

ASSISTANCE PRACTICES OF MEDICAL AND NURSING TEAMS FOR HOSPITALIZED PEOPLE IN PALLIATIVE CARE

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ABSTRACT

Objective: to analyze the practices of Medical and Nursing teams for hospitalized people in Palliative Care.

Method: a qualitative research study linked to the post-critical perspective, carried out between November 2020 and April 2021 in a teaching hospital from southern Brazil. The participants were three physicians, four nurses, three nursing technicians and four hospitalized adults monitored by a Palliative Care consulting team. Vignette and data extraction from medical records were used as data production techniques. The Atlas.ti program, cloud version for students, was used for data management. The data were submitted to content thematic content analysis and interpreted with theoretical notions of life technologies, therapeutic economics and biopolitics.

Results: the practices were directed towards physical distress. The technologies, represented by devices and medications, were the main ways of approaching this. Even if controversial, some practices tend to be used with a view to prolonging the days of life, if that should be the family's wish. The family tends to be used as a link between the hospital and the home; however, it needs to be cared for.

Conclusion: the practices of Medical and Nursing teams partially converge with Palliative Care recommendations and principles. Even under the monitoring of a specialized team, the behaviors prescribed by care teams are supported, above all, on moral values and empirical judgment. Such stance has repercussions on the resistance to accepting death as an existential event and inherent to life, keeping it still medicalized, even from different perspectives, such as Palliative Care.

DESCRIPTORS: Palliative care. Hospitals. Palliative care nursing at the end of life. Palliative medicine. Patient assistance team.

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PRÁTICAS ASSISTENCIAIS DE EQUIPES MÉDICAS E DE ENFERMAGEM ÀS PESSOAS EM CUIDADOS PALIATIVOS HOSPITALIZADAS

RESUMO

Objetivo: analisar as práticas de equipes médicas e de enfermagem às pessoas em cuidados paliativos hospitalizadas.

Método: pesquisa qualitativa, vinculada à perspectiva pós-crítica, realizada entre novembro de 2020 e abril de 2021 em um hospital de ensino do sul do Brasil. Os participantes foram três médicos, quatro enfermeiros, três técnicos de enfermagem e quatro adultos hospitalizados acompanhados por equipe de consultoria em cuidados paliativos. Como técnica de produção dos dados foram utilizadas vinheta e extração de dados de prontuários. O programa Atlas.ti, versão *Cloud* para estudantes, foi utilizado para o gerenciamento dos dados, submetidos à análise de conteúdo, do tipo temática, e interpretados com noções teóricas de tecnologias de vida, economia terapêutica e biopolítica.

Resultados: as práticas estiveram direcionadas ao sofrimento físico. As tecnologias, representadas por equipamentos e medicamentos foram as principais formas de abordagem para tal. Algumas práticas, mesmo que controversas, tendem a ser utilizadas com vistas a prolongar os dias de vida, se esse for um desejo da família. A família tende a ser utilizada como um elo entre o hospital e o domicílio, porém, carece de ser cuidada.

Conclusão: as práticas de equipes médicas e de enfermagem convergem, em parte, com recomendações e princípios dos cuidados paliativos. Mesmo sob o acompanhamento de equipe especializada, as condutas prescritas por equipes assistenciais são respaldadas, sobretudo, em valores morais e julgamento empírico. Tal postura repercute na resistência da aceitação da morte como um evento existencial, inerente à vida, mantendo-o ainda medicalizado, mesmo sob perspectivas diferenciadas, como os cuidados paliativos.

DESCRITORES: Cuidados paliativos. Hospitais. Enfermagem de cuidados paliativos na terminalidade da vida. Medicina paliativa. Equipe de assistência ao paciente.

PRÁCTICAS ASISTENCIALES DE EQUIPOS MÉDICOS Y DE ENFERMERÍA PARA PERSONAS EN CUIDADOS PALIATIVOS INTERNADAS

RESUMEN

Objetivo: analizar las prácticas de equipos médicos y de Enfermería para personas en Cuidados Paliativos internadas.

Método: investigación cualitativa vinculada a la perspectiva post-crítica, realizada entre noviembre de 2020 y abril de 2021 en un hospital escuela del sur de Brasil. Los participantes fueron tres médicos, cuatro enfermeros, tres técnicos de Enfermería y cuatro adultos internados bajo seguimiento del equipo de asesoramiento en Cuidados Paliativos. Se utilizaron viñetas y extracción de datos de historias clínicas como técnicas de producción de datos. Se utilizó el programa Atlas.ti, versión cloud para estudiantes, para administrar los datos, que fueron sometidos a análisis temático de contenido e interpretados con nociones teóricas de tecnologías de vida, economía terapéutica y biopolítica.

Resultados: las prácticas estuvieron dirigidas al sufrimiento físico. Las tecnologías, representadas por dispositivos y medicamentos, fueron las principales formas de abordaje para ellos. Aunque controversiales, algunas prácticas tienden a ser utilizadas con vistas a prolongar los días de vida, si ese fuese el deseo de la familia. La familia tiende a ser utilizada como enlace entre el hospital y el domicilio, aunque debe ser atendida.

Conclusión: las prácticas de equipos médicos y de Enfermería convergen parcialmente con recomendaciones y principios de los Cuidados Paliativos. Incluso bajo la supervisión de un equipo especializado, las conductas prescritas por equipos asistenciales se apoyan especialmente en valores morales y decisiones empíricas. Tal postura repercute en la resistencia a aceptar la muerte como un evento existencial e inherente a la vida, manteniéndola medicalizada incluso desde perspectivas diferenciadas, como los Cuidados Paliativos.

DESCRITORES: Cuidados paliativos. Hospitales. Enfermería de cuidados paliativos al final de la vida. Medicina paliativa. Equipo de asistencia al paciente.

INTRODUCTION

In the contemporary world, the end of life occurs mostly in hospitals, where people are sent due to the technological apparatus and the human and material resources capable of providing comfort and relief from family burden¹. Nevertheless, in this space, health professionals are subjected to personal and environmental stressors that interfere with the care experiences².

Among these stressors we can mention weaknesses in academic training – and throughout life – to act in the face of demands arising from finitude, limitations in the ability to communicate within the team, with patients and with families, as well as deficient structures in the institutions to welcome and implement what is recommended by Palliative Care². Palliative Care (PC) is a holistic approach aimed at promoting quality of life for people of any age, with serious diseases and health-related distress, their families and caregivers³.

In a hospital, technological development and training focused on heroic interventions direct professionals to use the available techniques in favor of life continuity. As a consequence, potentially inadequate interventions, faulty communication and unsatisfactory approaches to distress arise⁴. It is also perceived that the limits between abandonment and therapeutic obstinacy, the prolongation of life in distress, the costs involved in end-stage care and/or the medicalization of the final stages of a disease arouse uncertainties and doubts during the professionals' performance⁵.

In this space, the Nursing team is directly responsible for care and, by staying day and night with patients and family members, plays a key role in PC monitoring and at the end of life. Together with physicians, they act directly in decision-making regarding the practices carried out during the monitoring of people who respond or not to the disease-modifying treatment. In this article, practices refer to actions, to what can provide productive effects, reflecting on transformative experiences of people's relations with themselves and with the world⁶.

Transposing to PC, practices that aim at modifying the care experiences of patients, families and caregivers can sometimes move in the duality between excessive interventions and abandonment in relation to care, especially at the end of life. In the meantime, discussions about the technologicalization of life emerge. Under the theoretical framework that supports this study, technology can be understood as "a set of social and human relations within which devices and techniques are only one element."^{7:32}. Life technologies aim at controlling the vital processes of the body and mind and not merely at curing diseases when they manifest themselves. They seek to change the nature of the organism, with the objective of recalculating vital processes and modifying the future⁷.

Some studies⁸⁻¹⁰ have addressed dilemmas and controversies involving decision-making regarding the suspension or limitation of life-sustaining treatments. Certain practices prescribed to hospitalized adults in Palliative Care have not been recommended in the literature in the final stages of a disease, such as the use of peripheral or central venous catheters, artificial hydration and nutrition, frequent measurement of vital signs, antibiotic therapy, and laboratory and imaging tests¹¹.

In this sense, it is assumed and justified that the practices of the Medical team in a hospital are still centered on the perspective of a cure, even when the person is being monitored under the Palliative Care philosophy and the disease no longer responds to the modifying treatment; as well as that the Nursing team practices lack theoretical support and tend to discipline the person's body, without considering the PC principles.

Given the context, the questions are as follows: which are the practices of Medical and Nursing teams carried out with hospitalized adults in Palliative Care? How are these practices developed? In order to problematize the questions, the objective was to analyze the practices of Medical and Nursing teams for hospitalized people in Palliative Care.

METHOD

This is a qualitative research study linked to the post-critical perspective. It is noted that the research was developed in order to follow the precepts set forth in the *Consolidated Criteria for Reporting Qualitative Research* (COREQ). Data production took place between November 2020 and April 2021. The scenario consisted of clinical and surgical inpatient units for adults, as well as the Palliative Care consulting team of a teaching hospital from southern Brazil. The institution is a regional reference in Oncology and has a consulting team in PC since 2016, as well as a home-based care service with the PC philosophy, established since 2009.

As data production techniques, vignette application and extraction of information from medical records were used. Vignette is a methodological strategy through text, image and a technological or written resource, which simulates an experience based on reality to stimulate the participants to expose their perceptions, reflections and way of acting¹². The vignette used was prepared by a physician working in hospital and home-based PC and reviewed by two PhDs in Nursing with experience in the area of adult care.

The medical records consulted were of patients who met the inclusion criteria: being at least 18 years old, being hospitalized in one of the clinical or surgical units for adults of the hospital where the study was developed and being monitored by the Palliative Care consulting team. The exclusion criterion was death of the patient before three meetings, due to the fact that a reduced follow-up time would not produce a deeper understanding of the practices performed.

This consultation aimed at identifying clinical information, courses of action, prescriptions and records of health professionals about the patients. This information was used in a complementary way to the semi-structured questions that accompanied the vignette applied to the professionals. It is worth noting that all patients were monitored by the physician and nurse from the institution's Palliative Care consulting team, who were among the research participants. However, not all were cared for by the other participating professionals, as they were patients from different inpatient units. The Palliative Care consulting team works by moving across hospital units, guiding teams that directly assist patients and request their support.

The vignette addressed the clinical situation of a woman with metastatic breast cancer in the final stage of life, hospitalized, followed by questions about the decisions and course of action taken in relation to patients in situations such as the one presented. With the professionals that cared for the patients who had their medical records consulted, discussions were added on the similarity of the case monitored in the practice with the vignette case, in order to explore the practices carried out. The study participants were physicians, nurses and nursing technicians who met the inclusion criterion: working for at least three months in the hospital. Those who were on some type of leave were excluded.

Of the 27 professionals contacted, 10 agreed to participate in the research. The vignettes lasted between five and 20 minutes. In relation to the vignettes, they were applied remotely via Webconf or Google Meet, according to the preference of the chosen health professionals, initially discarding the hospital space as scenario for this stage. However, as some consider this way of making vignettes a hindering element, a meeting was scheduled in a room at the institution to be held in person. This situation took place with four participants.

The study sample was purposed, through the intentional choice of a professional nurse and a technician from each unit. At this stage, for the physicians, the prescribers and those responsible for the patients to be monitored would initially be chosen and, for the nurses and technicians, those indicated by the consulting team. However, it was difficult for the professionals from all categories to return the invitations, opting for the selection based on some of the professionals' prior knowledge

and the indication of those who agreed to take part in the vignettes, thus using intentional sampling and snowball sampling. These sampling methods were chosen after 17 professionals did not answer the email messages and calls inviting them to participate in the research. Although the number of participants can be considered small, it is believed that they assisted in understanding the practices, as the data from the vignettes were complemented by the records extracted from the medical charts.

The data arising from medical records were organized in an Excel spreadsheet. The answers from the vignette application were recorded in audio using a digital recorder. Subsequently, the files were literally transcribed by the first author into a Microsoft Word document. In all, 65 pages were generated from transcription of the vignettes. The 10 transcripts referring to the health professionals and a file referring to the practices identified in the patients' medical records were incorporated into the Atlas.ti program. The practices from the medical records were copied literally and typed in a Word file.

The data were submitted to thematic content analysis¹³, consisting of pre-analysis, exploration of the material and treatment of the results, inference and interpretation. Pre-analysis is the phase in which the material to be analyzed is organized in order to render it operational, systematizing the initial ideas¹³. In this research, this stage was undertaken by transcribing, reading, reviewing and organizing the materials from the data collection in folders in the Dropbox data storage and file sharing program, and also in Atlas.ti.

Exploration of the material consists in defining categories and identifying the registration units and the context units in the documents¹³. This stage was operationalized through coding the data in the Atlas.ti program and, subsequently, through the categorization, which took place in parts in Atlas.ti and also by preparing a table based on the closeness of the contents to the theoretical notions chosen to guide the analyses. Thus, 28 codes were listed, totaling 403 excerpts, which were synthesized into three analysis categories. Two of the three are presented as results in this article.

Finally, data treatment, inference and interpretation, considered as the third and last analysis pole, concerns the moment when the researcher condenses and highlights the information for analysis, culminating in inferential interpretations. It is the moment of intuition, of reflective and critical analysis¹³. In this research, this stage was initiated in the coding process, when the theoretical notions were associated with the contents, in order to comprise the categories, and continued at the time when the excerpts representative of each category were extracted and with the interpretation and discussion with the authors who theoretically support the research and other studies in the Palliative Care area.

The theoretical notions that supported the analyses were life technologies⁷, therapeutic economy¹⁴ and biopolitics¹⁵. Life technologies refer to the set of relationships that involve social and affective aspects linked to devices and techniques aimed at optimizing vital processes⁷.

In this biomedical and technological scenario, a new type of citizenship emerges: the biological one. It encompasses citizenship projects that link citizens' conceptions to beliefs about the biological existence of human beings as individuals, families, lineages, communities, populations, races and species. In this context, they engage with biological explanations and build new relationships with medical authority figures in the health process¹⁶.

Accordingly, the concept of therapeutic economics emerges, which concerns the totality of therapeutic options in a given location, as well as the logic underlying the resource patterns by which these therapies are accessed. This type of economy is organized based on three main elements: the practices, the people who perform them and the forms of knowledge that support them¹⁴. In this research, these three elements are understood from the following perspective: the practices are those actions developed by the Medical and Nursing teams and possible to be described and identified from the collection in the records in the medical charts and in application of the vignettes; the people who support them are physicians, nurses and nursing technicians; and the forms of knowledge are the wisdom and values recorded and activated by the professionals to decide on the courses of action

taken, identified through the vignettes and medical records and confronted with the Palliative Care principles.

It is worth noting that such concepts are part of this current configuration of biopolitics. From the seventeenth century, biopolitics emerges as a new form of power in which political power (the State) assumes the function of managing life, focusing on the body as a support for biological processes (the body-species). This new mechanism starts to deal with health issues such as population demographics, public hygiene, endemic diseases and aging, and begins intervening and controlling these processes, seeking to gain control over death¹⁷.

Regarding the ethical aspects, this research followed the guidelines and regulatory standards set forth in Resolution 466/2012 of the Brazilian National Health Council. The project was approved by the Research Ethics Committee and, to preserve the anonymity of the participating patients, they were identified by using the expression Person in Palliative Care (PPC) + a letter in alphabetical order, according to inclusion in the study (A, B, C, D). No detailed characterization was carried out for the professionals due to their reduced number, in addition to being linked to the medium-sized institution.

RESULTS

In relation to the professionals, there were three physicians, four nurses and three nursing technicians, with their age varying between 26 and 49 years old. As for the patients, there were four participants, with medical diagnoses of ischemic hypoxic encephalopathy (PPCA), prostate cancer (PPCB), nervous anorexia (PPCC) and amyotrophic lateral sclerosis (PPCD), and follow-up time in the research of 90, 11, 56 and 154 days, respectively.

In 2020, the research period, there were transfers and adaptations aimed at patients affected by the Coronavirus to the detriment of those with other needs, including PC. [...] *for you to have an idea yesterday I was moved to the contactors' transition unit, so today I'm already in the clinical team, which at first was supposed to be a clinical and Palliative Care team, but in fact the project is not going as it should* (P8).

Regarding the use of terminologies to designate a person with a disease that does not respond to the modifying treatment, the following terms emerged: Palliative Care, end of life, patient with no social life, management, maximum comfort management, patient in a vegetative state, end-stage patient, out of therapeutic possibility, exclusive Palliative Care and complementary Palliative Care. [...] *the family was told that in case of heart arrest, measures such as CPR could be futile, as the patient does not present any social life* (PPCA Medical record). [...] *it'd be exclusive Palliative Care* (P9). [...] *a patient in a vegetative state, right?* (P8). [...] *the one I hate the most is 'management' and also 'MCM', 'maximum comfort management', I think it's horrible* (P3).

Measurement of vital signs and hygiene care were practices highlighted as priorities and should be maintained until the end. [...] *check for signs with the same frequency, check the diaper with the same frequency, because sometimes, when the patient is like this, there's almost no more diuresis or evacuation, but even so I think it's necessary to change the diaper once a shift, it gets sweaty, it hurts. [...] vacuum every time that it's necessary, the care that we do on a daily basis with any other patient that is not palliative* (P6).

Skin care and nutrition were also cited as important to be performed. [...] *the diet should be rethought because continuing to offer it orally is also a risk many times. But if a person already has a tube, if they haven't got one, it's more discomfort* (P3). *I contact the hospital's skin team* (PPCD Medical record). [...] *I always took great care on the issue of the bony prominences of [PPCD], to try to position him in the best way* (P1).

In relation to pain care, some professionals interviewed reported not using scales for their assessment, mainly taking into account the easier one and adopting strategies similar to the known

scales, such as the Visual Analog Scale. [...] on a scale from 0 to 10, pain management here is like this, where 0 is very bad and 10 would be 100%, I think it's below 5 for sure (P3). [...] I've never seen a scale here and I've never seen any peer using it. I ask about pain intensity, if it's weak, strong, very strong. [...] I look at the person a lot to tell if they're in a lot of pain (P2). In the patients we monitor, we ask questions. We explain them from zero to ten, [...] when the person can't understand, sometimes we take a face (P4).

Among the practices for pain relief, in addition to the evaluation, use of medications and referral to the other professionals from the multidisciplinary team were identified. [...] based on pain intensity I will see if I will use non-opioid analgesics, moderate or strong-acting opioids, sometimes I use a lower dose for pain treatment. Physical examination, right... It's a very didactic issue like that, to treat pain, we use the WHO treatment scale, I think that's basically it. Oh, and I also request occupational therapy a lot, because I think it helps a lot like this, to find positions that relieve pain, right? Take out of immobilism, ask for physiotherapy, right? (P8). [...] perform reaction test with 1 mg of SC morphine and observe (the patient reports having already had a reaction and is afraid, but agrees with the idea) (PPCB Medical record).

Another aspect was dyspnea and palliative extubation, a strategy (unsuccessfully) triggered in one of the study patients. [...] what I think is more difficult, which I find difficult, is dyspnea, because sometimes it seems that it's a very distressing thing, which sometimes seems that we can't give full comfort without palliative sedation (P9). [...] I even thought about the possibility of palliative extubation, but this is something that has never been done in the institution, and we ended up not evolving in this sense, for understanding that there's certain cultural barrier (P10).

Practices related to the therapeutic limitations were reported by the professionals. [...] if she needed me to prolong her life a little longer for some reason, I think that an antibiotic treatment, thinking not only about symptom control, might make sense to prolong her life a little, depending on the value (P8). [...] I explain about other therapies, such as antibiotic therapy for infectious conditions, and about how this can affect the patient's condition; however, a family member would like that if the patient needs these measures, that they be done (PPCA Medical record). "When that patient, that family, understands the situation and the team is also enlightened, they understand the situation, the can take (artificial hydration and nutrition). Otherwise, it becomes a snowball, it's a very complicated issue like that (P4). [...] wai. (wait) for cultures. [...] requests removing the central venous access and observing thermal curve. [...] change gastrostomy tube. [...] vesical catheter removal" (PPCA Medical record). [...] I think so, what do we not want? Prolong distress or increase invasive procedures, excessive puncture too; we have hypodermoclysis" (P3).

The psychoemotional demands were considered. [...] Make room for listening and validating the feelings of the mother, who seems to have healthy grief (PPCA Medical record). In the context of spiritual and religious needs, difficulties were identified in exploring them and, when this occurs, the interventions are mediated by the PC consulting team. [...] I rarely see any other religion here, sometimes some pastors, priests come, but rarely (P5). We always ask the person what makes sense to them. 'What has, brings meaning to your life, what do you seek?'. I think that spirituality is a bit of that (P4).

With regard to the practices with families, there was certain weakness in the sense of caring for and welcoming them. [...] there is no such space, so this space is as we organize it, for example, in [name of the unit] we tried, it was not a private room, because there are 'bins', so you could listen a little on the other side, but we organize for the team to talk to the family member there in that little room. It's the same thing in [unit name] (P3). In most situations, it was perceived as a member who participates in the decision-making process on care and its implementation. [...] we talked to (cousin's name), the patient's cousin, with whom she has a very close relationship, and who was chosen by

her mother along with her sister (sister's name), to be responsible for talking to the medical team and assisting in decision-making. [...] she understands the severity of the case and the need for a careful evaluation of which therapies can really contribute to quality of life, without prolonging suffering (PPCA Medical record).

In addition, the family is frequently activated to enable the patient's return home, which can be a facilitating or hindering aspect, depending on their socioeconomic conditions. [...] *a family member reports the wish to receive the patient at home and not in an institution; however, they're unable to organize financially. He reports that they're awaiting assistance. [...] waiting for family to be discharged* (PPCA Medical record.)

DISCUSSION

The professionals working in the care teams and in the Palliative Care consulting team reported impediments in care continuity due to the structural and human adaptations caused by the COVID-19 pandemic. That said, the concept of therapeutic economics¹⁴ is triggered, which involves the set of therapeutic options available in a context and the forms of thought and organization mobilized to offer them to a given population.

From it, it is possible to think about the discourses and technologies used for the emergence of new ways of maintaining life because, in a pandemic period, the attempts to make the population live influenced the health professionals' decisions. These decisions began to be determined by the institutional arrangements that have been made, which resulted in less availability of professionals from the care and consulting teams in PC, who needed to be transferred to different sectors. This weighting was necessary, as it may have had repercussions on the professionals' evaluation mode and decision on the practices, for whom and how they should be carried out.

The professionals used several terminologies to refer to people with a disease that does not respond to the modifying treatment. Considering that the words invent the practices, the use of certain terms reflects the way care is offered and the dualism expressed and experienced by the professionals, who sometimes align with the Palliative Care principles and others express the biomedical training elements that constitute them and subjective as subjects.

"Comfort management" is an expression used in some hospitals to determine that a patient's care will be centered on ease measures, with no indication of cardiopulmonary resuscitation. There is no literature defining this terminology; therefore, although commonly used, it is an inadequate reference.

The expression "Exclusive Palliative Care" has its predominant use in the Brazilian scenario and refers to PC offered separately from a disease-modifying treatment, especially in the advanced phase. In assuming this approach, it is important for the physician to talk with patients and family members about the disease stage and prognosis, the treatment options and the possibilities of their limitations, in addition to the real and unrealistic perspectives on them, a work that can be eased by consulting teams¹⁸. In this sense, it is clear, especially from the medical records, that the physicians in this research seek to address expectations about the disease and treatment, work with the families' feelings and try to respect time in relation to the elaboration of anticipatory grief.

In contrast, the terms "patient in a vegetative state", "no social life" and "end-stage patient" emerged from the medical records and vignettes, reinforcing the stigma on the theme. Vegetative state is characterized by the absence of awareness of the self and of the external environment, in which the patient does not show any interactivity sign, except for painful stimuli that cause changes in vital signs¹⁹. In the context of this research, this term was equated with the term "no social life". In this sense, reducing a person's life to a state of non-responsiveness, disregarding their biography, history and family, is a way of equating them with an object in inertia, something that goes against the Palliative Care principles.

In relation to measurement of vital signs and body hygiene, practices evoked mainly by nursing technicians, it was indicated that the patients should be offered the same care regardless of the disease stage. The link with the institution's Skin Group was recognized, through the attention paid to the prevention of pressure injuries. On the one hand, Nursing teams are concerned with comfort, maintenance of dignity and the sense of "justice" in care provision, attitudes that are convergent with the PC principles. On the other hand, there is certain weakness in recognizing the proportionality of PC according to the evolution stage of the disease, indicating the need for education with these professionals.

A Brazilian study addressed a proposal for permanent education in hospital PC. In it, it was identified that 33 of 45 nursing technicians had no previous training on the topic and that, among those who did, they had acquired it in the service itself. The need to foster institutions where the professionals are incorporated to extend the training process during the practice was reinforced, including all actors involved in care²⁰.

Internationally, frequent measurement of vital signs is not recommended in the active phase of death, recognized as the hours and days before death¹¹. In the final stages, the patient follow-up with the family and the team should be prioritized, avoiding the feeling of abandonment.

Measures aimed at body hygiene and injury prevention are important for promoting comfort, and ensuring these care measures is a way to avoid physical, social and emotional discomfort. Caring for body hygiene can restore dignity and should extend to the postmortem period²¹. Hygiene care, including the skin, is key to promoting comfort.

However, in PC, especially in the final stage of life, some care measures should be considered. Areas such as the face, ears, fingers and toes should be prioritized, as they tend to be affected late in life by peripheral vasoconstriction. Some possible practices in this regard are correct fixation of medical devices so that they do not injure the skin, and frequent repositioning of the head and thermal protection of the limbs to avoid heat loss and worsening of hypoperfusion. In addition to that, treatments that reduce odor and improve appearance of the lesion are recommended, even if it does not heal, aiming at quality of life²².

The participants, both physicians and nurses, mentioned dilemmas related to the benefits of nutrition at the end of life. Nutrition and hydration are practices linked to symbolic, cultural, social and emotional issues, considered fundamental to life. Decisions about their interruption cause discomfort both in health professionals and in families, who associate lack of food with patients' suffering²³.

With regard to symptom control, especially pain, it was verified that some professionals are unaware of pain assessment scales, that others make use of instruments but without the conviction that "that scale" constitutes a tool that allows making a decision, drug administration in this case. A study²⁴ conducted with patients affected by advanced cancer showed that PC teams perform better in terms of controlling symptoms such as pain, dyspnea and depression, when compared to other professionals' approaches. They also tend to obtain improvements in patients assisted 48 hours after hospitalization, which can be justified by the educational character and more appropriate interventions provided by such teams.

Frequently mentioned by the professionals of this study, opioids are indicated for pain and dyspnea control in PC. In relation to morphine, the association of its use with the proximity of death was identified, at the same time that it was recognized as a strategy for comfort. A study²⁵ carried out in 17 Latin American countries found that, especially in the Southern Cone region (Argentina, Brazil, Chile, Paraguay and Uruguay), the main barriers to accessing opioids in Palliative Care were lack of knowledge, skills and training in health professionals regarding their prescription, inadequate assessment of pain and fear of addiction.

Given the above, it is noticed that the teams are investing in addressing symptoms and physical care and that medications emerge as a technology used in a powerful and preponderant way in the hospital context. Physicians, nurses and nursing technicians, subjectified by training with a focus on the biological aspect, sometimes restrict comfort to drug administration. This importance given to medications is partially due to the concept of susceptibility. In the context of knowledge about the biological aspect, there is the possibility of intervention, that is, the body is malleable and biology is not fate. Therefore, there is no longer predestination as certainty; there is the possibility of modulating and altering, for example, the physiological mechanism of pain and other symptoms⁷.

Another aspect evidenced was the predominance of not using advanced life support measures such as cardiopulmonary resuscitation (CPR), a finding that is in line with a study¹¹ that considers this inadequate, especially at the end of life. Palliative Care teams act as facilitators with the assistant teams in the decision-making process and in approaching families about cardiopulmonary resuscitation²⁶. Regarding the use of antibiotic therapy, the professionals considered the particularities of each situation, prioritizing the control of other symptoms. Maintaining the prescription of antibiotics also seems to ensure comfort and warmth to the families, by transmitting the idea that something is being done for the patient, although there may not be benefits from this action in some cases.

Suspension of the antibiotics is one of the decisions that raises the most doubts in the PC practice. A study²⁷ found that, despite their training in the area, physicians working in PC tend to insist on antibiotic therapy even in the face of the final days or hours, even replacing medications in case of lack of response. In specific situations, such as with cancer patients with low functionality and at risk of evolving to death, there is greater care and chances of suspending the therapy in question.

With regard to invasive devices such as a urinary catheter and venous catheter, they were removed after a given hospitalization time and hypodermoclysis was cited as a way to reduce the frequency of venipunctures. Thus, it is perceived that life technologies⁷ are used to intervene in biological processes considered natural, and that improvement technologies can be thought of in the short term in order to modify the patients' timeline, if they choose to do so or the professionals themselves do it.

There seems to be a contradiction in relation to two of the PC principles, namely: asserting death as a natural life process and not postponing or delaying occurrence of this event. When operating with life technologies such as medications, devices and care measures, it is identified that physicians, nurses and nursing technicians regain control and interfere, in a way, in this time of death. They make it escape its occurrence in the so-called "natural" period. There is certain exercise of power by the professionals that can "cause life or return death,"^{17:130} which refers to the biopower. In this way, technological rituals mediated by the professionals avoid death by chance, considered unbearable for society¹⁷, making the scenario of dying again disciplined and guided by technical and scientific rationality, even from a philosophical perspective that intends to bring it back to the domain of people, existence and the social.

With regard to the spiritual approach, the professionals recognized its importance; however, most of them reported not having the ability to develop it during the care provided at the hospital. This finding differs from the study²⁸ carried out with an Oncology Palliative Care team, which showed that the professionals consider spirituality as a facilitator in their work, because through it, it is possible to provide comfort that is not only physical to the patient. Furthermore, reflecting on spiritual issues would ease the professionals' personal concerns related to the end of life and death, in addition to giving meaning to the professional performance.

Finally, in this study, the family was also approached from a dualistic perspective by the professionals, whether physicians, nurses or nursing technicians. On the one hand, it is considered crucial, as it is up to the family caregivers to contribute to decision-making together with the team, in order to incorporate practices and techniques to enable the return home, so desired by the palliative

discourse. On the other hand, there is a gap in the hospital space to welcome them, as an entity to be effectively cared for and not merely performing agents. Dialog, listening and acceptance in times of frailty, such as in communicating hard news, end up being put in the background or executed with limitations due to the institution's structural constraints.

Regarding this aspect, a Portuguese study²⁹, which clinically validated the defining characteristics of the "Caregiver Role Strain of a person in a palliative situation" Nursing diagnosis, showed that even under Palliative Care, caregivers, notably spouses, experience the tension of their role, evidenced by the feeling of being trapped in their function, fatigue and apprehension in relation to the future of the sick family member.

Furthermore, the calculations on the advantages and disadvantages of this movement of people on PC returning to their homes and the way in which professionals act and incorporate the family in order to make it feasible refer to the notion of biopolitics. Biopolitics comprises a series of strategies arranged by the State and institutions in order to promote the life of a given population. It is a way of managing people's lives, in their plurality, in a given space¹⁵.

To operationalize it, safety mechanisms emerge that involve a set of calculations on birth rates, mortality, probability of developing certain diseases and being affected by them, costs and effectiveness in relation to certain practices with a view to predicting risks and acting in order to minimize or eliminate them when possible. In other words, they are mechanisms that analyze the possibilities for making a population live and let it die¹⁵.

In the context of letting die (as death is inherent to life and it is not possible to escape it), there is an urgent need to manage the spaces and circumstances under which the end of life takes place, defining priorities and reorganizing and modulating behaviors. Thus, home-based care services, such as those pointed out by the participants and existing in the institution where this research was carried out, emerge as a biopolitical strategy capable of reducing expenses (economic, human and emotional) and convincing people with certain diseases that dying well is dying at home through speeches that emphasize the benefits of home-based care³⁰.

As a limitation of this research, we should mention the COVID-19 pandemic, which caused hindered access to more participants. Furthermore, the electronic medical records lacked some clinical information that might have improved the analyses.

CONCLUSION

This study made it possible to analyze the practices of Medical and Nursing teams with hospitalized people in Palliative Care. Regarding the medical practices, the importance of individual assessment, pain control through drugs and validation of diverse information and expectations about diagnoses, prognosis and grief with caregivers were highlighted.

The professionals did not recommend advanced life support and invasive procedures, but pointed out that, in certain situations, extending life through invasive treatments can make sense. In other words, certain practices can be prescribed according to the care objectives defined by the medical team, in an attempt to increase the days of life to promote a feeling of comfort to the family.

The Nursing professionals highlighted dyspnea and pain control, in addition to practices related to hygiene, vital signs, skin care and injury prevention. The nutritional issue was briefly mentioned and associated with skin lesions, and there were disagreements regarding its benefits in PC. Spirituality seemed to be little explored and the family emerged as a link between hospital and home. However, there was a need for structural qualification for their welcoming and caring.

Finally, the initial assumptions are resumed, which were partially validated, as the practices presented to hospitalized adults in Palliative Care seem to be decided and implemented in the midst of dualism. Sometimes there is the recourse to the PC recommendations and principles. On other

occasions, there is predominance of the intuitive, empirical and moral aspect. Some practices still seem based on a curative perspective, even in the face of a disease that does not respond to the treatment.

It was learned that believing in technology as a possible way to promote comfort and care at the end of life supports an economy that modulates the experience of illness and dying based on scientific, biological and technological discourses. Such stance has repercussions on the resistance to accepting death as an existential event, inherent to life, still keeping it medicalized, even when it takes place from different perspectives, such as the Palliative Care.

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