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Nutritionists and palliative care at the end of life: an integrative review

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Abstract

Nutritional support in palliative care aims to improve the quality of life of the patient through the control of symptoms associated with food, prioritizing the desires of the individual. There are controversies regarding the real contribution of food to the comfort of patients in palliative care at the end of life, and it is still necessary to clarify the specific skills of the nutritionist in this area. In view of these gaps, this review integrative objective to know how nutritionists act with patients in palliative care end of life. The final sample was composed of seven articles that point out differences between conventional nutritional care and in palliative care and present bioethical dilemmas related to food. It is concluded that it is necessary to know better how nutritionists act in the palliative care. Further studies on the topic should be developed, considering not only nutritional aspects, but also the character symbolic of food.

Keywords: Nutritional sciences. Nutritionists. Diet. Hospice care.

Resumo

Nutricionistas e cuidados paliativos no fim de vida: revisão integrativa

O suporte nutricional nos cuidados paliativos visa melhorar a qualidade de vida do paciente por meio do controle de sintomas associados à alimentação, priorizando os desejos do indivíduo. Há controvérsias quanto à real contribuição da alimentação para o conforto de pacientes em cuidados paliativos na terminalidade de vida, e ainda é preciso esclarecer as competências específicas do nutricionista nessa área. Tendo em vista essas lacunas, a presente revisão integrativa objetiva conhecer como nutricionistas atuam com pacientes em cuidados paliativos no fim de vida. A amostra final foi composta por sete artigos que apontam diferenças entre o cuidado nutricional convencional e em cuidados paliativos e apresentam dilemas bioéticos relacionados à alimentação. Conclui-se que é preciso conhecer melhor o modo de atuar dos nutricionistas na assistência paliativa. Mais estudos sobre o tema devem ser desenvolvidos, considerando não só aspectos nutricionais, mas também o caráter simbólico da alimentação.

Palavras-chave: Ciências da nutrição. Nutricionistas. Dieta. Cuidados paliativos na terminalidade da vida.

Resumen

Nutricionistas y cuidados paliativos al final de la vida: revisión integradora

El apoyo nutricional en los cuidados paliativos tiene como objetivo mejorar la calidad de vida del paciente a través del control de los síntomas asociados a la alimentación, priorizando los deseos del individuo. Hay controversias en cuanto a la contribución real de los alimentos para el confort de los pacientes en cuidados paliativos al final de la vida, y todavía es necesario aclarar las habilidades específicas del nutricionista en esta área. En vista de estas lagunas, la presente revisión integradora tiene como objetivo saber cómo actúan los nutricionistas con los pacientes en cuidados paliativos al final de su vida. La muestra final estuvo compuesta por siete artículos que señalan diferencias entre el cuidado nutricional convencional y los cuidados paliativos y presentar dilemas bioéticos relacionados con la alimentación. Se concluye que es necesario conocer mejor cómo actúan los nutricionistas en los cuidados paliativos. Se deben desarrollar estudios adicionales sobre el tema, considerando no solo los aspectos nutricionales, sino también el carácter simbólico de la alimentación.

Palabras clave: Nutricionistas. Dieta. Cuidados paliativos al final de la vida.

Research

The authors declare no conflict of interest.

Palliative care is a multidisciplinary approach that seeks to prevent and alleviate pain – whether physical, social, psychological or spiritual – of terminally ill patients and their families [1]. In 2018, Brazil published guidelines *for the organization of palliative care (PC) in the Unified Health System (SUS)* [2]. These guidelines consider that palliative care must be applied in a continuous and integrated manner.

Food is also part of palliative care. The American Dietetic Association [3], for example, proposes that the diet of patients with advanced-stage diseases should provide emotional comfort and pleasure, reducing anxiety and increasing self-esteem and independence.

As Carvalho, Luz, and Prado [4] state, *eating goes beyond a physiological issue of nutrient requirements forming traditions, accompanying rites of passage, freeing spirits and establishing relations between the individual and society*. When thinking about food, one should also consider its symbolic nature. Through food, we ingest nutrients necessary for survival, but we also engage with meanings, dreams and images [5]. Language exemplifies how significant food is: "feeding" someone is a human action that represents respect for life and care for others [6].

Our lives are permeated by our relationship with food, including the pleasant memories that certain foods arouse, and its importance is not diminished by the onset of a serious illness. In this scenario, what the individual experiences are the sensations caused by the absence or difficulty of ingestion.

The diet of patients in palliative care undergo many changes, particularly loss of taste sensitivity and difficulty in swallowing, digesting and absorbing food. All these changes can contribute to the development of depressive episodes, increase the individual's isolation, and compromise their confidence and self-esteem [7].

Nutritional care in palliative care works with the possibility of not feeding the patient in specific situations. This measure, taken for the patient's comfort, however, often bothers family members or the patients themselves, who stress: *if you don't eat, you can't live* [8]. This creates a conflict that raises important bioethical questions.

Reflecting on this topic is extremely relevant, given the symbolic nature of food, which interact with the ideas of life and death and involves the anxieties of family members and the professional team. In the final moments of life, food takes on different meanings. It can be denied or desired, but it no longer fulfills the concrete function of nourishing, posing challenges for the nutritionist, who must deal, for example, with the possibility of not eating towards the end of life. The uneasiness of facing such challenges was what motivated this literature review.

Method

The approach chosen for this research was the integrative review due to its great importance in the field of health, as it enables the search, critical assessment and synthesis of evidence on a given topic. These characteristics allow to assimilate relevant results and identify gaps that guide the development of future research. Integrative reviews also help health professionals define behaviors and make decisions, providing critical knowledge [9].

The present review consisted of six stages: 1) elaboration of a research question; 2) establishment of a search strategy and inclusion/exclusion criteria; 3) definition of data to be extracted from the selected studies; 4) evaluation of included studies; 5) interpretation of results; and 6) results presentation [9].

Based on the research question "what do publications portray about nutritional care for patients in end-of-life palliative care?", the bibliographic survey was conducted between April and August 2020, on the Capes Journal Portal: Scientific Electronic Library Online (SciELO), Scopus and Web of Science databases.

Our search strategy consisted of four terms registered in the Health Sciences Descriptors (DeCS): "*ciências da nutrição*/nutritional sciences"; "*nutricionista*/nutritionists"; "*cuidados paliativos*/palliative care"; and "*cuidados paliativos na terminalidade da vida*/hospice care". Boolean operators "and" and or were used to refine the search: "nutritional sciences "*or*" nutritionist *and* palliative care *or* hospice care," combination that returned the most articles.

Articles published in English, Portuguese or Spanish, regardless of publication year, available online for free and in full and addressing the role of nutritionists in hospice care were included in the final review. Duplicates, studies published in languages other than English, Spanish and Portuguese, studies not available online for free and in full, and studies on topics outside the research object were excluded.

Results and discussion

A first bibliographic search, without refinement, returned 124 articles – 29 in SciELO, 67 in Scopus and 28 in Web of Science –, of which 31 remained after applying the inclusion criteria. We then evaluated the titles and abstracts of these papers and selected seven articles – all of which answered the research question – to include in the integrative review sample. Table 1 details the search performed in the databases.

Table 1. Databases search results

Database	Total of articles found	Total after refinement	Total selected for full reading
SciELO	29	20	6
Scopus	67	2	0
Web of Science	28	9	1

Note that, of the total number of studies found in the first bibliographic search, few discussed the role of nutritionists in end-of-life palliative care. Table 2 summarizes the seven articles that make up the research sample.

Table 2. Information on selected articles, according to the research question

Title; authors, year	Identification, journal, country	Objective	Results
"Bioética e nutrição em cuidados paliativos oncológicos em adultos"; Benarroz, Faillace, Barbosa; 2009 [10]	Article A, *Cadernos de Saúde Pública*, Brazil	Discuss bioethics and nutrition in adult oncological palliative care.	Concern with feeding patients with late stage cancer, as well as the strategies and forms of procedure, remains an object of discussion among health professionals. Besides controlling signs and symptoms, one must know the patient's eating habits, and nutritional care must be integrated with cancer care. This intervention, which requires effort and dedication, calls for very conscientious professionals.
"Suporte nutricional em cuidados paliativos"; Pinho-Reis; 2012 [11]	Article B, *Nutrícias*, Portugal	Systematize current knowledge regarding nutritional care in palliative care, considering the meaning of food, objectives, nutritional assessment, types of care and ethical considerations inherent to this area.	To establish the most adequate nutritional care in palliative care, the nutritionist first needs to accept the philosophy and principles of palliative care and recognize the cultural, religious, social, spiritual and complex meaning of food in this context. The goal of nutritional care is to improve quality of life; thus, the goals set must be suitably adapted and in accordance with palliative therapy, put into practice after rigorous nutritional assessment.
"Nutrição, qualidade de vida e cuidados paliativos: uma revisão integrativa"; Morais and collaborators; 2016 [12]	Article C, *Revista Dor*, Brazil	Verify whether or not nutrition can improve the quality of life of patients in palliative care.	The dietary approach must, above all, offer pleasure and comfort, respecting the autonomy of patients and their family. Thus, along with other therapeutic measures, food can improve the quality of life of patients without possibility of clinical cure.

continues...

Table 2. Continuation

Title; authors, year	Identification, journal, country	Objective	Results
"Os nutricionistas e os cuidados paliativos"; Pinto, Campos; 2016 [13]	Article D, *Acta Portuguesa de Nutrição*, Brazil	Contextualize the role of the nutritionist in palliative cancer care and discuss factors involved in integrating nutritionists in this type of care.	The article describes the role of food and nutritional assistance in palliative cancer care, highlighting the action of nutritionists as an important factor for the quality of the service offered and the well-being of patients and their families.
"Nutrition and hydration in the end-of-life care: ethical issues"; Pinho-Reis, Sarmento, Capelas; 2018 [14]	Article E, *Acta Portuguesa de Nutrição*, Portugal	Discuss and understand current knowledge on ethical issues related to food, nutrition and hydration at the end of life.	The ethical issues discussed decades ago remain the same today. The authors conclude that, on many issues, there has been little development in the area of nutrition and hydration in end-of-life care, although voluntary cessation of feeding and hydration has been more often discussed in the literature. But original research in this area is still scarce. They also point out that decision-making in the face of ethical conflicts in end-of-life palliative care can affect feelings, emotions and attitudes.
"Planejamento da assistência ao paciente em cuidados paliativos na terapia intensiva oncológica", Santos and collaborators; 2017 [15]	Article F, Web of Science, *Acta Paulista de Enfermagem*, Brazil	Analyze the understanding of health professionals about end-of-life palliative care in an oncology intensive care unit, discussing the objectives of this assistance.	The need to ensure comfort, care for the patient's family and invest in integrating palliative and critical care was highlighted. Professionals point out that care planning based on palliative care is still incipient and lists challenges for the practice, showing concern with the humanization of care. The understanding of nutritionists is absent from the discussion.
"Características de la alimentación del paciente oncológico en cuidados paliativos", González, Gusenko; 2019 [16]	Article G, *Diaeta*, Brazil	Describe the dietary characteristics of oncology patients in palliative care.	The study concludes that the diet of cancer patients in palliative care must be individualized to suit nutritional recommendations.

The analysis of the studies identified four thematic axes: 1) "nutritional care and integration of nutritionists in end-of-life PC" (articles A, B, C, D, E and F); 2) "nutritional care and quality of life for end-of-life PC patients" (articles A, B, C and G); 3) "bioethics and end-of-life PC: knowledge needed by the nutritionist" (articles A, B and E); and 4) "controversies and weaknesses in the training and performance of nutritionists who work with terminal illnesses" (articles B and C).

Axis 1: nutritional care and integration of nutritionists in palliative care

Some studies on nutritional therapy in PC emphasize the importance of multidisciplinary work and respect for the patient's food preferences [17]. Nutritionists are expected to obtain scientific knowledge and develop their professional practice, since, as Pinto and Campos [13] point out, many questions have yet to be clarified, and defining the necessary clinical and ethics for working in this field is urgent [18].

Benarroz, Faillace, and Barbosa [10] highlight the concern with feeding patients living with late stage cancer, which leads to discussions among health professionals about which strategies should be adopted. Such discussions, as Pinho-Reis, Sarmento, and Capelas [14] note, involve ethical issues that still require due consideration in the area of nutrition, so that debates that began decades ago are still relevant.

As Pinho-Reis [11] shows, controversies regarding end-of-life oral and artificial feeding are at the center of current discussions. While patients have the right to request cessation of feeding, as long as this does not cause death faster than the normal progression of the disease, no consensus on the topic exists. Nutritionists must therefore carefully consider all their interventions, evaluating risks and benefits.

The same article states that caring for a patient who is unable to or chooses not to eat requires the nutritionist to accept PC philosophy and principles. Pinho-Reis [11] also highlights the importance and complexity of food in this context, which involves cultural, religious, social, and spiritual aspects.

Pinto and Campos [13] state that it is urgent to discuss how nutritionists are integrated into PC teams, since their work is fundamental for the quality of the service offered and the well-being of patients and their families. Morais and collaborators [12] corroborate such perspective by referring to the nutritionist as a professional responsible for providing nutritional guidance to patients and families, which requires communication capacity, a skill as important as the technical knowledge of nutrition.

According to the Code of Medical Ethics [19], in the case of incurable and terminal illnesses, the physician must offer all the palliative care available without undertaking futile diagnostic or therapeutic actions. In this respect, Pinho-Reis, Sarmento, and Capelas [14] point out the importance of changing the nutritionists' code of ethics to clarify the possible interventions in certain clinical cases. Changes in the code could also elucidate the nutritionist's role in ethical deliberations, since this professional has specific skills and abilities to work in multidisciplinary health and nutritional therapy teams [20].

When analyzing the perspective of health professionals regarding end-of-life PC in an oncology intensive care unit (ICU), Santos and collaborators [15] reveal the invisibility of the nutritionist in this context. Pinto and Campos [13], in turn, emphasizes the scarcity of studies that clarify the work of this professional in oncological PC services. Despite such paucity, the authors argue that nutritionists play a key role in improving the quality of life of terminal patients, who often experience denial of food as the main consequence of their worsening health status [13].

Santos and collaborators [15] reveal the predominance of the biomedical/curative paradigm in health care. Such paradigm sees death as something pathological rather than a natural condition of life, thus generating situations of therapeutic obstinacy, defined by Benarroz, Faillace, and Barbosa [10] as a conservative medical practice that consists of using all available medical technology to prolong the dying process. Several factors contribute to this practice, including the growing technicism in health care, the professional's difficulty in understanding the end of human life (which arouses feelings of frustration, failure and impotence), lack of specific training and fear of being sued by patient's family members [21].

Nutritional care in end-of-life palliative care brings many questions on what is technically possible and correct. These questions require debates in the field of bioethics, especially regarding professional training.

Axis 2: Nutritional care and quality of life

Axis 2 refers to nutritional care and its relationship with the quality of life of terminally ill patients. This topic appeared in four articles [10-12,16] whose results we present below.

Pinho-Reis [11] emphasizes that oral feeding must be the preferred dietary route for PC patients, with the patient's preference always prevailing. Controlling symptoms related to food is essential, since they impact the patient's quality of life and comfort. The author stresses that such symptoms affect not only appetite and nutrient use, but also the pleasure obtained through food, thus highlighting the importance of nutritional care to enable eating, control symptoms and pay attention to ethical issues and the meaning of eating for patients and families [11].

González and Gusenko [16] argue that nutritional intervention in PC should focus mainly on symptom control (nausea, early satiety, vomiting, constipation, diarrhea, dysgeusia, ageusia, dysphagia, xerostomia) and maintaining an adequate state of hydration, preserving as much as possible the patient's weight

and body composition. The authors also stress the need to respect the wishes of patients and their families, considering the risks and benefits of artificial nutrition.

Regarding end-of-life symptoms, Benarroz, Faillace, and Barbosa [10] mention that anorexia can be controlled by offering the patient's favorite foods. Instead of forcing food, the patient's desire to eat is thus encouraged. In cases of early satiety, in turn, meals can be divided and food consumption reduced. To menage these symptoms, the literature [10,11] suggests behaviors for each sign presented, being up to the professional to ensure that the chosen behavior goes hand in hand with the wishes of the one receiving care.

PC patients can suffer more profound changes in the feeding route, changing from oral to artificial, as shown by Pinho-Reis [11]. Regarding these changes, the author emphasizes a lack of studies addressing the fears and expectations of patients and families and portraying the real risks, benefits and influences of artificial feeding and hydration in palliative care.

Discussing the dietary characteristics of cancer patients in palliative care, González and Gusenko [16] reaffirm the importance of early referral of these patients to a nutritionist, given the various difficulties in food intake. According to the authors, nutritionists are trained to adapt diets to the needs of this specific population, helping to control symptoms and improve quality of life [16].

They also point out that individual assessment is essential to avoid unnecessary restrictions and the use of nutritional supplements that, by not fitting PC goals, can cause fatigue and rejection, making it difficult for patients to adhere to other recommendations [16]. As the National Consensus on Oncological Nutrition [22] states, life expectancy is an essential factor in nutritional planning for adult PC patients, since end-of-life care begins at a stage in which death is imminent (usually within the last 72 hours of life).

Morais and collaborators [12] emphasize that nutritional, caloric, protein, and hydration needs must be established according to the patient's acceptance, tolerance and symptoms. The goal is to provide comfort and quality of life to the patient, and not just to ensure adequate nutrient intake. Unnecessary invasive interventions, such as enteral nutritional therapy or parenteral nutrition therapy, must therefore be avoided. Situations where the sick person no longer wants to eat must be respected by the physician whenever the patient is competent to decide, thus respecting the principle of autonomy [23].

We must also consider the symbolic aspects of eating and all the affectivity and subjectivity that permeate our relationship with food, especially in the end of life. A literature review carried out by Medeiros-da-Silva and collaborators [24] draws attention precisely to the need for more studies on this topic.

Axis 3: bioethics and end-of-life palliative care

Axis 3 highlights the importance of nutritionists knowing about bioethics in PC, a topic addressed in three articles [10,11,14].

Besides nutritional care, palliative care requires constant discussions about the ethics of life – bioethics – as highlighted by Benarroz, Faillace, and Barbosa [10]. The authors emphasize that PC is related to bioethics – a field that proposes a shared, complex, and interdisciplinary reflection – because they deal directly with pain, loss, and suffering in the face of imminent death of patients with no therapeutic possibility of cure [10].

Pinho-Reis [11] points out that nutritional care in palliative care requires the nutritionist to be prepared to participate in ethical deliberations within a multidisciplinary team. Knowledge of the bioethical principles of autonomy, beneficence, non-maleficence and justice helps professionals to avoid futile and unnecessary interventions. Professionals must abide to the patient's wishes, as in cases where patients refuse to eat, as long as this decision does not cause their death faster than the natural course of the disease [11].

On the refusal of food, Pinho-Reis, Sarmento, and Capelas [14] highlight that, in Portugal, conscious patients can express their will regarding end-of-life nutrition and hydration by means of advance guidelines, recording wishes and decisions in a living will or appointing a health care attorney. If the patient is in no position to decide and has not prepared guidelines, health professionals can decide based on

what they believe the patient would like to do or on information provided by family members [14].

When there is no document recording directives, the nutritionist must inform the patient about this possibility. In Portugal, in situations where patients are in no position to manifest their will and no advance directives exist, if artificial nutrition has not been refused at the onset of the disease, this initial intervention will prevail, whenever there is no reason to do otherwise [11].

Pinho-Reis, Sarmento, and Capelas [14] stress that introducing artificial feeding and hydration pose an ethical challenge to the nutritionist; thus, the establishment of advance directives must be encouraged before the ability to decide is lost.

In Brazil, advance directives of will are addressed by CFM Resolution 1,995/2012 [25]. A survey [26] with 36 Brazilian resident physicians from a public hospital showed that these professionals recognize the importance of the living will in respecting the patient's autonomy at the end of life. Physicians claim that this instrument humanizes care and point out the need for a legal provision that regulates its formal use in Brazil.

One of the pillars of contemporary bioethics is the quest to recognize and guarantee the rights of end-of-life patients. In this regard, Dadalto [27] discusses the need to adopt a model of advance directives for Brazil, considering the increased number of individuals interested in this instrument, especially after the publication of CFM Resolution 1,995/2012 [25].

Dadalto [27] suggests that this Brazilian model should consider the difference between advance directive and living will, having as a reference the French bipartite system, which provides different documents for patients with serious illnesses and for healthy people. But as the author herself points out, in Brazil the topic is still being discussed by society, a first step towards its consolidation. No specific law nor a bill in progress concerning advance directives exists in the country.

Axis 4: controversies and weaknesses in the training and performance of nutritionists

Axis 4 reflects on controversies and weaknesses in the training and performance of nutritionists who work in end-of-life PC. Two studies [11,12] addressed this topic.

A survey with professionals who work or have worked with end-of-life PC patients showed that most nutritionists lacked training in palliative care (extension, qualification or specialization courses) [21]. Maingué and collaborators [21] emphasize that such trend towards therapeutic obstinacy as an attempt to exercise professional duty reveals the need to debate decision-making and intensify PC training, thus minimizing ethical conflicts.

Another study, conducted with multidisciplinary teams, sought to understand how intensive care professionals experience terminal illness and its bioethical impasses [28]. This study, however, presented no data on the nutritionist's role in the team, which attests to the importance of focusing on the relationship between PC and nutrition in the dying process.

Artificial nutrition, like hydration, is a major controversial issues in nutritional care in palliative care. In some situations, the patient themselves can request the feeding to be stopped, since every sick person has the right to refuse food, as long as it does not accelerate the death process; in others, it is the multidisciplinary team itself that discusses whether nutrition and artificial hydration should be started, maintained or suspended [29].

Nutritional conduct in palliative care must respect the patient's wishes, providing maximum comfort and reducing suffering through adequate therapies [12]. But controversy on to the real power of food to contribute to this process still exists. For Morais and collaborators [12], the recovery of patients whose nutritional status has been compromised is not always achieved by implementing nutritional therapy.

According to Pinho-Reis [11], there is still plenty of room for progress regarding nutritional care in PC, and studies must work to fill these gaps and help nutritionists to further individualize their interventions, optimizing their training and establishing their specific skills.

In Brazil, nutrition courses are guided by National Curriculum Guidelines [20] that present a series of skills and competencies, including the role to be played by nutritionist in multidisciplinary and nutritional therapy teams. Professionals must be able to assess, diagnose and monitor the

nutritional status of healthy and sick individuals in hospitals, clinics, outpatient clinics, offices, long-term care facilities for older adults, nutritional therapy centers and homes [20].

For Costa and Soares [29], a fragmented logic of knowledge has predominated in nutrition courses, impregnated with the biological model, which gives little importance to the human and social dimensions of the subject. This logic gives little value to the biopsychosocial character of food, which is worrisome given that the main object of the nutritionist's work is the relationship between human beings and food.

Nogueira da Silva [30] highlights that health practice is radically impregnated by Western rationality, which influenced the biomedical model by applying the Cartesian method to medicine. This results in a care focused on healing, in which death is a topic to be avoided. In scientific terms, to die is to cease to exist; however, besides this biological factor, death is characterized by being a socially and culturally construed process [31].

In the second chapter of the Code of Ethics and Conduct of Nutritionists [32], which addresses interpersonal relationships, one notices the absence of duties regarding the professional's role in caring for end-of-life patients. The only duty that can indirectly apply to the situation is *to use the power or hierarchical position in a fair, respectful way, avoiding oppressive attitudes and conflicts in relationships, not using the position for personal benefit or for the benefit of others* [33].

But considering that end-of-life diet is one of the main bioethical conflicts faced by nutritionists, it would be appropriate for the profession's code of ethics to address, precisely in the chapter on interpersonal relationships, futile or obstinate therapeutic actions. The code should also include guidelines on respecting the patient's will (or, if this is not possible, their legal representative's will), as in the Code of Medical Ethics.

Importantly, we found no articles discussing the teaching of bioethics in undergraduate nutrition courses. It is thus impossible to know whether nutrition students are receiving the necessary training to provide care to end-of-life patients and face the bioethical conflicts involved in this context.

Final considerations

The results of this integrative review show that few are the studies that explore nutritional care for patients in hospice care – which, in itself, poses a limitation for the discussions presented in this article. Such scarcity points to the need for further research on the topic. To this end, we must strengthen research and implement actions for the initial and continuing education of nutritionists to develop specific knowledge and skills for palliative care.

Moreover, although we have documents with guidelines on the care to be offered by nutritionists, little is known about how these professionals react in practice, beyond conventional models. Given this scenario, some questions emerge: what are their doubts and anxieties? What difficulties do they face when dealing with dying patients? How can they allow these patients not to eat? Are these professionals prepared for this specific situation?

Much is yet to be discussed in this area so full of dilemmas. Food has a symbolic character that goes far beyond nutritional aspects and pre-established recommendations. It is fundamental to consider this dimension when studying the relationship between nutritionists and patients undergoing end-of-life palliative care.

Research

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