



REVISIONES

Orthotanasia and palliative care practices in patients with terminal cancer: a systematic review of the literatura

Práticas de ortotanásia e cuidados paliativos em pacientes com câncer terminal: uma revisão sistemática da literatura

Prácticas de ortotanasia y cuidados paliativos en pacientes con cáncer terminal: una revisión sistemática de la literatura

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ABSTRACT:

The objective of this work was to investigate the scientific production about orthotanasia and palliative care in patients with terminal cancer. For that purpose, a systematic literature review was carried out through a search for articles in the periodical portal of the Coordination for Improvement of Higher Education Personnel (Capes), published in Portuguese, in the time interval from 2011 to 2016, using as descriptors: "Orthotanasia" AND "Cancer" ($f = 6$); OR "Palliative Care" AND "Cancer" ($f = 70$). After application of exclusion criteria, 19 articles were analyzed. The results showed the existence of therapeutic obstinacy. On the other hand, the importance of the process of humanization of death and decision-making on orthotanasia by professionals, patients and relatives is reinforced.

Keywords: Orthotanasia; Palliative care; Cancer.

RESUMO:

Objetivou-se investigar a produção científica sobre a prática de ortotanásia e cuidados paliativos em pacientes com câncer terminal. Para tanto, realizou-se uma revisão sistemática da literatura por meio de busca por artigos no portal de periódicos da Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (Capes), publicados em português, no intervalo de 2011 a 2016, que apresentavam os descritores: "Ortotanásia" AND "Câncer" ($f = 6$); OR "Cuidados Paliativos" AND "Câncer" ($f = 70$). Após seleção por meio de critérios de exclusão, analisaram-se 19 artigos. Os resultados evidenciam a existência da obstinação terapêutica. Por outro lado, reforçam a importância do processo de

humanização da morte e da tomada de decisão sobre a ortotanásia feita por profissionais, pacientes e familiares.

Palavras-chave: Ortotanásia; Cuidados paliativos; Câncer.

RESUMEN:

Se objetivó investigar la producción científica sobre la práctica de ortotanasia y cuidados paliativos en pacientes con cáncer terminal. Para eso, se realizó una revisión sistemática de la literatura por medio de búsqueda de artículos en el portal de periódicos de la "Coordenação de Aperfeiçoamento de Pessoal de Nível Superior" (Capes), publicados en portugués, en el intervalo de 2011 a 2016, que presentaban los descriptores: "Ortotanasia" AND "Cáncer" ($f = 6$); OR "Cuidados Paliativos" AND "Cáncer" ($f = 70$). Después de la selección por medio de criterios de exclusión, se analizaron 19 artículos. Los resultados evidencian la existencia de la obstinación terapéutica. Por otro lado, refuerzan la importancia del proceso de humanización de la muerte y de la toma de decisión sobre la ortotanasia hecha por profesionales, pacientes y familiares.

Palabras clave: Ortotanasia; Cuidados paliativos; Câncer

INTRODUCTION

The process of globalization that occurred in the last century brought about an increasing integration of the economies and societies of several countries and has caused changes in health and disease patterns throughout the world. The so-called epidemiological transition was characterized by a decrease in mortality rates due to infectious diseases and a simultaneous increase in the rate of chronic degenerative diseases, especially cardiovascular diseases and cancer⁽¹⁾.

Cancer is considered a public health problem in developed and developing countries for it causes more than six million deaths each year, accounting for about 12% of all causes of death worldwide. According to the National Cancer Institute - José Alencar Gomes da Silva (INCA), cancer is the second largest cause of death in Brazil, with 190,000 cases per year, 60% of which are diagnosed at an advanced stage. These numbers are increasing, and it is estimated that by 2020, cancer will become the disease with the highest mortality rate in the country.

The causes of cancer are diverse and the disease happens when there is a disorderly growth of malignant cells that invade the tissues and organs and that may spread as a metastasis to other parts of the body. Carcinogenesis refers to the progression of malignant tumors, which is studied based on the aspects and mechanisms related to it that can be spontaneously initiated or be stimulated by the action of chemical, physical or biological carcinogenic agents. The active, progressive, aggressive and life-threatening nature of this disease causes feelings of fear, insecurity, rejection and denial⁽²⁾.

The treatment involves performing invasive and painful procedures with several side effects at different times of the therapies that are necessary for patients with this pathology. Thus, the fear of the disease stems not only from the threat of death, but also from the way of dying, that is, to die of cancer, with much suffering. This is because during the process of becoming a cancer patient, it is common for professionals, patients and family members to seek all treatment alternatives aiming at healing until the last days of the patient's life, even when there is no positive prognosis. This therapeutic obstinacy is called dysthanasia⁽³⁾.

The term dysthanasia is poorly understood, even in the academic world, but it is one of the most common practices in the health field. It is a Greek word whose prefix "*dis*" means "removal" indicating the exaggerated prolongation of a patient's death. It refers to useless treatment processes that seek to combat death at any cost and prolong the life of a terminally ill patient, even if that implies unnecessarily subjecting him to intense suffering. In this case, the process of dying, rather than living, is prolonged⁽⁴⁾.

In contrast to this practice, the World Health Organization (WHO) advocates that when the disease progresses and curative therapy is not possible for cancer patients, the health care team should recognize the need to change the therapeutic approach. This implies a different understanding of oncological care, beyond biotechnology care⁽⁵⁾.

In these cases, dysthanasia should give way to orthotanasia. The term orthotanasia originates from the prefix *orto*: right *and* *thanatos*: death, and is employed with the meaning of proper death, at the right time. It consists in not using unnecessary and inhumane procedures in order to overcome the natural process, which would imply an increase in suffering. It does not mean neglect or abandonment of the patient. It is rather a therapeutic process guided by humanization in which care is designed to provide quality of life and death for the patient. Thus, the practice of orthotanasia characterizes the manifestation of good or desirable death, at the right time, without interruption of the treatments necessary to soften the pain⁽⁶⁾.

This change in therapy can be made feasible and facilitated if the hospital institution has a palliative care team. The World Health Organization (WHO) defines Palliative Care as an approach that promotes the quality of life of patients and their families in the face of any life-threatening disease with any prognosis, regardless of age, and any time of the illness when unmet expectations or needs are expressed. For this, the early identification and impeccable evaluation and treatment of pain and other distressing physical, psychosocial and/or spiritual situations is necessary, from the diagnosis of the disease to terminality⁽⁷⁾.

Palliative actions can occur in four phases: early palliative care, when the patient presents good functional status, with an estimated prognosis of months or years; complementary, in the case of intermediate functional status, with estimated prognosis of weeks to months; predominant, when the patient presents low functional status, with characteristics of irreversibility of the underlying disease, and estimated prognosis of days or a few weeks; or exclusive, intended for patients with low functional status and rapid and irreversible decline of the general state, i.e., end-of-life care⁽⁸⁾. Palliative Care presents as fundamental pillars: (1) integral and humanized care from an interprofessional team; (2) effective communication between patient-family-professionals; and (3) the quest for quality of life and death for the patient⁽⁷⁾.

In the first pillar, integral care is provided by the work performed by a multiprofessional and interdisciplinary team. The focus of attention becomes the patient, who is seen as a biographical and active being, far beyond the illness to be cured that affects him, with the right to information and full autonomy to make decisions about his treatment. Adequate practice of Palliative Care advocates an individualized attention to patients and their families, the pursuit of excellence in the control of all symptoms, the prevention of suffering, and emphasizes, as a philosophy, the valorization of life and the perception of death as a natural process⁽⁹⁾.

As a second pillar for the accomplishment of palliative care, the communication among the health team members, and of them with the patients and their relatives is a condition *sine qua non* indisputable. Communication must be clear, objective, comprehensive and honest, respecting the patient's desire and providing only the amount of information he needs (no more, no less). This task poses a great challenge for health professionals, especially regarding the communication of bad news⁽¹⁰⁾.

These practices lead to the third pillar of palliative care: to rescue the patients' dignity, respecting their autonomy and prioritizing the principle of non-maleficence as a means of avoiding "therapeutic obstinacy", so that patients under palliative care may have greater quality of life and death^(7,8).

In view of the above, palliative care in the terminal stage of life, especially in cancer patients, is important because it offers a differentiated therapy with the main objective of promoting humanized care. Adopting a care practice based on the quality of life in the finitude of a person's life implies trying to minimize suffering during the terminal stage and provide biopsychosocial and spiritual well-being^(9,11).

To support the decision-making of doctors about the discontinuation of curative therapy and adoption of palliative care, the Federal Council of Medicine (FCM), through the FCM *Resolution n° 1,805 of November 28, 2006* (2006), known as the Orthotanasia Resolution, states that the physician is allowed to limit or suspend procedures and treatments that prolong the patient's life in terminal stages of severe and incurable disease. This guarantees the provision of the necessary care to relieve the symptoms of pain and suffering, from a perspective of integral care, respecting the will of the patient or his/her legal representative.

It is recognized, however, that even when legally supported, this practice does not prevail in hospitals due to the social and cultural resistance and academic training of health professionals towards decision-making in this matter. This finding evidences the need for a more extensive approach to the entire health team, including the evaluation of research that may broaden the understanding of the practices of orthotanasia in the literature⁽¹²⁾. In view of the above, the objective of this study is to investigate the scientific production on the practice of orthotanasia and palliative care in patients with terminal cancer.

METHOD

Study Type

To reach the objective of this study, a systematic review of the literature was carried out. This is a method of synthesis of evidence used to critically evaluate and interpret the important researches available addressing a particular issue, field of knowledge or phenomena of interest. Studies produced by means of reliable and rigorous methodologies are included in the review, since they are explicit and systematic procedures that select, identify and evaluate the quality of the evidences. A comprehensive literature review process allows to identify, locate, evaluate and synthesize the clusters of evidence arising from scientific studies to achieve a reliable view of the estimated effect of the intervention⁽¹³⁾.

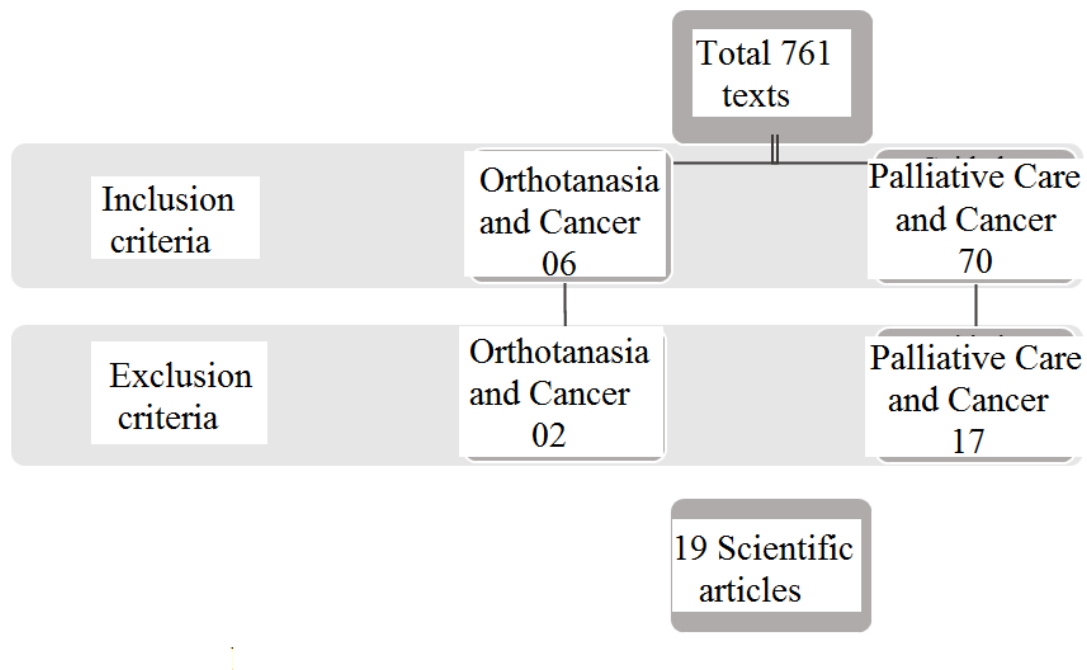
Article Selection Process: Inclusion and Exclusion Criteria

The selection of the literature was carried out in February and March 2017 in the periodical portal of the Coordination for Improvement of Higher Education Personnel (Capes). The first search, conducted without filters, initially located 14 texts by means of the combination of the descriptors "orthotanasia" AND "cancer" and 747 texts from the use of the descriptors "palliative care" AND "cancer".

From this survey, the following initial inclusion criteria were defined: complete articles, available in Portuguese, published between 2011 and 2016. After application of these inclusion criteria, the texts were reduced to 76 scientific articles: 6 obtained by combining the descriptors "orthotanasia" AND "cancer" and 70 texts using the descriptors "palliative care" AND "cancer".

Then, exclusion criteria to be applied in the 76 texts were defined as follows: duplicated texts ($f = 03$), books ($f = 02$), texts not directly related to the subject matter ($f = 26$), texts that did not depict empirical studies ($f = 18$), and texts that appeared in the survey but were out of the delimited time period and published in other languages ($f = 05$). At the end of the selection and exclusion process, 19 articles, all published between 2012 and 2016, remained in the analysis (see Figure 1).

Figure 1 Selected articles for analysis after application of inclusion and exclusion criteria.



RESULTS AND DISCUSSION

The articles analyzed were published between 2011 and 2016: 6 articles (31.58%) in 2012, 7 articles (36.84%) in 2013, 5 articles (26.31%) in 2014, and 1 article (5.26%) in 2016. The period that had the apex of publications was 2012 and 2013, and no article was published in 2011 and 2015 (see Figure 2). The titles, authors and years of publication of the analyzed studies are listed in the Figure 3.

Figure 2 Years of publications of articles selected for analysis.

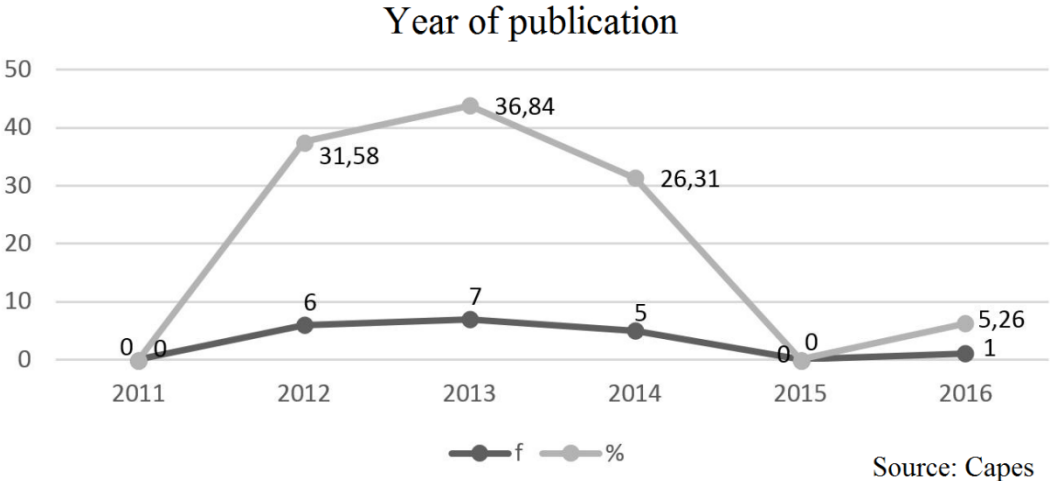
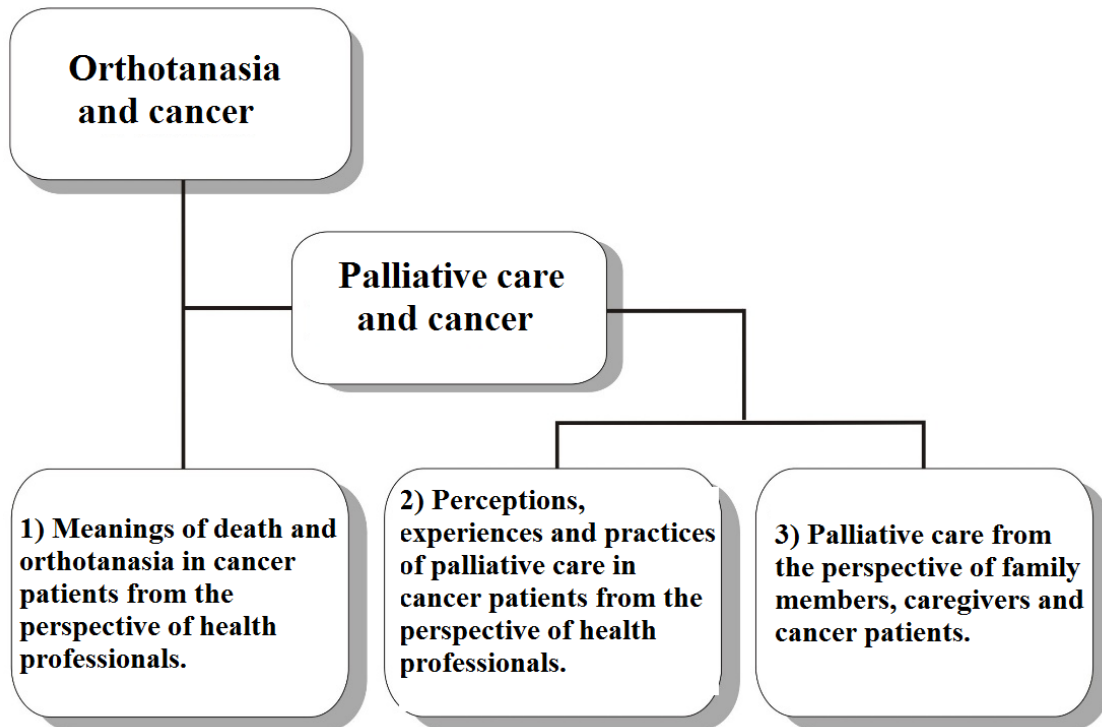


Figure 3 Studies analyzed on orthotanasia and palliative care in cancer patients.

Text	Title	Author(s)	Year
1	Hope of the person with cancer: a study in the context of chemotherapy.	Pinto, Caldeira, Martins	2012
2	Implications of interdisciplinarity in the organization of nursing work: a study in a palliative care team.	Matos, Pires, Gelbcke	2012
3	Suffering of cancer patients in palliative situation.	Alves, Jardim, Freitas	2012
4	Occological nursing care from the perspective of the family caregiver in the hospital context	Sales, Grossi, Almeida, Silva, Marcon	2012
5	Spatiality of being a nursing professional in the world of care for children with cancer.	Mutti, Padoin, Paula	2012
6	Nurses and the care of children with cancer with no current possibility of cure.	Monteiro, Rodrigues, Pacheco	2012
7	The importance of communication in palliative care in pediatric oncology: focus on the Humanistic Nursing Theory.	Sá França, Costa, Lopes, Nóbrega, França.	2013
8	Musical encounters as a resource in oncology palliative care for users of support groups.	Silva, Sales	2013
9	Body and finitude - listening to suffering as an instrument of work in oncological institutions.	Miranda, Lo Bianco	2013
10	Experiencing palliative care to children with leukemia: the view of professionals.	Nascimento, Rodrigues, Soares, Rosa, Viegas, Salgado	2013
11	The meaning of death for physicians regarding the terminality of patients submitted to Bone Marrow Transplantation.	Santos, Aoki, Oliveira-Cardoso	2013
12	The nurses' perception of the meaning of palliative care for terminal cancer patients.	Fernandes, Evangelista, Platel, Agra, Lopes, Rodrigues	2013

The 19 selected articles were organized into categories to a clear visualization of how the theme has been approached. For the organization of the categories, the relatedness of the topics covered by the scientific texts was taken into account in order to allow the presentation and discussion of different practices found in the studies. At the end of the division, the following categories were listed: 1) Meanings of death and orthotanasia in cancer patients from the perspective of health professionals; 2) Perceptions, experiences and practices of palliative care in cancer patients from the perspective of health professionals; and 3) Palliative care from the perspective of family members, caregivers and cancer patients (see Figure 4).

Figure 4 Categories that emerged in the analysis of the documents.



Category 1 - Meanings of Death and Orthotanasia in Oncology Patients from the Perspective of Health Professionals

Three studies emerged in this category ($f = 03$). The meaning of death and orthotanasia in cancer patients is described by health professionals, particularly physicians and nurses.

Santos, Aoki and Oliveira-Cardoso⁽¹⁴⁾ sought to investigate the meaning of death for physicians who work with critically ill patients in the context of Bone Marrow Transplantation (BMT). The participants were the five physicians working at a BMT unit of a university hospital in the countryside of São Paulo. The results show that in the medical-hospital scope, death is almost always reduced to technicist rationality, and therefore it must be combated at all costs. The meanings attributed to death are supported by the values of contemporary society and subjectivated in the paths and difficulties faced by physicians throughout their lives and in their academic training, influencing the way in which they experience the process of dying of the patients.

The reports of 10 oncologists of public health services of the Federal District shown by Sanchez and Sanches and Seidl⁽⁴⁾ clarify that oncologists are health professionals who often deal with the end of life. The participants showed an association between the offer of comfort and the non-performance of invasive or extraordinary measures. In this case, orthotanasia would consist in letting life take its course. Some reports pointed out that minimizing suffering is a must in this process. For the authors, the proposal of orthotanasia is not to hasten death, but to humanize it, that is, to place the person at the center of the process, favoring the autonomy of the choices. This involves, therefore, solidarity, approximation and respect.

According to Cassol, Quintana, Velho and Nunes⁽¹⁵⁾, nurses are professionals directly involved in the care, always close to situations of pain, death and hopelessness of terminally ill patients. In this process, the patient or family member is not always able to make treatment choices. In this context, rethinking the behaviors related to human finitude contributes to minimizing the difficulties faced by professionals before death, in the sense of reducing the therapeutic obstinacy, providing a humanized care to the terminal patient.

Based on these studies, the first category contemplates the performance of professionals (physicians and nurses) who deal with the dying process of cancer patients. The analysis of these studies allowed the understanding that the questions that pervade death are treated with caution by some health professionals. The presence of interdicted death was evident, through medical rationality and its objective to save lives, even though this means resorting to therapeutic obstinacy. On the other hand, the importance of the process of humanization of death and decision-making by professionals, patients and family members towards orthotanasia was reinforced, although an understanding of the meaning of this behavior is not easily accessible to everyone. It is also worth mentioning the lack of studies dealing with orthotanasia.

Category 2 - Perceptions, Experiences and Practices of Palliative Care in Cancer Patients from the Perspective of Health Professionals

The second category comprises articles ($f = 11$) that address the topic of experiences and practices of palliative care in cancer patients from the point of view of health professionals. In this category, the analysis of the articles were divided into two subcategories: 2.1 Perceptions and practices of health professionals on palliative care in adult cancer patients ($f = 06$); and 2.2 Palliative care experiences and practices in pediatric oncology ($f = 05$).

Category 2.1 - Perceptions and practices of health professionals on palliative care in adult cancer patients.

Based on a study carried out with an interdisciplinary team that provided palliative care to cancer patients in a public institution in the South of Brazil, Matos, Pires and Gelbcke⁽¹⁶⁾ sought to identify the influence of interdisciplinary practice in the organization of nursing work. The results showed that the Palliative Care Service should involve and integrate outpatient, home and hospital care, as well as articulate and integrate the actions of the various health professionals that make up the team. The activities to be developed with cancer patients and their families, the approach, and the home visits to be performed, should be decided by the professionals after extensive discussion.

Fernandes et al.⁽⁹⁾ carried out an exploratory research with nine care nurses of a hospital that assists oncological patients under palliative care, located in the city of João Pessoa (PB), in order to gather information on their perception about the meaning of palliative care in terminal cancer patients. The professionals involved recognized the importance of the multiprofessional team, making available to nurses reflections on the use of communication as an essential element of care provision for patients and families under palliative care.

Regarding the importance of communication as a care practice, the study by Miranda and Lo Bianco⁽¹⁷⁾ demonstrated that listening to the patient's speech by professionals is a fundamental working tool in an oncological institution. The authors characterize two possible positions to be adopted by the person who deals with death and with finitude of life: to resist the encounter with the finite and perishable dimension of life; or to listen to the patient, recognizing that this event is something common to all, so that the patient may feel supported and not alone with his suffering.

While exploring other forms of encounter between professionals and patients, a phenomenological research structured in the existential analysis of Heidegger, Silva e Sales⁽¹⁸⁾ sought to unveil cancer. It was found that the encounter mediated by music represents a resource for nursing care in oncologic palliative care that inspires life to the users' days, impressing on them the feeling of care and resignifying their existence.

In a discussion of the pains and sufferings of terminal patients, Queiroz, Mota, Bachion and Ferreira⁽¹⁹⁾ pointed out that preventive measures should be adopted in the case of cancer patients with prevalence of pressure ulcers in the domiciliary process. The results of the study will enable palliative care teams to review their practices and suggest strategies for instructing caregivers on both prevention and treatment of pressure ulcers.

Finally, Garcia, Rodrigues and Lima⁽²⁰⁾ said that palliative care is not yet adequately structured, a reality that turns this issue into a public health problem and causes initiatives in this context to become relevant. According to the authors, the establishment of priorities for the structuring of a palliative care service is essential, including the administration of drugs for pain control, humanization, multidisciplinary and the awareness and education of professionals.

Category 2.2 - Palliative care experiences and practices in pediatric oncology.

Nascimento et al.⁽²¹⁾ emphasized the difficulty that the multidisciplinary team professionals face to deal with the feelings arising in a context of a child affected by leukemia under palliative care. However, although this field of action generates suffering and distress on the part of the professionals, it is noticed that the multiprofessional team feels connected and likes the area, and is focused on promoting respect, security, and hospitality to the children and their families.

In this perspective, Mutti, Padoin and Paula⁽²²⁾ conducted a phenomenological Heideggerian investigation with nursing professionals and provided an understanding of the difficulties that the nursing team faces to care for children who have cancer in advanced stages, whose illness no longer responds to curative treatments. The authors clarify that in the daily care of children with cancer, nursing professionals need to separate the professional from the emotional sphere, and point out the need for

developing multiprofessional strategies in the care of these professionals, considering that they also need to be taken care of.

Accordingly, the study by Reis et al.⁽²³⁾ reports the relationships established by nursing team professionals in the care provided to children with advanced oncologic disease, without therapeutic possibilities of cure. It is recognized that these relationships reflect the difficulties of providing care for cancer, endorsed by the fact of the patient being a child, because the concept of this disease is associated with suffering and death.

With focus on the operationalization of the assistance, Monteiro, Rodrigues and Pacheco⁽²⁴⁾ carried out a study with the objective of comprehensively analyzing the care provided by nurses to hospitalized children with cancer out of the possibility of cure. The results showed that the use of support and comfort measures to alleviate suffering due to disease progression should be prioritized, aiming at the well-being of these children and their relatives. Such care strategies of the team imply commitment with systematically promoting any healthy measure to provide comfort. It was found necessary to direct care also to family members present in the situation, with the purpose of supporting them, providing attitudes of affection, kindness and respect.

As in the studies with adult cancer patients, the study of France, Lopes, Costa, Nóbrega, and France⁽²⁵⁾ performed with nurses working in pediatric oncology indicated that communication is an effective element in the care of children with cancer and in the promotion of palliative care. The results pointed out that authentic communication between nurses and children can occur, as well as between all those involved in the palliative care process. In this relationship, communication is the axis for its development, and is conceived by nurses as one of the most relevant instruments in palliative care.

In a final analysis of this category, which included more articles on the subject, we highlight the importance of professional practices in the care for cancer patients from a more humanized perspective and the relevance of communication in this practice. The difficulties in caring for children with cancer and their relatives were highlighted, as well as the fact that the team itself must also be cared for.

Category 3 - Palliative Care from the perspective of Family Members, Caregivers and Cancer Patients

With regard to this category, the five selected articles ($f = 05$) discuss palliative care from the perspective of family members, caregivers and the patients. The studies pointed out the importance of the human relationship during the terminal process.

Pinto, Caldeira and Martins⁽²⁶⁾ carried out an observational, cross-sectional study with 92 cancer patients undergoing chemotherapy to analyze the hope indices of these patients and understand how they are influenced by some sociodemographic, clinical and religious variables. They found that the time under chemotherapy influences the hope of patients. As time passes, hope tends to diminish, reflecting the people's natural desire to remain attached to life. The results highlight the importance of keeping patients abreast of their clinical situation and of helping them to find meaning and purpose in life by planning possible goals and encouraging them to live a healthy spirituality.

Alves, Jardim and Freitas⁽²⁷⁾ applied the Inventory of Subjective Experiences of Suffering in Situation of Disease to 38 patients under palliative care hospitalized at a surgery and hemato-oncological service. Patients manifested intermediate levels of global distress and a significant correlation between age and the extent of socio-relational suffering was observed. The authors reinforced the importance of nursing interventions for people under palliative care, in order to develop interventions aimed at preventing and alleviating the suffering of these patients.

Sales, Grossi, Almeida, Silva and Marcon⁽²⁸⁾ aimed to report the experiences and expectations of the companion's of cancer patients regarding the nursing care received. They found that the care directed to family members of patients who have no hope of cure is not restricted to nursing actions, but also requires administrative measures and, above all, infrastructure in the hospital environment.

Similarly, Sanches, Nascimento and Lima⁽²⁹⁾ conducted a research with family caregivers of children and adolescents who died of cancer being followed-up in a teaching hospital. The study found that the process of illness in children and adolescents is intensely experienced by the family. They face multiple changes when they learn the diagnosis of cancer. These changes are related to physical, psychological and financial aspects and, in particular, and to the imbalance in social and family life interconnected to the overload experienced by family caregivers.

The research carried out by Silva e Lima⁽³⁰⁾ aimed to understand the nurses' perspective on the participation of the family in palliative cancer care and analyze nursing care strategies to meet the needs of family members. The results show that the nurses' perspective on the presence of family members in hospitalization and oncology palliative care tends to value the positive aspects, considering the opportunity to enable them to perform the care at home, and to embrace it, seeking to meet their needs .

In short, the studies analyzed in the category three show the importance of the involvement of family caregivers in the process of cancer treatment and palliative care, understanding that family members also need care. The patient's perception of the disease and the index of hope during chemotherapy treatment are also highlighted in this category.

FINAL REMARKS

Based on the results of the present study, it is observed that medical training and rationality perpetuate the practice of therapeutic obstinacy in terminal cancer patients. On the other hand, they reinforce the importance of the process of humanization of death, effective professional-patient communication, joint decision-making and family participation. They also emphasize the need for providing care for the family and the professionals.

Some initiatives have been carried out and discussed with regard to the process of humanization of care for terminally ill patients in relation to family members and the health professionals involved, although the need for a broader approach in this field is still significant. There is an urgent need to expand the clarification about the practice of orthotanasia and palliative care for family members, health professionals, ill people and the society in general, so as to make it possible to employ more practices of humanization and dignification of death.

The study presents some limitations, such as the small number of publications addressing the process of orthotanasia for oncological patients; there was a notable scarcity of studies approaching this theme in the literature. This work has the contribution of providing theoretical subsidies for future studies, and assisting the work of health professionals in the care of terminal cancer patients.

Recognizing the need to expand the analysis on this topic, it is expected that this study contribute to foment the discussion on the practice of orthotanasia and palliative care in end-stage cancer patients. Therefore, further researchers and scholars are invited to invest in the investigation of this theme.

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