paliativos (ANCP). Manual de cuidados paliativos.
3. Brasília: ANCP; 2023 [acesso em 21 de outubro 2024]. 624p. Disponível em: https://www.gov.br/saude/pt-br/centrais-de-conteudo/publicacoes/guias-e-manuais/2023/manual-de-cuidados-paliativos-2a-edicao/view.
4. Silva BS, Costa EE, Gabriel IG de SP e S, Silva AE, Machado RM. Perception of oncological patients in palliative care on their own end-of-life. Cogitare Enferm. [Internet]. 2016 [cited 2024 nov 21];21(4). Available from: http://dx.doi.org/10.5380/ce.v21i4.47146.
5. Frias L, Lopes N. Considerações sobre o conceito de dignidade humana. Rev Direito GV. [Internet]. 2015 [cited 2024 nov 10];11(2). Disponível em: http://dx.doi.org/10.1590/1808-2432201528.
6. Pergolizzi J Jr, LeQuang JAK, Wagner M, Varrassi G. Challenges in Palliative Care in Latin America: A Narrative Review. Cureus. [Internet]. 2024 [cited 2024 nov 10];20;16(5):e60698. Available from: http://dx.doi.org/10.7759/cureus.60698.
7. Soares LGL, Gomes RV, Japiassu AM. Trends in Health-Care Utilization at the End of Life Among Patients With Hematologic Malignancies in a Middle-Income Country: Challenges and Opportunities in Brazil. Am J Hosp Palliat Care. [Internet]. 2019 [cited 2024 nov 21]; 36(9). Available from: http://dx.doi.org/10.1177/1049909119828086.
8. Oliveira AC, Silva MJP. Autonomy in palliative care: concepts and perceptions of a health teamwork. Acta paul enferm. [Internet]. 2010 [cited 2024 nov 21];23(2). Available from: http://dx.doi.org/10.1590/S0103-21002010000200010.
9. Zaccara AAL, Batista PSS, Vasconcelos MF, Dias KCCO, Aguiar PKF, Costa SFG. Contributions of The Theory of The Peaceful End of Life To The Nursing Care For Patients Under Palliative Care. Rev Fun Care Online. [Internet]. 2020 [cited 2024 nov 10];12. Available from: http://dx.doi.org/10.9789/2175-5361.rpcfo.v12.9558.
10. Delgado-Guay MO, Palma A, Duarte E, Grez M, Tupper L, Liu DD, Bruera E. Association between Spirituality, Religiosity, Spiritual Pain, Symptom Distress, and Quality of Life among Latin American Patients with Advanced Cancer: A Multicenter Study. J Palliat Med. [Internet]. 2021 [cited 2024 nov 21];24(11). Available from: http://dx.doi.org/10.1089/jpm.2020.0776.
11. Mendes KDS, Silveira RCCP, Galvão CM. Integrative literature review: a research method to incorporate evidence in health care and nursing. Texto contexto - enferm. [Internet]. 2008 [cited 2024 dec 12];17(4). Available from: http://dx.doi.org/10.1590/S0104-07072008000400018.
12. Araújo WCO. Health information retrieval: construction, models and strategies. ConCI. [Internet]. 2020 [cited 2024 nov 5];3(2). Available from: http://dx.doi.org/10.33467/conci.v3i2.13447 .

13. Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan - a web and mobile app for systematic reviews. Syst Rev. [Internet]. 2016 [cited 2024 nov 5];5(1). Available from:

14. https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-016-0384-4.

15. Souza MT de, Silva MD da, Carvalho R de. Integrative review: what is it? How to do it?. Einstein (São Paulo). [Internet]. 2010 [cited 2024 nov 5];8(1). Available from: https://doi.org/10.1590/S1679-45082010RW1134.

16. Ursi ES, Gavão CM. Perioperative prevention of skin injury: an integrative literature review. Rev Latino-Am Enfermagem. [Internet]. 2006 [cited 2024 nov 5];14(1). Available from: https://doi.org/10.1590/S0104-11692006000100017.

17. Sailian SD, Salifu Y, Preston N. Dignity enhanced through faith & family support in palliative care: a qualitative study. BMC Palliat Care. [Internet]. 2024 [cited 2024 sep 5];23(1). Available from: http://dx.doi.org/10.1186/s12904-024-01478-4.

18. Bovero A, Cotardo F, Lops C, Botto R, Geminiani GC. Is there a relationship between end-of-life cancer patients' dignity-related distress and caregivers' distress? An exploratory study. Palliat Support Care. [Internet]. 2023 [cited 2024 sep 5];21(4). Available from: http://dx.doi.org/10.1017/s1478951522000840.

19. Bovero A, Tosi C, Botto R, Pidinchedda A, Gottardo F, Asta G, et al. A qualitative study to explore healthcare providers' perspectives on end-of-life patients' dignity. How can dignity be defined, and which strategies exist to maintain dignity? J Cancer Educ. [Internet]. 2022 [cited 2024 sep 5];37(2). Available from: http://dx.doi.org/10.1007/s13187-020-01808-z.

20. Butkevičienė R, Kuznecovienė J, Harrison D, Peičius E, Urbonas G, Astromskė K, et al. Being Heard: A qualitative study of Lithuanian health care professionals' perceptions of dignity at the end-of-life. Medicina (Kaunas). [Internet]. 2021 [cited 2024 sep 5]; 57(12). Available from: http://dx.doi.org/10.3390/medicina57121318.

21. Liu L, Ma L, Chen Z, Geng H, Xi L, McClement S, et al. Dignity at the end of life in traditional Chinese culture: Perspectives of advanced cancer patients and family members. Eur J Oncol Nurs. [Internet]. 2021 [cited 2024 sep 5];54(102017). Available from: http://dx.doi.org/10.1016/j.ejon.2021.102017.

22. Liu X, Liu Z, Cheng Q, Xu N, Liu H, Ying W. Effects of meaning in life and individual characteristics on dignity in patients with advanced cancer in China: a cross-sectional study. Support Care Cancer. [Internet]. 2021 [cited 2024 sep 5];29(5). Available from: http://dx.doi.org/10.1007/s00520-020-05732-2. de Voogd X, Oosterveld-Vlug MG, Torensma M, Onwuteaka-Philipsen BD, Willems DL, Suurmond JL. A dignified last phase of life for patients with a migration background: A qualitative study. Palliat Med. [Internet]. 2020 [cited 2024 sep 5];34(10). Available from: http://dx.doi.org/10.1177/0269216320948708.

23. Östlund U, Blomberg K, Söderman A, Werkander Harstäde C. How to conserve dignity in palliative care: suggestions from older patients, significant others, and healthcare professionals in Swedish municipal care. BMC Palliat Care. [Internet]. 2019 [cited 2024 sep 5];18(1). Available from: http://dx.doi.org/10.1186/s12904-019-0393-x.

24. Vehling S, Mehnert A. Symptom burden, loss of dignity, and demoralization in patients with cancer: a mediation model. Psychooncology. [Internet]. 2014 [cited 2024 sep 5];23(3). Available from: http://dx.doi.org/10.1002/pon.3417.

25. Karlsson M, Milberg A, Strang P. Dying with dignity according to Swedish medical students. Support Care Cancer. [Internet]. 2006 [cited 2024 sep 5];14(4). Available from: http://dx.doi.org/10.1007/s00520-005-0893-5.

26. Chochinov HM, Hack T, McClement S, Kristjanson L, Harlos M. Dignity in the terminally ill: a developing empirical model. Soc Sci Med. [Internet]. 2002 [cited 2024 sep 5];54(3). Available from: http://dx.doi.org/10.1016/s0277-9536(01)00084-3.

27. Alves RSF, Oliveira FFB. Palliative Care for Health Professionals: Advances and Difficulties. Psicol Ciênc Prof. [Internet]. 2022 [cited 2024 oct 15];42:e238471. Available from: https://doi.org/10.1590/1982-3703003238471.

28. Ferrell B, Chung V, Koczywas M, Borneman T, Irish TL, Ruel NH, Azad NS, Cooper RS, Smith TJ. Spirituality in cancer patients on phase 1 clinical trials. Psychooncology. [Internet]. 2020 [cited 2024 oct 15];29(6). Available from: http://dx.doi.org/10.1002/pon.5380.

29. Dittborn M, Turrillas P, Maddocks M, Leniz J. Attitudes and preferences towards palliative and end of life care in patients with advanced illness and their family caregivers in Latin America: A mixed studies systematic review. Palliat Med. [Internet]. 2021 [cited 2024 dec 15];35(8). Available from: http://dx.doi.org/10.1177/02692163211029514.

30. Daubman BR, Pérez-Cruz PE, Leiva O, Wong AW, Stoltenberg M. Furthering Palliative Care Training in Latin America: Development and Assessment of an Advanced Diploma Course in Palliative Care in Chile.

J Pain Symptom Manage. [Internet]. 2022 [cited 2024 dec 15];64(2). Available from: http://dx.doi.org/10.1016/j.jpainsymman.2022.04.181.

31. Vindrola-Padros C, Mertnoff R, Lasmarias C, Gómez-Batiste X. Palliative care education in Latin America: A systematic review of training programs for healthcare professionals. Palliat Support Care. [Internet]. 2018 [cited 2024 dec 12];16(1). Available from: http://dx.doi.org/10.1017/S147895151700061X.