

Evaluation of knowledge among anesthesiologists about palliative care

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Abstract

To assess anesthesiologists' knowledge about palliative care through an individual questionnaire. The sample was 95, with 65 male and 30 female. Sixty-two of the anesthesiologists reported quality of life as the term that best expresses the palliative care, and 53 consider the combination of home care/ hospital the most convenient for the treatment of a patient who requires palliative care. It was observed that 83.2% of the interviewed (n = 79) have not been prepared for patients who require palliative care and that 88.4% mention to a colleague when a patient dies (n = 84). Most respondents (n = 46) disagreed with the practice of euthanasia. As for the perception of palliative care on a scale of 0 (no knowledge) to 10 (full knowledge), there was a majority of the average response of 5 (n = 28). It shows the need to reflect about care in the field of anesthesiology.

Key words: Palliative care. Terminal care. Terminally ill.

Resumo

Avaliação do conhecimento dos anesthesiologistas sobre cuidados paliativos

Avaliar o conhecimento dos cuidados paliativos entre anesthesiologistas por meio de questionário individual. A amostra teve 95 profissionais, dos quais 65 do sexo masculino e 30 do feminino. Sessenta e dois anesthesiologistas informam que "qualidade de vida" é o termo que melhor expressa os cuidados paliativos e 53 consideram a combinação da assistência casa/hospital a mais conveniente para o atendimento do paciente que requer esses cuidados. Observou-se que 83,2% dos pesquisados (n=79) não receberam preparação para lidar com paciente que requer cuidados paliativos e 88,4% comentam com colegas quando um paciente morre (n=84). A maioria dos entrevistados (n=46) discorda da prática de eutanásia. Quanto à autopercepção do conhecimento sobre cuidados paliativos, numa escala de 0 (nenhum conhecimento) a 10 (conhecimento total), a maioria das respostas alcançou média 5 (n=28), o que mostra a necessidade da reflexão acerca do cuidar na área da anesthesiologia.

Palavras-chave: Cuidados paliativos. Assistência terminal. Doente terminal.

Resumen

La evaluación del conocimiento de los anesthesiólogos acerca de los cuidados paliativos

Evaluar el conocimiento de los cuidados paliativos entre los anesthesiólogos a través de un cuestionario individual. La muestra fue de 95, de los cuales 65 eran del sexo masculino y 30 del femenino. Sesenta y dos de los anesthesiólogos informan "la calidad de vida" como el término que mejor expresa los cuidados paliativos y 53 consideran que la combinación de cuidado en el hogar / hospital es más conveniente para el cuidado del paciente que lo requiere. Se observó que el 83,2% de los investigadores (n = 79) no recibieron la preparación para lidiar con el paciente que requiere cuidados paliativos y el 88,4% comentan con sus compañeros cuando un paciente muere (n = 84). La mayoría de los encuestados (n = 46) no estaban de acuerdo con la práctica de la eutanasia. En cuanto a la autopercepción del conocimiento sobre los cuidados paliativos, en una escala de 0 (ningún conocimiento) a 10 (pleno conocimiento), la mayoría de las respuestas alcanzó el promedio de 5 (n = 28). Esto demuestra la necesidad de reflexión acerca del cuidar en el área de anesthesiología.

Palabras-clave: Cuidado paliativos. Cuidado terminal. Enfermo terminal.

Aprovação CEP Hospital Universitário Lauro Wanderley/UFPB – 359/09

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The author(s) declare(s) that there is no conflict of interest.

Palliative care (PC) is a model of care that can only be expressed in a specialized way around 1967, when Cecily Saunders founded St. Christopher's Hospice in London, beginning the work of spreading the philosophy of the hospice movement in order to promote quality of life compared diseases without the possibility of cure. Such care aim to assist patients upon approach to improve the quality of life in diseases that threaten the continued existence, understanding the process of dying as inevitable and natural. The CP based on therapies that seek to provide, in time, decent quality of life and decrease the symptoms that the disease causes, always respecting individual rights, without forgetting that the family should also be assisted ¹⁻².

The CPs are procedures that seek to control pain and other symptoms, such as psychological, social and spiritual order. So your goal is to provide best quality of life for patients and families facing problems associated with threatening diseases ³. The palliative care arrived in Brazil in the early 80s, when the health system prioritized hospital-centric mode, essentially curative.

According to Kovács ⁴, the concept of CP has changed over time as the care philosophy was developing in healthcare environments. Traditionally been seen as procedures only at death, but they are currently offered at an early stage of progressive terminal illness, advanced, incurable until the last moments of life. It should be noted that care should value things that were in the background: the human, ethical and spiritual dimensions of the person ⁴⁻⁶.

The CP translate significant change in the role of professional health services, which in addition to take care of life should also take care of the dying process, considering these are interventions aimed at those end-of-life situation, aimed to alleviate unpleasant symptoms caused by the disease incurable. Whereas the training of health professionals has always been focused on the biological aspects, and its predominantly private practice consisting of fragmented interventions of different professionals for the same patient, it is understood that is so important to use humanitarian principles among professionals ⁷⁻⁸.

In summary, palliative care are centered on the right of the patient to live her remaining days with dignity and die, forming interdisciplinary field of total, active and comprehensive care provided to patients with advanced disease and end stage. This set of interdisciplinary actions seeks to provide a "good death" to patients with terminal illnesses, as well as support to families and caregivers ⁹.

Specifically in the field of anesthesia, the expansion of palliative care is even more recent, verifying that the challenges to the anesthetist attending the patient requiring palliative care have been increasing due to the growing progress made with new techniques of analgesia and sedation. The palliative care in anesthesia is intended to provide comfort, give the other his own care and give you the power to take responsibility for it. Among these new techniques highlight the patient-controlled analgesia (PCA) ¹⁰⁻¹¹.

It is, in short, act and react to death situation with the patient and family properly forward, fighting to preserve their physical, moral, emotional and spiritual, connecting with the patient and pledging to assist you and allow can also decide for yourself how and when to use palliative sedation to ease their symptoms ^{10,12}. Caring in palliative anesthesia is to provide relief and recognize your patient as a unique human being. Therefore, it is essential to control symptoms such as pain and fatigue, anorexia, constipation and dyspnea, among others ¹²⁻¹³. Based on these assumptions, the objective of this study was to assess the knowledge about palliative care among anesthesiologists in the city of João Pessoa, Paraíba, Brazil.

Methods

Exploratory research, descriptive type was performed with a quantitative approach, with anesthesiologists Anesthesiology Society of the State of Paraíba (SAEPB) who conduct their professional activities in the city of João Pessoa / PB and agreed to participate voluntarily in this work, in the months of January and February 2012.

Of 126 anesthesiologists recorded in SAEPB, contacted by telephone, 95 (75.4%) accepted the sample. Data were collected personally by the researchers through a structured questionnaire with closed multiple-choice, which contained questions about palliative care questions.

The research was made in accordance with ethical recommendations of Resolution CNS / MS 196/92, replaced by Resolution CNS / MS 466/12¹⁴. Participants confirmed the consent by signing the consent form (ICF), which received a copy. Justifies the choice of professionals for many of them attend continuously or esporádica patients in this situation, requiring their care. However, the study was not restricted to those professionals who deal exclusively with patient lying with end-stage disease, with the inclusion criteria anesthesiologist with activity in the city of João Pessoa.

For data analysis we used the Statistical Package for the Social Sciences for Windows (SPSS) version 19.0. Descriptive data were expressed as percentages, mean, median, mode and standard deviation. To perform the statistical analysis the chi-square test with Monte Carlo simulation was used.

Result and discussion

The study involved the participation of 95 anesthesiologists city of João Pessoa / PB, 65 males (68.4%) and 30 females (31.6%). Regarding marital status, there was a predominance of married, with 65.3% (n = 62), with the smallest portion of the sample of widowed individuals, representing only 2.1% (n = 2) of the total.

Most individuals were aged between 41 and 50 years (26.3%) and only 7.4% (n = 7) between 25 and 30 years. As for the time of graduation, 33.7% (n = 32) had 30 years or more, with an average of 21.3 years. Regarding the weekly workload, the majority 43.2% (n = 41) of respondents work between 40 and 70 hours per week, with an average of 65.1 hours. Regarding religious affiliation, larger sample groups are Catholics (73.6%, n = 70) and Protestants (13.7%, n = 13). The majority 63.2% (n = 60) claimed to be practicing.

In Table 1 we observe responses to the questions: "Word that expresses CP" and "where to meet patient requiring CP". It was found that the term "quality of life" which is best expressed as palliative care (65.3%, n = 62). When asked where should be the care of the patient requiring palliative care, most respondents (55.8%, n = 53) responded "home / hospital", followed by 36.8% (n = 35) who consider "home" and only 3.2% (n = 3), the "hospice".

Table 1. Data for the questions: "Word that expresses palliative care and where to meet patient requiring CP"

Variance	N	%
Palavra que expressa cuidados paliativos		
Pain	2	2,1
Family	1	1,0
Death	24	25,3
Not ansered	2	2,1
Ortotanasia	4	4,2
Quality of life	62	65,3
Onde deve ser o atendimento do paciente que requer cuidados paliativos		
Home	35	36,8
Home/hospital	53	55,8
Hospice	3	3,2
Hospital	3	3,2
Not ansered	1	1,0

N= number of anesthesiologists.

Table 2 summarizes the responses to the questions "Did you receive preparation for dealing with patient requiring CP?"; "Did you experience personal loss"; "When it happens the death of patient you attended, addresses [the fact] with colleagues anesthesiologists?". For most researched - 83.2% (n = 79) - preparation failed to deal with patients requiring CP terminals. When asked whether they have experienced personal loss, 92.6% (n = 88) answered yes. Regarding the question "When death happens to a patient you attended, comments with your colleagues anesthetists?", 88.4% (n = 84) responded affirmatively.

Table 2. Data related questions: “Received preparation for dealing with patient requiring palliative care”; “She experiences the experience of personal loss” and “approaches with colleagues the death of a patient”

Questions/replies	N	%
Recebeu preparação para lidar com paciente que requer cuidados paliativos?		
Yes	16	16,8
No	79	83,2
Vivenciou a experiência de perda pessoal?		
Yes	88	92,6
No	7	7,4
Quando acontece a morte de paciente que você assistiu, aborda [o fato] com seus colegas anestesiolistas?		
Yes	84	88,4
No	11	11,6

N= number of anesthesiologists.

Table 3 summarizes the data obtained on positioning in relation to the practice of euthanasia in relation to sex of respondents. Thus, it was found that both 29 (63.0%) of respondents males and 17 (37.0%) females disagree with their practice, totaling 46 individuals. The chi-square suggests no association exists between the data. Thus, it appears that gender does not interfere with the positioning on the practice of euthanasia.

Table 3. Data refers to positioning in relation to euthanasia practices regarding sex

	Do not know		Agrees		Disagrees		Do not answer		N
	N	%	N	%	N	%	N	%	
Female	8	38,1	4	14,8	17	37,0	1	100,0	30
Male	13	61,9	23	85,2	29	63,0	0	-	65
Total	21	22,1	27	28,4	46	48,5	1	1,0	95

N = number of anesthesiologists.

Regarding the perception of anesthesiologists regarding knowledge about CP, on a scale of 0 to 10, it was observed that the highest frequency (mode) was 5; the average was 5.8; median, 6.0; and stan-

dard deviation, n = 28 to 1.54. Revealed a significance level of 0.755. Therefore, most of the sample gave score ranging between 4 and 7 for the standard deviation was 1.54. The chi-square test suggested no association between the data, ie, sex did not influence the assignment of the note.

Discuss the topic of palliative care presupposes making reflective exercise that involves family, caregiver, death and patient autonomy, among others. Initially, there was to be little research on palliative care directed to anesthesiologists and little is known about the views and the placement of these professionals. Regarding the question that sought to identify the proper word for “palliative care”, 65.3% of respondents indicated the term “quality of life” as the one that best lends itself to definition.

The patient who meets the end-stage disease and chemotherapy treatment shows decrease in physical, emotional, cognitive and social functions, for at this moment is the increased fatigue, nausea and vomiting, pain, insomnia, appetite loss and diarrhea. So it is so difficult to measure quality of life (QOL) of the terminal patient. It should be noted that this definition includes six main domains: physical health, psychological state, level of independence, social relationships, environmental characteristics and spiritual standard. So quality of life is an eminently human notion, which has been understood as satisfaction found in family, love, social life and environmental, and existential aesthetic itself¹⁵⁻¹⁶.

Deepening the subject, it is observed that the anesthesiologist who works in palliative care seeks to mitigate or lessen the discomfort by passing the patient and family. For the privilege of proximity to those who are in the dying process, this coexistence can turn into a source of comfort for those who ar- rosta the inevitability of death. Given this circumstance, seek to provide palliative care to the patient and his family the best quality of life in the time remaining to him^{15,17}.

Among the options for the care of the patient requiring palliative care, respondents recognize that anesthesiologists preferred combination is the home / hospital (55.8%, n = 53). In this sense, even the medical caregiver understands that the combination home / hospital is the most complete. This

means change from the usual place of death and induces the need to create and implement effective and integrated programs in hospitals, to provide this service, as the trend is that patients reverse their preference as to the point of care - what seems to be happening, manifesting itself in the fact that patients prefer, increasingly, stay at home, with family and the people they love.

The Federal Medical Council issued Resolution 1805/06, all doctors need to know. Deals with the life of terminally ill and has deontological and ensuring essential care to relieve symptoms that can lead to suffering, always respecting the patient's wishes and bringing you more comfort in the terminal state. Put the question in these terms, the approach to be adopted for the patient in process of inevitable death will always be debated, it wonders if it will be worth removing the patient's home and transport him to the hospital only to die¹⁸.

Most anesthesiologists surveyed (83.2%, n = 79) reported having received no preparation for dealing with patients requiring palliative care. These considerations are in line with studies in several countries show that gap in the training of health professionals in relation to palliative care, indicating the need to stimulate the formation^{19,20}. Although palliative care is also little publicized among anesthesiologists, this approach is extremely relevant to this professional group that is often the one assigned to assist the patient in the last moments of life.

Due to this deficiency in training, adoption of futile measures most likely stems from the lack of professionals on palliative care. Regarding this situation in Brazil, it appears that there are several challenges to overcome, including the possible to overcome this deficiency in the training of health professionals about the finitude of life process. It is essential that the anesthesiologist be prepared to palliative care, enhancing patient autonomy, whose position must comply whenever possible.

If it is feasible to see that the change of mindset of the professionals for the adoption of CP is required, it is noticed also that these are not always willing and receptive to change with new paradigm shift. Considering the care of the dying patient goes beyond the technical procedures, we must address the human dimension encompassing - within the possibilities - aspirations, desires, needs and wishes of terminally ill patients. Before this, we are led to believe that you need to perform hard work in terms of changes (personal, social and human), from trainers appliances that shape professional with excellent technical preparation and no humanistic emphasis^{21,22}.

As a result of advances in technology, the demand for technically skilled professionals and will always be growing at the expense of concern with the human soul. This phenomenon of the advancement of technology has led medicine to target increasingly offering beyond the specialties, subspecialties, which makes his professional confine themselves to some segments of the body, causing them to forget wholeness of the human person as a being with body and soul, and therefore requires holistic view on integrated treatment of your health²².

Anesthesiologists who act as caregivers also are in fragile situations when they encounter a patient without therapeutic possibilities²³ observed in this study that many of them commented with colleagues the death of patients under their care, since usually share information about the day to day work. This situation seems to be relatively common, considering that these professionals have vital role in caring for the dying patient, since the terminal phase can be terribly difficult for the patient and for the caregiver as much as what you can do for the patient is very little. Nevertheless, reported that doctors consider the patient's death as his science failed and frustrated, contain feelings of guilt for failing to avoid it²⁴ To Horta, health professionals and other areas need to face the reflection challenges of the dying and death process - we can help even in the preparation of their experiences²⁵.

On euthanasia, anesthesiologists study positioned themselves as follows: 46 disagreed, 27 agreed, and 22 did not respond or did not know. Euthanasia is not accepted in most of societies, ethical conduct is prohibited, constituting in anticipation of the death of someone in the act of mercy without any personal profit. From the perspective of Cabral, the word "euthanasia", of Greek origin, was introduced by Francis Bacon in the *Organon*. With the etymological meaning of "good death", ie smooth, peaceful, without suffering, euthanasia is characterized as a medical procedure whose purpose is to eliminate the pain and indignity of terminal illness through direct and active induction of the death of its bearer^{2,26,27}.

It was evident in this study that the knowledge about palliative care is insufficient, which can be explained as failure in medical training, during which little is said of the death. Thus, anesthesiologists should receive preparation for how to deal with the challenges that arise in the field of patient care that requires palliative care. It is also necessary that the anesthesiologist has, in addition to technical and scientific competence, human competence, experiencing the

true values to act consistently and responsibly, because at this point the practitioner must understand the fears and fears of patients, as well as inquiries about inherent to anesthetic to minimize factors that may affect the welfare of these 28 aspects.

In this perspective, we must take care of medical education, through reflection and discussion around the process of training and development. Thus, it is important to recognize the need for training in the specific field of palliative care, in order to contribute to improving the delivery of healthcare by health professionals because of these concerns are constant and daily conflicts of any physician who deals with patients terminals ^{16,29}.

Final considerations

The present study has examined the knowledge and anesthesiologists of the city of João Pessoa, Paraíba, on palliative care. This type of care is in philosophical and conceptual field still under construction, so that their practice is challenging for that category of medical professionals, especially because both the science itself as a training focus on technicalities practice focused on healing.

Although hospice action is also driven by the

proposed technical and scientific attention, incorporates other subjective issues. The medical assistance to the sick who need palliative care has - essentially - the human dimension. To fully meet these patients, requires the adoption of measures that do not aim to heal more, but relieve suffering; so why the need for palliative care is to have priority as the value of human dignity, which implies to consider fully, not only from the standpoint of diagnosis, but also in relation to the treatment of the disease and what can be done when resources are exhausted therapy.

In this context, highlights the relevance of reflection on palliative care for this category of professionals, highlighting the involvement of anesthesiologists in the care of these patients in the final moments of life, aware of the importance of their role as a pillar of medical care in the face the indispensable assistance which should provide them in the last moments, relieving them pain and suffering.

It is believed that the data presented in this research can collaborate to highlight the need to evaluate the anesthesiologist caregiver in the process of patient care that need palliative care. It is essential inculcamos the need for future research in the area of palliative care anesthesiologists, in order to contribute to improving the performance of this medical task.

Acknowledgements

Aos anesthesiologistas da SAEPB e da Coop anest-PB que exercem suas atividades na cidade de João Pessoa/PB.

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Participation of authors

Maria de Fátima O. Santos has participated on the conception and design of the study by the elaboration of a Research Project and the statistical analysis and data interpretation, besides writing. Natália Oliva Teles has contributed in the revision and data analysis. Harison J. de Oliveira has contributed in the statistical analysis and its interpretation. Nicole de Castro and Joana Cariri have contributed in the critical revision and Edilza Câmara in the revision of literature.

