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Palliative care at the end of life and the role of the psychologist

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ABSTRACT

Palliative Care (PC) is defined as care aimed at patients diagnosed with progressive, incurable and/or chronic-degenerative diseases, and may cover any life-threatening illness that culminates in its finitude. In view of this, the PC aims to provide pain relief and relief from the suffering of invasive treatments, providing dignity, comfort and welcome to improve the quality of life of the patient diagnosed with an incurable disease; This care can also cover the individual's family members and caregivers, providing them with welcoming, assistance and support to face the issues arising from the progression of the disease. Thus, the objective of the present study is to describe the participation of the multiprofessional team in PC, the patient and his family, that is, all those involved in this process of illness until the end of life, mainly to investigate how Psychology acts in the care of the patient, the family/caregiver and the health team. For this study, the literature review method was used. In this literature review, 27 scientific articles, 02 books, 01 Resolution of the Federal Council of Psychology, 01 Manual of Palliative Care of the National Academy of Palliative Care, 01 Manual of Palliative Care of the Hospital Sírio Libanês, 01 Booklet of the Brazilian Society of Geriatrics and Gerontology, 01 thesis. It will record how coping occurs during the trajectory of the diagnosis of this patient's disease until the end of life, as well as the participation and experience of the family, the multiprofessional team and in particular the participation of Psychology within this scenario, as it is the scientific field that covers the holistic sphere of the individual, and has the premise of dealing with issues involving human relationships, bringing the necessary comfort in the face of this new context of an established disease that will cause the terminality of existence. In this way, the psychologist is the professional trained to study mental processes, such as feelings, thoughts, behaviors, understanding their subjectivity and in this context, helping the individual to understand his self in the face of the serious and irreversible clinical state that precedes the proximity of death, resolving pending issues with himself and his family, giving support so that everyone can be at peace at the time of farewell. Finally, it will discuss the importance of humanized care in PC through the inclusion of specific subject in the graduation of health professionals, giving special attention to the field of psychological knowledge since it is the professional protagonist of this scenario.

Keywords: Palliative care, Family, Terminal patient, Multiprofessional team, Psychology, Aging, Psychologist's performance, Psychological intervention.

1 INTRODUCTION

Modern life provides us with the experience of longevity, we can see that technological and scientific advances have led to a reduction in the mortality rate on the planet, however, most elderly people affected by highly serious diseases, such as those of chronic-degenerative origin, do not benefit from these more modern resources of medicine. (GOMES; OTHERO, 2016). For Galriça Neto (2010) *apud* Gomes; Othero (2016), due to the struggle to find a cure for diseases and the evolution of care instruments in the health area, a culture of denial of death is observed, leaving for a second moment the health interventions that promote a dignified end of life that does not aim at the cure but at the quality of life of the individual.

Starting from the point of providing the patient with quality of life, Palliative Care (PC) emerges as an innovative way of providing care in the health area, differentiating itself from curative medicine by focusing on comprehensive care, prevention and symptomatic control of serious life-threatening diseases. (MATSUMOTO, 2012 *apud* GOMES; OTHERO, 2016). The PC are aimed at the individual in his or her entirety and need for intervention in symptoms of a physical, social, emotional and spiritual nature, being a multidisciplinary work, the team has the help of doctors, nurses, nursing technicians, social workers, psychologists, pharmacists, physiotherapists, occupational therapists, nutritionists, spiritual assistants of an ecumenical nature or of the religion of the patient's and family's preference (MACIEL, 2008 *apud* GOMES; OTHERO, 2016).

According to the World Health Organization – WHO (2002), PC aims to improve the quality of life of patients and their families, facing all the problems associated with the disease through the prevention and relief of suffering, through the identification, evaluation and treatment of pain and other physical, psychosocial and spiritual problems. The team of health professionals must have an education for death, in the sense of having a critical look at the training of these professionals, through training and continuing education, so that they can be prepared to experience and deal with the natural and intrinsic demands of illness, death and mourning (BRAZ; FRANCO, 2017 *apud* LIBERATO, 2015).

Health professionals who work in PC, called palliative care specialists, need to be qualified and properly trained in the care of patients and their families. Most PC teams come into play when there is a proposal to stabilize the disease, at this stage the treatment is conducted in a more exclusive line in order to prioritize comfort measures (BRAZ; FRANCO, 2017).

The palliative care professional is a facilitator, there is no neutral listener, so the most important thing is empathy with the patient, humanized listening. In this sense, the issue of autonomy, the decision of treatments, the necessary interventions is important, the properly prepared team can present possibilities and, in the best way, communicate with the family and patient in order to establish the best alternative about the end of life with dignity (KOVÁCS, 2016).

The team also needs to be attentive to the family, as it is a caregiver and also needs care, especially when the patient's degree of dependence on the caregiver is high, it is necessary to know the limits of the family, because with the increased level of stress due to the patient's terminal illness, the family also becomes a patient, which Kovács (2016) calls *the "hidden patient"*, due to the illness of these family members during or after the palliative patient's illness, especially small families with little social support and often with insufficient financial resources.

In this context, the professional psychologist goes through the interaction with the professionals of the multidisciplinary team, with the patient and the family, in order to evaluate and intervene with the patient and his family members who are experiencing the situation of the disease, thus seeking to understand the psychic resources of those involved in coping with the treatment, how to support the emotional demands that arise in coping with the terminality of life (LANGARO, 2017). The psychologist also helps the multidisciplinary team to understand the psychodynamics of the patient and the family so that the team can improve the care for them, thus improving the patient-family-team relationship and communication.

The deepening of PC studies brings to light a debate around a field of scientific knowledge that is so broad and, however, so little explored, because in Western culture there is little talk about death and there is no education for death, as well as there is no education for aging and consequently in the next phase, the finitude of life (KOVÁCS, 2016).

In view of this, it is necessary to discuss, describe and expand the knowledge and dissemination of PC in patients who are diagnosed with incurable diseases that will lead them to the end of life, in order to promote the improvement in the quality of life of this patient, as well as their family members when faced with a disease that will end in death, It is also worth discussing and describing the importance of the multiprofessional team, its involvement in the care of the patient and the family from the discovery of the disease to the end of the individual's life.

In the same way, discussing and describing the role of the Psychology professional working in the health team in PC demonstrates the importance of this aspect of scientific knowledge, as it interacts in the promotion of care for human beings in all its amplitude, especially at the moment of their existence when they are more fragile and need shelter and comfort. In this sense, Psychology acts in the application of tactics that help the patient to deal with his subjectivity, promoting understanding, acceptance and the search for quality of life, learning to deal with daily issues that involve palliative treatment in the time that he still has left to live, as well as assistance and reception to family members and/or caregivers in order to promote a psychic contribution to deal with the demands that are presented to him.

2 THEORETICAL FOUNDATION

2.1 PALLIATIVE CARE

In recent decades, we have observed a gradual aging of the population, as well as a preponderance of chronic-degenerative diseases with slow evolution that generates functional impairment and dependence. Population aging can be noticed gradually, since the nineteenth century, due to better social conditions, basic sanitation, urbanization, in addition to the use of antibiotics and vaccines. The aging process results from the decline in the fertility rate, that is, the increase in the proportion of elderly individuals and the decrease in younger individuals (NASRI, 2008).

According to Nasri (2008), the average life expectancy of Brazilians has increased by almost 25 years, in the last 50 years, without having observed significant improvements in the living and health conditions of the population. In view of the urbanization of the population, the work structures and the intense way that modern life provides, as individuals age, they will live with one or more chronic diseases, since the absence of disease is a prerogative for few. From the twentieth century onwards, we have seen technological advancement combined with medicine, transform deadly diseases into chronic ones and promote the longevity of patients. Such patients who have already been diagnosed and labeled "*beyond the possibility of cure*" end up receiving undue care, emphasizing the cure with invasive and high-tech methods that almost always ignore the patient's suffering and do not always take care of the main symptom that in chronic cases is the most terrible: "*pain*" (NATIONAL ACADEMY OF PALLIATIVE CARE, 2012).

According to Gomes; Othero (2016) *apud* Galriça Neto (2010), the longevity of the population is not always synonymous with the quality of life in old age or after the process of illness. The intensity of the struggle to find a cure for diseases and the sophistication of health instruments have led to a culture of denial of death, relegating to the background health interventions that promote a dignified end of life, without the guarantee of a cure; Death began to be denied and seen as a defeat or failure by health professionals. According to ANCP (2012), it does not refer to cultivating a posture averse to technological medicine, but to questioning "*technolatry*" and thinking about the conduct of human beings in the face of mortality, seeking the necessary balance between scientific knowledge and humanism in order to promote dignity to life and the possibility of dying in peace.

According to the WHO (2002), life-threatening diseases, whether acute or chronic, with or without the possibility of reversal or curative treatments, bring the need to look at broad and complex care in which there is interest in the totality of the patient's life with respect to their suffering and that of their families, this type of care was defined as "*Palliative Care*".

Palliative Care (PC) is the approach that aims to promote the quality of life of patients and their families, through the early assessment and control of unpleasant physical, social, emotional, and spiritual symptoms, in the context of diseases that threaten the continuity of life. Care is provided by a multidisciplinary team during the period of diagnosis, illness, finitude and mourning (WHO, *apud* MANUAL OF PALLIATIVE CARE).

The Brazilian Society of Geriatrics and Gerontology – SBGG (2015), in its booklet, brings a brief history of PC, starting in the period from Prehistory to the Roman Era, where ancient civilizations faced life-threatening diseases in a communitarian way and in this sense, the role of the healer was of paramount importance. In the fourth century, a Roman religious doctor named Fabiola founds a shelter for the poor, the sick and pilgrims and calls *it "hospice"*, a word originating from the Latin *"hospes"*, which means to host a guest. From the Middle Ages and the Crusades, with the spread of Christianity, monasteries welcomed the sick and disabled people, in the sixth and seventh centuries, rich women and widows worked in these monasteries as "nurses", in the Crusades sick or tired travelers stayed in these monasteries and many stayed there until the last days of life. During the Protestant Reformation, many monasteries were extinguished and between the seventeenth and nineteenth centuries Charitable Institutions emerged in Europe, which sheltered the poor, orphans and the sick, starting to have the characteristics of Hospitals. Then, in 1842, the term *"hospice"* was applied for the first time in an institution that cared for people with terminal characteristics. In 1897 to 1905, the Irish Sisters of Charity is one of the first organizations to care for terminally ill patients. In 1897 Our Lady's Hospice was founded in Dublin and in 1905 St. Joseph's Hospice in London.

In 1948 Cicely Saunders, a nurse and social worker in London after caring for a terminal cancer patient, is motivated to study medicine, then in 1967, after years of work and study at St. Joseph's Hospice, Cicely Saunders founds St. Christopher's Hospice in London, and becomes the pioneer of the *"modern hospice movement"*. From there, in 1974, Florence Wald founded the first *hospice* in the United States of America in Brandford, Connecticut. In Canada, Dr. Balfour Mount, opens a *hospice* at McGill University in Montreal. In 1975, the Royal Victoria Hospital (Montreal, Canada) opened a terminal care unit that soon after became known as the "PC Unit". Soon after, in 1977, the San Diego Hospice (California, USA) was founded. From 1982 to 1983, the Medicare Hospice Benefit legislation was regulated in the USA. In the 1990s, the definitions *"hospice"* and *"Palliative Care"* evolved to designate the same concept that aims to reduce suffering and improve quality of life in terminal patients (SBGG, 2015).

In Brazil, Professor Marco Túlio de Assis Figueiredo begins the first palliative care at the Paulista School of Medicine of UNIFESP. In 1996, the National Cancer Institute (INCA) inaugurated the Oncological Therapeutic Support Center and later became a PC unit in Rio de Janeiro. In 1997, the Brazilian Association of PC was founded and the first PC course was created at USP. The year 1998 is marked by the First Congress and National Forum of PC, in 1999 the First event of the INCA of Pain and Oncology PC took place and in 2000, the Hospital of the State Public Servant of São Paulo begins to apply PC in home care. From 2002 onwards, the SUS included PC in Oncology and in 2004 the SBGG created the Permanent PC Commission and initiatives and interest groups on the subject emerged throughout the country.

The year 2005 was marked by the foundation of the National Academy of PC and in the following year the Federal Council of Medicine created the "Technical Chamber on Terminality of Life and PC" and the Ministry of Health the "Technical Chamber of PC Assistance". For 2009, the Federal Council of Medicine includes PC as a fundamental principle in the Code of Medical Ethics. In 2011, the Brazilian Medical Association adopts Palliative Medicine in the medical specialties of Pediatrics, Family Medicine, Internal Medicine, Anesthesiology, Oncology and Geriatrics, the following year the CFM launches Resolution No. 1995/2012 on Advance Directives of Will. In 2014, AMB included palliative medicine in the medical specialties of Intensive Care Medicine and Head and Neck Surgery (SBGG, 2015).

According to SBGG (2015), PC is a philosophy of care and refers to the use of techniques to care for patients with advanced diseases intensively, considering the finiteness of this patient's life, such care is also extended to their family members and caregivers, its applicability is indicated during the last stage of the patient's life, starting from the moment it is diagnosed in a state of progressive and immutable decline until death.

According to the definition of the WHO (2002), the application of PC offers the patient relief from pain and all the excruciating prognosis, guarantees the quality of life considering that death is a natural process in which everyone will culminate, not anticipating or delaying its threshold, comprises the psychological and spiritual facts in the care of the individual who is in PC, as well as allowing this individual to live as effectively as possible until his death, on the other hand, with the performance of the multiprofessional team in dedication to the patient and the family, it favors them to have a support network, where they can obtain counseling and support to deal with the adversities of the disease and all the problems that arise in this context, therefore; CP is opportune early in the course of the disease combined with other therapies, such as chemotherapy or radiotherapy.

According to Campos *et al* (2019), the patient selectable for PC has an active, progressive and life-threatening disease, and may not be restricted to patients in the terminal phase, as PC is also indicated for chronic, evolutionary and progressive diseases in different stages, considering only changes in the breadth of care and intervention, consistent with the phase of the disease and its natural process.

PC helps patients and family members to face physical, psychological, social, spiritual and practical issues, dealing with their fears, expectations, needs and hopes, with this resource they prepare for self-determination in the process of dying and the end of life (SBGG, 2015).

According to the ANCP (2012), in order to guide PC, it is necessary to know and identify some principles, such as starting as soon as possible the follow-up in PC combined with treatments that can provide a change in the disease, including all essential research to improve the management of the symptomatic condition, reinforcing the importance of life by not anticipating or postponing the natural process that takes place until its end, always enable irrefutable relief of pain and any symptoms that cause discomfort to the patient, envision the patient in all his biopsychosocial and spiritual context, in view of this the importance of the multidisciplinary team that can provide support to the individual improving his quality of life, making this individual able to remain as active as possible until his death, involve the patient's family members and/or caregivers as an integral part of the process, providing proper reception and support during the illness until the grieving process.

According to the SBGG, the premise of PC is to promote the relief of existing symptoms in order to prevent the occurrence of other problems, aims to give rise to relevant and considerable experiments regarding personal and spiritual development, it is convenient for all patients diagnosed incurable with a disease that will progress to the end of life, applicable to any age and at any time of the disease (SBGG, 2015).

In view of this difficult scenario, PC appears as a progressive form of health care and has been gaining ground in the last decade, differentiating itself from curative medicine and focusing on comprehensive care, acting to control symptoms, alleviating pain and suffering in such a way that the patient has a humanized treatment and, consequently, the family and/or caregivers (ANCP, 2012). For Nunes (2017) *apud* Basílio (2013); due to the urgency of humanization and respect in integrative care in medicine, the palliative process arises with the objective of relieving the pain and suffering of terminally ill patients, persistent vegetative states or diagnosed with chronic diseases.

In PC, the following are involved: care for the dying human being and care for the family with condescension and empathy, incessantly seeking to relieve the main stressful symptoms of the patient through practices aimed at the patient and not at his disease, in order to provide him with dignity at the end of life and not the postponement of his suffering, which translates the autonomous participation of the patient in the decisions that compete in the intervention of his disease, in order to provide an end of life with quality by a dynamic of dying without avoidable suffering that are continuously linked to traditional medical practices, therefore, an interdisciplinary team is organized in order to favor the patient and his caregiver/family 24 hours a day, uninterruptedly, extending care in the follow-up to the mourning phase, starting this care, if possible, from the curative treatment (FLORIANI; SCHRAMM, 2008).

In accordance with Floriani; Schramm (2008), the search for the patient's quality of life has been repeated as one of the cornerstones for PC, and there is a large number of studies on the definition of quality of life in end-of-life care, its possible indicators, notably for the patient, caregiver and/or family. PC contradicts the continuous use of technology to maintain life in a patient diagnosed with incurable and progressive disease; Alternately, it is a care practice that does not shorten the patient's life, which offers the patient autonomy to find the best faculty to solve his life, undertaking his decision-making capacity.

The definition of PC appears in the form of care, emerging as a path to question what to do when "there is nothing more to do" for the patient, since the cure no longer has the possibility of happening, signaling the notoriety of physical pain, however, without leaving aside social isolation, psychic and spiritual suffering arising from the disease (MONTEIRO *et al*, 2020 *apud* KOVÁCS, 2003), the patient who is in PC has his dignity rescued in the face of the terminality of life, which is the main objective of palliative care professionals: comfort, welcoming, protection, improving the feeling of security, through an interrelationship between active care and softening care (MONTEIRO *et al*, 2020 *apud* KOVÁCS, 2003).

> PC is a modality of CARING, which aims to improve the quality of life of patients and their families in the face of problems associated with diseases in which a cure is no longer possible with the knowledge currently available, through prevention and relief of suffering, early identification, impeccable evaluation and treatment of pain and other stressful symptoms. PC exist to help the patient and his family to live with the best possible quality of life in all stages of the disease, and not only in the last days, as

> the objective is to treat not only the psychic suffering, but also the psychosocial suffering of both (patient and family), as well as spirituality and the contextualization of life. (BIFULCO; CAPONERO, 2016, p.38-39).

In view of the above, it is important to emphasize the hegemony of communication in PC, the harmonious dialogue between the patient, the family and the health team is a fundamental strategy to create a good interpersonal relationship between the parties. This shelter for the human being who is in a state of suffering makes it possible to share their anguish, minimizing symptoms of anxiety and depression, encouraging the patient's autonomy in this moment of changes and losses. In this way, verbal and non-verbal communication complement each other and provide the identification of the patient's explicit and implicit contents, the knowledge of the disease and the proximity of death can torment an individual who was healthy, causing extreme reactions of suffering to him and his family. Congruent communication is indispensable in the promotion of PC, as it acts directly in the expressive mode of a good connection between the team, the patient and the family, it is a fundamental resource for adequate work in this context of intense pain and suffering (CAMPOS *et al*, 2019).

2.2 THE PERFORMANCE OF THE MULTIPROFESSIONAL TEAM IN PALLIATIVE CARE

Teamwork requires that all members are engaged and know very well what is in their area of knowledge. Considering that the team is made up of professionals from various areas of knowledge, the key to the success of this work is communication. Historically, health teams are seen in a hierarchical way, where different professionals have their work socially recognized. However, the integration of the multiprofessional team in PC is a way of observing the patient in a holistic way and thus analyzing all aspects in the composition of the patient's profile for the elaboration of an individualized and specific therapeutic approach. In this way, the multiprofessional team with its multiple vision and individual perception can do a job in a comprehensive way. (ANCP, 2012). Palliative care, due to being a complex approach that aims to care for patients in PC, needs to have a multidisciplinary team composed of a doctor, nurse, psychologist, social worker, pharmacist, nutritionist, physiotherapist, speech therapist, occupational therapist, dentist and spiritual assistant.

According to the ANCP (2012), the palliative care physician performs clinical diagnoses, as he or she is knowledgeable about the disease, its natural history, the treatments performed, the evolution of the disease that is expected for that patient specifically at that moment, and must have contact with other medical specialties, which have already treated or are still treating the patient, to discuss a specific conduct. It also emphasizes that the doctor is responsible for establishing drug treatments or not, according to the moment of the patient's life, in order to minimize unpleasant symptoms, as well as to alleviate the patient's pain and thus ensure not only the relief of uncomfortable symptoms, but also give dignity to the patient until the end of his existence, avoiding procedures that could increase the patient's suffering.

According to the ANCP (2012), the main task of the physician in the PC team is to coordinate communication between the team, the patient and his family. The family and the patient receive from the physician the diagnosis, the therapeutic proposal and the prognosis of the disease, so it is the responsibility of this professional to communicate between the patient, the family and the team. In this sense, everyone must be aligned and speaking the "same language" so that the patient's Singular Therapeutic Planning (STP) is a joint construction of the entire team, with the patient and family actively participating in this construction, thus achieving congruence between the choices and decisions shared by the patient, the family and the PC team. With this, the objective of caring for the patient in a comprehensive and individualized way is achieved, always focusing on their well-being and quality of life, despite the progress of this patient's illness.

For the ANCP (2012), the nurse is the health professional who performs direct and indirect care for people in all care areas that need nursing actions. According to the Code of Ethics for Nursing Professionals, "nursing is a profession committed to the health and quality of life of the person, family and community". The role of the nurse has a more objective practice of a realistic nature, such as pain control, mastery of the hypodermoclysis technique, dressings of malignant skin lesions, therapeutic communication techniques, spiritual care, zeal for maintaining cleanliness, hygiene, comfort measures, management of the nursing team and work with families and communication with the multiprofessional team, Finally, the nurse's role in the team values effective, open and harmonious communication in the therapeutic context, in order to fulfill the negotiation of care goals agreed between the team, the patient and the family.

The role of the social worker in the PC team is guided by applicability to the patient, family members, social support network and the institution. In this sense, the professional traces the socioeconomic profile with the information that is fundamental in the conduct of the case, with this it is possible to understand the family and the patient in their limits and possibilities, the social worker is trained to carry out this approach and welcome these individuals in their anxieties and problems related to the socioeconomic order, place of residence, income, religion, education, profession and employment status of the patient. Through this information, the social worker outlines adequate parameters about the family's needs that will support the search for alternatives for the patient's care, as well as offer legal, bureaucratic and rights information and guidance, essential for the good progress of patient care and for the guarantee of dignified death. (ANCP, 2012).

The Nutritionist in the PC team values assisting the patient in all stages of the disease and in the therapeutic strategy, as nutrition has a preventive role, reducing the adverse effects caused by treatments and resignifying food, helps control symptoms, maintains satisfactory hydration and preserves the patient's weight and body mass. With the nutritionist in the multiprofessional PC team, it is guaranteed that the patient has quality of life and a dignified survival, considering that the nutritionist is the professional responsible within the team for giving resources and explanation to the patient and his family about the adopted diet and also knows how to respect the patient's will and meet his nutritional needs, in addition, it offers pleasure and comfort, which will contribute to the quality of life of the PC patient. (ANCP, 2012).

According to ANCP (2012), the physiotherapist in the PC team will set up a treatment plan directed to the patient with resources, techniques and specific exercises for each case, with the objective of relieving suffering, relieving pain and other stressful symptoms, thus making the patient more active, improving quality of life, with dignity and comfort. The physiotherapist will design the treatment program according to the patient's degree of dependence and progression.

The speech therapy professional helps in the patient's quality of life, acting to ensure the relief of the symptoms that the disease presents, or symptoms derived from medications, chemotherapy, radiotherapy and immunosuppression. Some diseases impact swallowing disorders (dysphagia), nausea and vomiting, odynophagia, anorexia, dehydration, altered level of consciousness and communication disorders, all these problems are linked to speech therapy. The speech therapist helps the patient to keep swallowing safe and possible orally, by adapting postures, ensuring the proper consistency of the food and together with the Nutrition professional define and offer small amounts several times, maintaining the presentation and size of the dish in order to reduce the feeling of failure around the diet, As the evolution of the disease, when dysphagia intensifies, ensure the patient's diet by establishing an alternative route, nasoenteral tube, gastrostomy or jejunostomy. In addition, it is also up to the professional to seek communication alternatives for patients with decreased level of consciousness, changes in mobility and muscle tone, memory deficit, reduced level of attention, in order to improve the patient-team-family relationship. (ANCP, 2012).

According to the ANCP (2012), in their practice the occupational therapist uses artistic, expressive, manual, leisure, self-care activities, among others, as therapeutic resources. With this, the aim is to establish the connection between the subject and his environment. The occupational therapist works in PC to accompany the patient in order to provide comfort, it is possible to maintain meaningful activities, through resources such as music and reading, but always provide greater welcome and comfort to the patient.

According to ANCP (2012), PC in Dentistry occurs in patients with progressive or advanced diseases with oral cavity involvement, due to the disease or its treatment, therefore, the dental professional will work to improve the quality of life of this patient. Performs dental care that can benefit the patient, through prevention or curative treatment in the control of oral and dental infections.

The presence of a spiritual assistant in the PC team helps to promote pain relief and other stressful symptoms, confirming life and seeing death as a natural process, linking psychosocial and spiritual issues to the care and support of this patient, as well as the family throughout the process of disease evolution and coping with grief. (ANCP, 2012).

> "In order to be able to offer this comprehensive care to the sick and their family, the intervention of the chaplain and his chaplaincy team, also called spiritual assistants, becomes very important. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 2005), noting that patients' spiritual values affected the way they responded to treatment, included an accreditation standard requiring Health Institutions to address patients' spiritual needs" (ANCP, 2012, p.364).

Spirituality is not linked to the sense of Religion, religion can be thought of as associated with religious communities and organizations, Spirituality is experienced as something warmer and more spontaneous, it is linked to love, inspiration, integrality, depth, divinity and mystery, being of a more personal and individual origin of each human being. The individual who relies on "faith in a God", a "Greater" being as his "Creator", will have a greater sense of well-being, belonging, being loved, dignity and peace, sharing a certainty that will be accompanied until the end of life, because he is under the control and care of this "Divine Being" whom he worships and respects, then, consequently, it will accept its designs (ANCP, 2012).

According to Nunes (2017) *apud* Basílio (2013), within medical science there is no precision for the terminal state or for the time of terminality of life in terminal patients, as there are no definitive parameters for patients with no possibility of cure and patients with the possibility of cure. Therefore, there is a rigidity of the medical professional regarding the definition of the diagnosis of PC. The diagnosis of terminality is extremely conflicting for the physician himself and also for the other health professionals of the multidisciplinary team, since in academic training a culture of treatment is developed aiming at the therapeutic cure of the disease and not palliative treatment that seeks only to alleviate pain and provide a quality of life with dignity for the incurable disease (NUNES, 2017 *apud* MENDES *et al*, 2009).

According to Nunes (2017) *apud* Mendes *et al*, (2009) despite the fact that there is no cure for the disease of the terminally diagnosed patient, it is possible to practice various conducts, in the case of the patient and the family, to bring relief from pain, discomfort, suffering, providing the patient with dignity, respect, being assisted in their needs and desires of last resort, thereby; The patient follows his natural path in a calm and serene way until the end of life. The field of action of the multiprofessional team aims to work in an integrated and articulated way between the dynamics of knowledge and practice in order to achieve a certain purpose (PINTO *et al*, 2020 *apud* SBGG, 2015).

In view of the finiteness of life, the team that works in the care of PC patients is expected to be properly prepared to deal with the fears, anguish and especially with all the suffering of the patient and the family, for this more than the scientific and technical knowledge of their specialty is required of the professional, it is also required of this professional to understand their subjectivity, of their ethical, social, cultural and spiritual issues. The team needs to be prepared to welcome the patient and their family members in a humanized way, to achieve this goal the team needs to be aware of the palliative philosophy that values and respects the patient at the end of life as an individual who has rights, considering their principle of autonomy, dignity, privacy and respect, such principles are the foundations of Bioethics (PINTO *et al*, 2020 *apud* SANTANA *et al*, 2009 *apud* CARDOSO *et al*, 2013).

Bioethics, which derives from the Greek words *bios* (life) and *ethike* (ethics), emerged in the mid-1970s in the United States of America and in Europe in 1980, where its epistemological foundations are discussed, but its main concern is to provide quality of life, thus being defined as the science of human survival. Thus, the multidisciplinary team, when making a diagnosis of a patient who is in PC, faces ethical questions, such as, does an individual in the terminal phase of cancer, suffering abominable pain, have the right to ask for curative treatment to be stopped? And should the doctor, in this case, comply with the patient's request? (PORTO; LUSTOSA, 2010).

In this sense, Bioethics, through its concepts, is intended to encompass the well-being of the patient who suffers from an incurable chronic disease, benefiting patient care, not being limited to the sequence of protocols, but to follow the principles of proportionality, reasonableness and objective good faith, which, as a rule, must be presented in all clinical decisions. respecting human rights in whether or not to proceed with invasive treatments that most of the time will only culminate in the prolongation of more suffering for the patient and his family and that in the end are not able to bring a cure (CAMPOS *et al*, 2019).

In line with Monteiro *et al* (2020), the focus of health professionals, since their training, should not be the cure of diseases, but the care of the patient, uniting technology and humanity in care. In its study, it also advises continuing education and advice on the conception of suffering in order to provide means to face difficulties and the elaboration of other behaviors that provide comprehensive and humanized care for patients, family members and the professionals of the team, it also emphasizes that it is the responsibility of the Institution to promote training for the professionals of the multiprofessional team, creating an environment of reflection on the subject, creating strategies for problem solving.

According to Rezende (2014), it is important to include studies that specifically address PC in the training of health professionals, in view of the high demand of patients indicated for this type of care, in order to ensure that these professionals, during graduation, are prepared to face life-threatening diseases and the vicissitude of death.

2.3 THE PALLIATIVE CARE PATIENT AND THE FAMILY

According to Espindola *et al* (2018) the family institution is the first space for the formation, development and socialization of the subjects, in it the individual has the first contacts to acquire cultural, ethical, moral and spiritual values, therefore, the institution of greatest value and personal and social meaning in the individual's life, it is a constitutive source of feelings such as love, satisfaction, well-being and support, but on the other hand, it is also a generator of dissatisfaction, stress and illness. In this sense, the harmonious support of the family generates feelings of belonging, care, esteem and provides emotional resources to deal with the conflicting situations of life. In times of discussion about gender identity, it is considerable to discuss this naturalization of care as a feminine attribution, as the feminine and masculine roles are socio-historical constructions, therefore, "*caring*" cannot be a specific competence of the feminine (ESPINDOLA *et al*, 2018).

The responsibility for caring for a family member who is ill often falls on those who are closest to him, it is not always mediated by feelings of love and affection, sometimes it can be seen as a moral obligation, which can hinder the performance of this function and requires resignification of the relationships between both. It is noted that the definition of care for patients at the end of life is generally attributed to women, namely: wives, mothers, daughters and daughters-in-law. We can observe that this care is incumbent on women due to cultural conceptions that consider the issue as something linked to the feminine (ESPINDOLA *et al*, 2018).

For Delalibera *et al* (2018) in PC the family caregiver can be any relative, partner or friend available to provide care to the patient with an irremediable disease, this relative/caregiver has a role of great importance, as he will monitor the patient in an observational way of symptoms, hygiene care, food, medication administration, in case of patients who are at home they will still have to organize themselves in the chores Domestic.

With the changes arising from the realization of the incurable disease and all the logistics that it will bring to the life of the patient and the family, the entire routine tends to be reorganized in order to provide the patient with the necessary care, whether in the hospital or at home, and it is in the face of this new way of life that a main caregiver will be designated. The main caregiver will be defined as the person who will be responsible for the daily care of the patient, which may come from the family nucleus or when it is not possible to have a caregiver who is assigned to provide care to the patient (LIMA; MACHADO, 2018; *apud* FLORIANI; SCHRAMM, 2008).

Despite the positive points linked to the function of "caring", the care in relation to a patient in terminal treatment is extremely tiring, stressful and poses a threat to the physical and psychological health of this caregiver, such as depression, anxiety, tension, sleep disturbances and reduced quality of life, withdrawal from social life and overload due to the conciliation of patient care and the need for work to maintain sustenance, generating a high burden, all this negatively impacts the caregiver who is prone to developing physical and mental fatigue, lack of social support and stress, with the worsening of the caregiver's quality of life, it is tendentious to reduce their functionality and reduce the ability to provide legitimate care to the terminal patient (DELALIBERA *et al*, 2018).

According to research carried out by Delalibera *et al* (2018) with a sample consisting of family caregivers of patients monitored by the PC Service of Hospital Santa Marcelina de São Paulo, it was concluded that the family caregiver mostly belongs to the female sex, married and the patient's daughter. He dedicates much of his time to patient care and in many cases has stopped working to take care of the patient full-time, as he does not have the help of other family members; Such caregivers have higher levels of anxiety, depression and somatization. Therefore, providing the caregiver with the development of a support network, with social and psychological resources, is decisive in the success of the caregiver's performance, as caregivers who did not have support in the care provision phase, after the death of the loved one may manifest psychopathological symptoms (DELALIBERA *et al*, 2018).

According to ANCP (2012), diseases diagnosed as incurable in the advanced stage have a lot of impact on the life of the patient and everyone around him, it changes the family structure and dynamics, especially when there is an overload of this family in the care of the patient, due to the intensification of symptoms and the advancement of the disease. In this sense, the caregiver presents physical and emotional exhaustion, with changes in the objective burden of care itself and subjective that affect their psychic and emotional state, all of which impacts the quality of life of the entire family that is involved in the care of this patient and can also impact the patient himself when aware and perceptive of the physical and mental state of his caregiver and those around him, considering their level of dependence on their caregiver.

> "According to the PC Manual, in a cross-sectional study carried out with patients hospitalized with breast or gynecological cancer with no possibility of cure, situations of depression and anxiety in their care were evaluated. The study applied the Hospital Anxiety and Depression Scale (HAD), a validated instrument that has good sensitivity, despite its low specificity, for patients with chronic pain. The results showed the presence of depression in 74% and anxiety in 53% of the caregivers. It concludes that the process of caring for an individual in the terminal phase generates intense emotional conflicts and suggests that other variables associated with the mental impact of caring need to be investigated" (ANCP; 2012, p.379).

Throughout the evolution of the disease, the family, more specifically the patient's caregiver, is impacted, especially when the patient's symptoms and the degree of dependence increase, requiring greater attention, dedication and care from the family, characterizing the lack of time for rest or other social activities, aspects related to social isolation and, consequently, the depression of these caregivers (ANCP, 2012).

Consonant, Nunes (2017) *apud* Mendes *et al* (2009), the family's attitudes help the patient's reactions, due to this, the family plays an important effective role both in the greater or lesser illness of the patient and in the improvement of the clinical condition. In view of this, the multidisciplinary team must assist the family from the confirmation of the patient's terminality to the grieving process, which goes through death until later months. Empathetic listening to the family member is the most relevant way that can be offered, enabling them to share and face their feelings so that they have the necessary support for the reception and care of this patient.

The participation of the family is relevant, because an individual, when receiving the diagnosis of the impossibility of curing his disease, suffers the consequence and it is always painful for both parties, in view of this; the reactions of each family tend to be different, such as denial, reservation or even closure to the conversation about the subject. In this sense, family members tend to resort to all possible treatments in order to obtain a cure, subjecting the patient to unreasonable suffering and sometimes in disobedience to the patient's will, due to excessive attachment to the life of the individual, who at this moment only needs to be understood and respected in his entire psychic sphere, without prolonging his existence. but to provide him with a life with quality and well-being until the moment of his departure (FERREIRA *et al*, 2008).

According to Ferreira *et al* (2008), the patient under PC at home mobilizes the entire family group and changes the entire routine of these people, being the focus of attention and care, while the chosen caregiver has to abstain from some routines in his life to dedicate himself exclusively to the patient, with this the family dynamics is changed to adapt this care, Creating new ways of organization and functioning, on the other hand, this change to provide care to the patient at this critical moment demonstrates to the patient that he is not alone in facing obstacles and also that he can count on a support network of family members who assume roles never played before, with a view to taking care of the patient's needs, improving their quality of life in the remaining time.

In this sense, in line with what Ferreira *et al* (2008) says, the family is available to a logistics of home PC to meet the patient's desire to remain at home, however, this entails many physical and psychological consequences for the family or caregiver, as care activities bring concerns, insecurities and isolation. In view of this, despite the acknowledgment of family members in keeping the patient at home, the Institutions are still the most suitable places for patients to stay in the last days of life, as they can provide this individual with more present and effective care from the multidisciplinary team, thus reducing the burden of the family environment. Thus, the reorganization of the family cycle in meeting the needs presented by the loved one who is in PC to dispense with a full-time support network in moments of crisis can be observed in companions of hospitalized patients who alternate to always remain a family member by the patient's side full-time (SANGALI *et al*, 2014).

It is confirmed that many family members feel that the care provided to PC patients ends up subjecting them to the exclusive family-patient relationship full-time, preventing the caregiver from being able to take care of themselves, generating a certain level of fatigue and stress that can impact the caregiver's illness, as there are impactful changes in relationships in this context, for example, husbands and wives, who report suffering for no longer identifying their partners due to bodily and especially personality changes arising according to the progress of the disease and the increase in the level of dependence in relation to the care that needs to be provided to the patient (ESPINDOLA *et al*, 2018).

On the other hand, Lima; Machado (2018) through an exploratory qualitative research found that the bond between caregivers and the patient is a generator of stress that leads to physical and mental exhaustion, thus impacting their quality of life, however, as the moment of farewell approaches, the caregiver tends to feel more anguished, sad and anxious, however, Despite all the physical and emotional fatigue, he wants to stay by the patient's side until the end, in this study it was also proven that it is important for the family member/main caregiver the memories lived from the past, as they gave meaning to the patient's life until his last moment, with this psychic scheme the caregiver discovered meaning for his life history when submitted to the patient's care.

For Sangali *et al* (2014), the importance of the participation of the family member/caregiver in the routine of the patient in PC is a reference of the patient's attitude and feelings, because for the patient to be next to a family member in these moments translates a contentment in personal fulfillment, as demonstrated by the reports of family members participating in a research carried out by Sangali *et al* (2014, p.78) in a PC unit of a SUS General Hospital, in the northwest region of the State of São Paulo: *"It is important to have someone with him here". "When we talk, she gets emotional." "She doesn't speak, but her unconscious knows I'm here." "He is happy, when someone arrives he transmits joy." "She feels good having one of us here talking about her grandchildren, her children."*

According to Sangali *et al* (2014), such reports show that there is a mixture of joy and sadness that result from the immediacy of the loss of a loved one and that this interaction provides unique experiences, so from the moment of information about the patient's terminal situation to the last moments of the patient's life, both are allowed to share experiences, confidences and emotions.

As the team transmits security, understanding, charisma, attention to the family, it manages to create a bond of good communication, as it disseminates trust, and the family members value the care applied with good humor, efficiency, agility, dedication, affection, attention and empathy. In this sense, the family, in addition to facilitating the team's care for the patient, helps to decipher the tastes, manias and expressions of patients who have difficulty in verbal communication, such information is essential for the planning of multiprofessional care for the patient (SANGALI *et al*, 2014).

According to Sangali *et al* (2014), the team responsible for PC makes all the difference in the care of the patient and family/caregiver, because with the quality of care for both, it is possible to help cope with fear, anguish, anxiety and the feeling of loss in the face of the proximity of the death of the loved one, the humanized and empathetic dialogue of the team will bring confidence to the patient and the family. The results arising from this alliance between patient, family and team will impact the solution of problems resulting from the advancement of the disease and treatment. In this sense, Sangali *et al* (2014) identify the principle of humanization in care that is very important in PC, as this way it is possible to have a refined and sensitive look at the importance *of "caring"* instead of *"curing"*, achieving the quality of life recommended for patients in PC.

In their research, Sangali *et al* (2014) showed that family members understand the meaning of PC, but also hope to increase the patient's life expectancy, aiming for the patient to be better treated inside the hospital than at home, placing their hopes in divine help and in the health team, also demonstrating the difficulties that family members face in accompanying the patient, not having enough time for themselves, in addition to fatigue and homesickness, with the multidisciplinary team being the main full-time supporter of the family member in the process of disease progression and proximity to death.

In line with Nunes (2017), an ideal agreement between doctor and patient helps both sides to cope with the terminality of life, because from the moment of knowledge of the diagnosis of a disease with no cure, the patient intends to put his life in order, he wants to get closer to the family members, in order to reapproach, undo conflicts and misunderstandings, because in the face of the end, the patient wants to establish a good image of himself and the team within the family can help you in this purpose.

Based on this assumption, conditions should be provided to the patient so that he can freely talk about his emotions, fears and doubts, enabling its resolution and elaboration. The "conspiracy of silence" should also be avoided, it is known that death is near and talking about it is essential for the patient to express his feelings, thus obtaining peace, relief and quality of life in the dying process (GOMES, 2010). Health professionals are trained to save lives and many try to do so at all costs. They use all the technological resources at their disposal in order to try to overcome death, which is seen as an enemy. But they know that it is a fight in which they will not be able to win, because death is an evident certainty and a natural fact that does not depend on their best efforts. However, assuming that in some situations there is nothing that can be done for the patient generates an erroneous image of the professional, suggesting that he does not care about the patient. The coping mechanisms developed by patients in the face of difficult situations experienced throughout life should be stimulated, aiming to maintain self-esteem and emotional stability (MENDES *et al*, 2009).

The communication of the multidisciplinary team with the caregiver, evidencing the approach of death, stimulates the process of psychic elaboration, contributing to the demonstration of feelings and preparation for the experience of the last moments with the patient, with communication about the threat of the patient's death, it is possible that the caregiver can forgive and ask for forgiveness, resolving conflicting situations or even offering the possibility of fulfilling some desire and also when the caregiver is listened to, supported and welcomed in his suffering, this will contribute to the way he will elaborate the proximity of the loved one's outcome (LIMA; MACHADO, 2018).

Another important point is the caregivers' renunciation of their desires and anxieties during the end-of-life period of their family members, which ends up wearing out this caregiver even more. In this sense, diseases that threaten the continuity of life cause intense emotional and psychic suffering to those involved, and the presence of psychologists in PC teams is therefore of paramount importance. (ESPINDOLA *et al*, 2018).

2.4 PSYCHOLOGY AS THE PROTAGONIST OF THIS SCENARIO

According to the Federal Council of Psychology, Resolution No. 02/2001 (2001, p.13), the hospital psychologist works in Health Institutions participating in the provision of secondary or tertiary health care services [...], attends to patients, family members and/or guardians of the patient, a member of the community within their area of expertise, members of the multiprofessional and eventually administrative team, aiming at the physical and emotional well-being of the patient. The psychologist works in the multidisciplinary team, participating in decisions inherent to the conduct to be adopted in relation to the patient, with the purpose of providing support and security to the patient and the family, subsidizing them with information according to their area of knowledge, promoting reflections on the operational and subjective difficulties of the team members. (CFP, 2001).

Within the multiprofessional PC team, the psychologist, due to the knowledge of the essence of the human being, in a biopsychosocial view, acts by assisting the family, the patient and the team, because in this care dynamic situations of prolonged stress, living with pain, suffering and impotence in the face of the finitude of life are involved. According to Cicely Saunders, who developed the notion of "total pain" in the 1960s, she admits that emotional, social and spiritual factors directly implicate the symptomatology of pain and the Psychology professional helps the patient in these aspects so that the patient develops his self-knowledge to deal with the issues that originate from the disease with an incurable diagnosis.

According to Rezende *et al* (2014), Psychology applied in PC facilitates the patient's understanding of his current perception of life, comforting him in his anguish and softening his emotional pain, respecting his new limitations and helping him to understand and accept the finitude of life, so that through the psychologist it is possible at this stage of life to promote good communication and acceptance of the death process for those involved, as well as bringing quality of life and dignity to the patient who is suffering.

The Psychology professional within the PC team needs to be aware of the possibilities and limits of their performance. This knowledge must be based on a theoretical framework of Psychoanalysis, Phenomenology, Analytical Psychology, Social Psychology, Behavior Analysis, etc., because it is through theory and practice that the identity of the psychologist within the team is defined. (ANCP, 2012).

For Melo *et al* (2013), the presence of a professional psychologist in the PC team supports questions and challenges that must be solved creatively, basing their work on the theoretical framework they have, because in the struggle for life, terminal patients need skills that help them in the sense of acceptance of life as it is presented to them, after the realization that there is no curative way for their disease, Therefore, the psychologist will provide the patient with the possibility of having his internal difficulties understood and, as much as possible, elaborated and overcome. Thus, Melo *et al* (2013) *apud* Comas, Schröder and Villaba (2003) in their study suggest some interventions that can be developed by the psychologist; such as the evaluation and diagnosis of the patient, followed by an evaluation of the family environment of this patient, especially in relation to the caregiver who will have a closer bond, communication with the team should also be observed when it comes to the diagnosis and the therapeutic plan planned for the patient. monitoring the patient's evolution; soon after developing the patient's coping skills, as well as the elaboration of information on the diagnosis of incurable disease, in order to develop ways for the patient to cooperate with his treatment to achieve the objectives established by the team to improve the quality of life, in order to perform the socio-family approximation.

In the psychological assessment, direct and close contact with the multiprofessional team is considered, as this reciprocal exchange allows the psychologist to obtain the necessary information and data from the patient and the family under all the technical scenarios involved in the PC, he also argues that the use of psychosocial assessment instruments, which weigh risk factors and behaviors that are indicators of emotional impact, Contributing to the differentiation between patients who need a more specific psychological intervention, and those who do not, with the application of evaluative questionnaires it is also possible to identify possible psychopathological disorders in order to favor the clinical diagnosis. In accordance with the author's recommendations, the semi-structured interview is suggested as an evaluation instrument that can lead to an open dialogue between the psychological and the patient in order to obtain the information expressed verbally about the disease itself and the interaction with the health team (MELO *et al*, 2013).

> Melo (2012, p.43) *apud* Alves *et al*, (2019, p.10), cites in their study the "Activities of the Psychology professional for intervention in PC", in order to guide the practice of Psychology professionals in PC:
>
> - To alleviate the patient's suffering until his death;
> - Improve the patient's quality of life, both in the hospital and at home when possible;
> - Provide full assistance to the patient's family;
> - Work on the emotional pain of patients and families;
> - Provide the search for their autonomy to obtain the patient's dignity;
> - Meet the patient's wishes, when possible;
> - Understand the patient's history;
> - Develop psychological support for the patient's well-being;
> - Perform activities in a multidisciplinary team;
> - Seek to sensitize the health team that is in direct contact with the patient outside the therapeutic reach;
> - Do psychological listening;
> - Use clarification techniques;
> - Be the link between patient/family and the health team;
> - Seek to work on the processes of dying, from conceptualization, to improve care for patients with life-threatening diseases;
> - In case of death, accompany the doctor in the act of communicating it and assist family members;
> - Work on spiritual issues, when brought up by the patient;
> - Do personal work to obtain a humanized practice;
> - Seek continuous training on PC with specializations and training, to keep up with the evolution of science.

According to Rezende *et al* (2014) *apud* Torres (1999), the psychologist, due to his origin in dealing with human relations, is committed to offering conditions for the elaboration of suffering with understanding, respect and dignity, he also emphasizes that the therapeutic bond is of paramount importance. The psychologist works from the diagnosis phase, demystifying the disease and helping the patient to communicate with the team, helping to break the silence when it is blocked by family members so that the patient does not have all the information about his disease during treatment, where the patient seeks to understand the meaning of all the suffering he is experiencing. Therefore, the psychologist provides support, acceptance and understanding, makes the opinions and decisions of the patient and the family count, so that the individual's condition as a human being is respected, considering his life history up to the present moment, so that his autonomy in assistance and care interventions is considered.

On the other hand, the professionals who work in the PC team also need to be assisted by a psychologist, as they are not developed in their professions to deal with the terminality of life and when faced with terminal patients they tend to feel imposing. According to Rezende *et al* (2014) *apud* Rodrigues *et al* (2005), due to the increase in chronic degenerative, disabling and fatal diseases, the health team gets sick when they have to face these demands that most of the time are not prepared, because all their training is to deal with curative treatments that aim at the clinical improvement of the patient, however, clinical improvement will not always mean the cure of the disease, which in the case of PC has repercussions on the quality of life, without pain and discomfort that are stressors for patients with incurable diseases and also on the dignity of having their wishes and desires respected in the most delicate moment of their existence.

In assisting the patient's family, the psychologist is essential, as he or she monitors all the suffering of the loved one, from diagnosis to the end of life, so it is natural to have feelings of guilt for the patient's condition and for the technical inability to help. In attentive listening to the family and their pain, the psychologist points out the ways that the family can show its affection, attention and care, clarifying the possibilities of support that the family/caregiver can offer to this loved one until the end of life, being a facilitator of this communication (REZENDE *et al*, 2014).

The patient in PC, in view of the disease that is presented to him, may present feelings of anger, fury, anguish against the family, against the health professionals, such expressions of feeling need to be understood and welcomed by the multidisciplinary team and especially by the psychologist, considering this new dynamic that the patient and the family need to adapt to (REIGADA *et al*, 2014 *apud* KÜBLER-ROSS, 1969).

The ANCP (2012) mentions that in some circumstances the psychologist is asked to intervene in situations where the patient and/or family are aggressive, do not follow the recommendations made, circumvent the rules of the services, accuse, blame, deny the seriousness of the patient's health condition, among other demands. The psychologist plays the role of the mediating professional, acting in the mediation of these conflicts, making the individuals involved in the dispute to review their concepts in the face of the situation presented, in order to seek a point of balance when facing certain situations that require a comprehensive look to seek the best solution common to all. According to Nunes (2017), the Psychology professional when working in PC needs to have training aimed at this purpose, as he will develop care, clinical listening and support to the patient, the family and even at times the team; Remembering that in all this dynamic, issues related to the terminality of life are involved and to a certain degree will impact the structure of the individual and his entire family.

In accordance with Ferreira *et al* (2011), when constituting the PC team, the Psychology professional needs training in the area to seek strategies that can help the patient in coping with and elaborating the intense emotional experiences that he will experience at the end of life, having the finesse of not becoming an invasive element in the treatment process, but a mitigating element to interact in the process between patients, family and multidisciplinary team, not forgetting that the focus is on the patient, and not on the disease itself, as well as improving the patient's quality of life and not postponing their suffering.

According to Nunes (2017) *apud* Silva (2008) due to changes in the level of consciousness of the terminal patient, visions and confusion between present and past events may occur, the psychologist is the professional who will do clinical listening without judgment or criticism and will help the patient in this dynamic. These manifestations of the patient may represent a ritual that precedes death and not just a simple delirium, it is important not to deprive the patient and the family of this moment, to help both in the elaboration of the issues that emerge from this conflict. Terminal patients may also present anxiety and depression as a result of this new reality that is presented to them, and the Psychology professional will help the patient in the development of coping strategies through psychotherapeutic techniques to manage and minimize these disorders in the face of the finiteness of life. In the end of life, the support of a professional psychologist and a spiritual belief are essential in welcoming the fears and emotions of the patient and family, the psychologist by the stimulation he makes in listening and welcoming patients and family members to manifest their feelings, fears, anguish and doubts will contribute to the elaboration of illness and death, in the same way, it will also help the patient with spiritual issues, as it is the professional who understands the human being also in this circumstance (NUNES, 2017).

In this sense, Soares (2007) explains that spirituality is intrinsic to the human being, as it allows individuals to seek a meaning, a meaning for life, in the processes of illness that overcome death, and the need for spiritual comfort is remarkable. According to Soares (2007) *apud* Wall *et al* (2007) in a study carried out with family members of terminal patients in the ICU, it was found that the degree of satisfaction with the general care of patients was correlated with satisfaction with spiritual care, the presence of a religious person, made available by the hospital's chaplaincy service, or even indicated by the family, was the main factor pointed out among the aspects evaluated in the study.

It is worth remembering that PC is not limited to the care provided to the individual at the end of life, but also to the family/caregiver and the health team of this individual who needs attention and support in their anguish and suffering in order to maintain balance in the face of the situation they are facing with the palliative patient. Considering that the PC team is always in very close contact with human suffering at the end of life and this implies emotional exhaustion for these professionals, generating the need for a space of care and attention to their own difficulties, psychological intervention is also necessary in the care of the professionals who are part of the PC team (ANCP, 2012).

For Rezende (2014) *apud* Ribeiro (2008) it is necessary to deal with the difficulties of individuals in general, therefore, death can be worked on and improved always aiming at a better quality of life for all participants in this demand. It is worth noting that the Psychology professional who is part of the PC team also needs psychological support, because like other health professionals, they need a space to express their feelings and emotions, venting their suffering in order to obtain better requirements to carry out their work with the patient, the family and the multiprofessional team. According to Rezende *et al* (2014), the role of the psychologist in PC is essential, as it mitigates the psychic and existential suffering of the participants in this scenario, deals with the improvement in the psychosocial quality of life of all those involved in the process, as well as in the acceptance and elaboration of grief.

Conform to Port; Lustosa (2010), the greatest challenge of the psychologist is to welcome the patient and caregivers, allowing them to have a life with the highest possible quality in the face of death, helping both to solve pending issues and express emotions when experiencing the finiteness of the individual's life. Hospital psychology requires a global understanding of the individual and his way of living, being extremely relevant to recover the human being beyond his physical biological dimension, placing him in a greater circumstance of understanding his psychic, social and spiritual dimensions. In view of this, the author emphasizes that Psychology is not limited to the patient at the end of life, as it also includes the family and the multiprofessional team; in their performance, they need to identify the best way to promote good communication, in order to obtain a good acceptance of the proposed care (PORTO; LUSTOSA, 2010).

It is up to the professional psychologist to provide care that aims at welcoming in a holistic way to meet their mental, spiritual and social needs (PORTO; LUSTOSA, 2010 *apud* FIGUEIREDO; BIFULCO, 2008). The psychologist has the obligation to understand and comprehend the scope of the complaint, symptom and pathology, by having a global view of the situation, from the perspective of knowing the human therapy, helps those involved in this process, through the emotional contribution to this final phase of life, it is up to him to educate those involved in this scenario of pain, suffering and loss, the best way to resolve pending issues and express their emotions, with patient and respectful listening and observation of words and silences (PORTO; LUSTOSA, 2010 *apud* KOVÁCS, 2008).

Arising from Porto; Lustosa (2010), the psychologist's praxis is situated between two antagonistic limits, on the one hand the certainty of not shortening life and on the other that of not postponing agony, suffering and death, observing that between both is care, bearing this in mind, the participation of this professional in this scenario is the point of balance that uncomplicates the PC process and has as primacy the quality of life in the face of death, always seeking to favor more quality of life in the days that still remain.

In agreement with Ferreira *et al* (2011), in order to deal with the issue of death in a natural way, it requires a therapeutic bond between patient and psychologist based on trust, respect and empathy, because it is in this sense that the acceptance, elaboration and overcoming of the illness will take place, in view of this, it is essential that the psychologist encourages the team and family members to respect the patient's rights and choices, providing clear information about the disease and its evolution, as well as respecting its limits of understanding and emotional tolerance, favoring its competence and autonomy for the choices necessary for its treatment, respecting its will in the finiteness of life and making the others involved in this logic understand and respect the subject's decisions as well. It should be noted that the individual in the face of death needs a support network, in order to solve their doubts, anguish, anxieties, seeking to resignify their own life and give meaning to the experience of death (PORTO; LUSTOSA, 2010).

In accordance with the study by Mendes *et al* (2009) *apud* Kübler-Ross (2005), terminal patients and, after the end of their lives, also the bereaved family, go through 05 stages: denial, anger, bargaining, depression and acceptance. Initially, they react with denial, which is a defense mechanism against anxiety in the face of confrontation with existential intransigence. At the end of life, denial presents itself and can last until the end of life, the permanence in this state will depend on several factors, such as: personality structure, family support, social support, type of culture, age, religiosity, etc. Anger is another form of reflection that is projected in the environment, most of the time for no understandable reason, An example is the attacks of fury that nurses and caregivers are targeted, for the simple fact that they remain longer and closer to the patient in care. These outbursts of anger are usually due to the interruption of existential activities, of constructions begun that will remain unfinished, of dreams that were hoped to come true.

Following the study by Mendes *et al* (2009) *apud* Kübler-Ross (2005), the bargain takes place in the onslaught that the patient makes in search of an agreement, with the purpose of prolonging the inevitable outcome: *"If God decided to take me from this world and did not respond to my appeals full of anger, perhaps it will be more condescending if I appeal calmly"* (KÜBLER-ROSS, 2005, p. 87). In bargaining the individual tries to get a reprieve in view of his good manners, as a rule the bargain is made with God and is usually kept secret, in order to obtain another time of life. Depression appears in a reactive or preparatory way, when expressing his consternation, it becomes easier for the individual to accept the painful process of accepting the situation in which he finds himself. Acceptance is the stage in the sequence, where the human being will not feel depression or anger, since he will have already expressed his feelings, it reveals itself as a pain already dissipated, elaborated, understood, finally accepted (MENDES *et al*, 2009).

In short, the psychologist's work in the PC scenario aims to create a healthy relationship between the terminal patient, the multidisciplinary team and the family, facilitating communication between both in this sphere of care. The performance of the Psychology professional is fundamental, as it seeks in a humanized way to apply their psychotherapeutic knowledge in favor of the human being, who presents himself with the diagnosis of terminality, prioritizing his choices and respecting his subjectivity, respecting his right to suffer and being entitled to have his dignity respected. Support for the health team and family is also in the focus of the psychologist, to always improve the quality of PC work, so that the health team is balanced in this context and supporting families who find themselves in this difficult existential dynamic (MENDES *et al*, 2009).

The Psychologist acts so that the patient and their family members or caregivers are in interaction with the care team, programming and planning the preferable ways to promote the psychic health of all; due to their training, the Psychology professional has a humanized look that excels in a construction environment in the face of the diagnosis of terminality, Having a different point of view from the doctor, as it creates a space where the subject values the way of living well, according to his will, as a unique being, the time he still has left, provides a *setting* for the expression of pain, anguish and suffering, always encouraging the patient to live enhancing his dignity until the end of life. (ALVES *et al*, 2019)

> According to the humanistic psychologist Rogers (1983), the psychologist's function is, therefore, to establish communication between the patient, the family and the health team, facilitating the construction of spaces to listen to everyone, listening to what is not said, metaphors, symbolic language, everything that is between the lines of what is being verbalized. By seeking this practice, the professional transfers the focus of his attention to the individual and not to the disease. Therefore, the psychologist acts as a guide of visions and welcoming of anguish, promoting humanized psychological assistance (PEDREIRA, 2013 *apud* ALVES *et al*, 2019, p.9).

It is pointed out that the work of the Psychology professional in the area of PC in Brazil is quite scarce, there are few professionals specialized in this field of activity, it is necessary to apply greater financial resources and public policies from the Public Power; so that they have more undergraduate courses and specializations to train the Psychology professionals involved in the care of this type of patient. In view of this, the Psychologist is able to offer a singular listening, safeguarding, interpreting and informing the patient, family and health team about the variations in behavior expressed, understanding the silences, strengthening the bonds of connection and support, resignifying the process of illness and death, with a view to the patient's quality of life until the end of his existence (FREITAS *et al*, 2018).

3 JUSTIFICATION

Modern life currently provides humanity with the pleasure of longevity, we note that from the twentieth century onwards advances in the field of Medicine, relying on technological resources, have provided an increase in life expectancy, impacting on the reduction of the mortality rate, despite the increase in life span, we cannot affirm that individuals have an improvement in the quality of life in old age or even after the change in the health status of this individual (GOMES; OTHERO, 2016). Diseases that result in the combination of life, with no possibility of cure, need a perception for broad care, which looks at the totality of the patient's life, aiming to minimize their suffering and that of their families. In this sense, PC offers harmonious and dignified treatment to patients diagnosed as "terminal" or even to patients diagnosed with chronic degenerative diseases that may evolve to a stage with no possibility of cure. PC aims to improve the quality of life of patients and family members, so it is important to reduce symptoms of pain and suffering (HSL; MS, 2020).

The choice of this study was due to the fact that it collects data that show where and how PC emerged through an investigation of the history from the beginning of *hospice* to the present day, the evolution of this type of care to patients with no possibility of cure diagnosed with chronic degenerative diseases that will culminate in the end of life, to investigate the roles of all those involved in this scenario, such as the multiprofessional team and also family members and caregivers, emphasizing and paying special attention to the role of the Psychology professional working in this scenario, since it is the field of science that studies the human being in all its spheres.

The present study will be important to society because it aims to add knowledge regarding PC that are applied in the end of life and to present the possibilities that terminal patients have to have quality of life in the face of a severe and irreversible clinical state, which precedes the proximity of death, minimizing uncomfortable symptoms. demonstrating that it is possible to have a humanized support network through the help of the multiprofessional health team.

In this sense, this study is also important to science because it serves to bring reflection and discussion of the theme to expand the knowledge of health professionals and encourage them to demystify erroneous beliefs in the face of the terminality of life, showing the importance of the work of the multiprofessional team and academic training aimed at understanding the end of life with dignity, without suffering, without discomfort and especially without pain.

The subject is of great relevance to the Braz Cubas University Center, because it is necessary that through scientific studies it is always possible to expand and disseminate academic knowledge, increasing dissemination and fostering academic training aimed at the understanding and applicability of PC in patients who are at the end of life.

Finally, it is important to demonstrate that death is present in the daily lives of health professionals and is a natural process of life, however, these professionals still see it in an adversarial way and in the face of the possibility of death, the professional behaves as an opponent to be defeated. In view of this, in training in the health area, it is necessary to understand death as a natural process and for this it is necessary to deconstruct and demystify this role of death as a frightening event.

4 RESEARCH PROBLEM

What is the relationship between Palliative Care and the psychologist's work at the end of life?

5 HYPOTHESIS

It is believed that there is congruence between Palliative Care at the end of life and the performance of the Psychology professional.

6 OBJECTIVE

6.1 GENERAL

Describe and discuss Palliative Care in the face of a disease that leads to the end of life.

6.2 SPECIFIC

To describe Palliative Care in patients facing the end of life;

Describe the performance of the multidisciplinary team in the treatment of palliative patients;

Describe the family in the reception of the patient;

To describe the participation of the Psychology professional in the interaction between the multiprofessional team, the patient and the family from the perspective of Palliative Care.

7 METHOD

According to Gil (2006, p. 26), the word methodology comes from the Greek *methodos* (meta+hodós) meaning "path to reach an end", therefore, the scientific method is a set of intellectual and technical procedures adopted to achieve knowledge.

For Sousa *et al* (2021), bibliographic research is based on reading, reflecting and writing everything that the author studies and dedicated himself to reconstructing the theory through the theoretical foundations, so it is described through material already prepared by other authors, mainly books and scientific articles.

In this way, when preparing a bibliographic review, a survey and critical analysis of the material already published on the topic that will be researched is carried out in order to provide updating, expansion of knowledge and contribution to new discussions about content (SOUSA *et al*, 2021 *apud* BOCCATO, 2006).

In this circumstance, with the bibliographic review, it is sought to analyze the existing works on the chosen subject to contribute to the delimitation of the theme and the contextualization of the problem through exploratory, selective and critical reading in order to choose, label and argue the research problem and analyze the initial assumptions, with a view to acquiring new knowledge on the researched theme (SOUSA *et al*, 2021).

> Science has as its fundamental objective to reach the veracity of facts. In this sense, it is not distinguished from other forms of knowledge. What makes scientific knowledge, however, distinct from others is that it has as a fundamental characteristic its verifiability. In order for knowledge to be considered scientific, it is necessary to identify the mental and technical operations that enable its verification. Or, in other words, to determine the method that made it possible to arrive at this knowledge. Method can be defined as the way to reach a certain end. And scientific method as the set of intellectual and technical procedures adopted to achieve knowledge. (GIL, 2006, p. 26).

The bibliographic review is defined as the exploratory study of information with the objective of providing the researcher with the search for knowledge for his research problem. With the exposition of the research methodology, it is intended to show the way to discern reality, so the bibliographic review is made to theoretically support the object of study defined by the researcher. (LIMA; MIOTO, 2007).

Based on this contextualization, the procedure adopted for the aforementioned study on PC in the Terminality of Life and the Psychologist's Performance was the survey of bibliographic data, with a view to researching the theme to expand academic knowledge, in order to obtain the necessary training to discuss the theme/chosen to carry out scientific research. Through tools such as Google Scholar, which is a reliable source of academic research that provides the location of articles, theses, dissertations and publications, electronic sites, such as the World Health Organization, Ministry of Health, National Council of Health Secretaries, National Academy of Palliative Care, Federal Council of Psychology, Brazilian Society of Geriatrics and Gerontology and virtual libraries: Scielo, BVS, Pepsic.

Thus, the following terms were used for the search: Palliative Care, Family, Terminal Patient, Multiprofessional Team, Psychology, Aging, Psychologist Performance, Psychological Intervention, publications were collected between the years 2001 and 2021, where approximately 940 works were found, and 34 works that were directly related to the objective of the research theme were selected for the investigation of the present study.

The inclusion criteria included studies that reported on aging, information on PC, quality of life of terminal patients, multiprofessional team and its scope of action in PC, family, caregiver, coping with the terminality of life, psychology, and the psychologist's performance in PC, which were used to carry out the work.

The exclusion criteria were those that showed irrelevant data, such as invasive treatments, invasive therapies, treatments with the purpose of prolonging life and that do not provide quality of life to the patient.

All studies used as a basis for the production of the literature review were read in Portuguese.

8 RESULTS AND DISCUSSION

It is understood that population aging and the preponderance of chronic degenerative diseases of prolonged and incurable treatment generate functional impairment leading to a high level of dependence. (NASRI, 2008). It is observed that the non-illness of the population is a prerogative for few individuals and that with the advancement of technology in the health area, more longevity has been obtained, thus creating a culture of denial of death, it was noticed that there was a prioritization of health interventions, from the mildest to the most invasive, leaving aside the practices that provide comfort to the patient, without guarantee of cure, but with quality, dignity and especially without physical and psychic pain and suffering in the time that he still has left to live. (GOMES; OTHERO, 2016 *apud* GALRIÇA NETO, 2010).

In view of this, it is worth discussing the application of PC in patients who are diagnosed with incurable diseases that will lead them to the end of life. In 2002, the WHO recommended PC for the care of a multidisciplinary team, aiming to improve the quality of life of patients and their families; based on the care of individuals who are facing a disease that threatens the continuity of life, applying techniques for the prevention and relief of suffering and pain, as well as other symptoms arising from the disease, such as physical, social, psychological and spiritual symptoms (ANCP, 2012).

> According to Professor Marco Tullio, PC is "a set of multiprofessional acts that aims to obtain control of the symptoms of the body, mind, spirit and social, which afflict man in his finitude, in the face of diseases that put life at risk" (BIFULCO; CAPONERO, 2016, p.51).

Thus, when describing PC in patients who are facing the end of life, it was found that PC can be introduced with the purpose of mitigating the physical, emotional, and psychological suffering of the patient and also of the family members who are present at this moment in the individual's life, thus seeking the primacy of living without suffering instead of invasive treatments. uncomfortable and that in the end do not effectively cure the disease and, what is worse, only bring more suffering to the patient and the family, perhaps only prolonging life, without advocating for its quality (WHO, 2002).

It is recorded that PC initially emerged from Prehistory, first by the healer, then by the creation of *hospice* for pilgrims and the poor, then passing through monasteries where disabled people, sick and tired travelers were also welcomed, staying until the end of life, with this the term *"hospice"* it began to be assigned to the Institutions that housed these individuals until the end of life. With the evolution of time, the concept of this type of "care" has been expanded and the techniques for treating patients who were facing the finitude of life have been improved, emphasizing more and more the extension of this sphere of treatment that aims to reduce suffering and improve the quality of life of terminal patients, making use of techniques that can be applied from the moment of diagnosis of the progressive and immutable disease to the end of life, and this care is also extended to the patient's family members and caregivers (SBGG, 2015).

It is noteworthy that the individual in chronic, progressive illness when in PC receives the support of the multiprofessional team for themselves and for their family members/caregivers in order to face all issues in the physical, psychological, social and spiritual spheres to deal with their fears and expectations; the multiprofessional team being a channel of humanized care based on good communication, empathy and welcoming of the patient and his caregiver (CAMPOS *et al*, 2019).

In continuity, in PC it is involved to treat the human being in the most delicate and subtle moment of his existence, it is prioritized to alleviate the stressful symptoms in order to provide him with dignity at the end of life and not to delay his martyrdom, priority is given to the practice of care that does not prolong life, but offers the patient the freedom to choose the best ability to resolve his existence, emphasizing his decision-making power over what suits him best. (FLORIANI; SCHRAMM, 2008).

It is pointed out that the main objective of the patient in PC is: comfort, welcoming, protection and safety. Thus, the multidisciplinary team in the treatment of patients listed to receive this type of care needs to develop a harmonious relationship between all those involved: patient, family and the team itself (MONTEIRO *et al,* 2020 *apud* KOVÁCS, 2003).

In view of the dynamics involved in patient care in PC, it is argued that all health professionals who make up the multiprofessional team need to be committed and must have a deep and specialized knowledge within their area of expertise, emphasizing good communication, as the patient needs to be seen by this team in a holistic way, analyzing all aspects to achieve the best therapy that should be applied in all areas of care, therefore, the construction of the Singular Therapeutic Plan (STP) must be planned by all professionals who are part of the team and presented to the patient and family who will also contribute to this construction, in order to obtain uniformity between the patient's choices and decisions regarding the progress of the therapeutic resources involved, which always prioritizes the good being, dignity and quality of life of the patient (ANCP, 2012).

On the other hand, it is noted that it is not possible to accurately specify the terminal state of a patient, therefore, the physician's resistance to determining a patient in palliative treatment is known, the terminal diagnosis brings great conflicts to the physician, as a professional of the team responsible for the evaluation and definition of an adequate prognosis for the patient. (NUNES, 2017 *apud* MENDES *et al,* 2009).

It is observed that the multidisciplinary team specialized in PC needs to be prepared and know how to deal with fears, anguish, doubts and especially with the suffering involved in this instance of the patient's and family's life, in addition to technical and scientific knowledge, it is expected that the professional demonstrates empathy, understanding of the subjectivity of these individuals, in order to provide quality care and the most humanized possible, because he will often enter into issues involving Bioethics, and it is necessary to decide and intervene in matters that are peculiar and may imply the ethics of his area of expertise. (PINTO *et al,* 2020 *apud* SANTANA *et al,* 2009 *apud* CARDOSO *et al,* 2013).

In this sense, the inclusion of studies that address the theme of PC already in the undergraduate course of health professionals will contribute greatly, because throughout their professional journey, when faced with patients eligible for this type of care, these professionals will be better prepared not to be shaken by the terminality of life and when faced with the loss of the patient, not to feel frustration or discouragement, but to face this situation in a natural way, prioritizing comprehensive qualitative care for the patient instead of curing diseases that are incurable (REZENDE, 2014).

It is described that the family is the first institution that the individual joins, the space where his first socialization occurs, his first contact for the formation of his personality, where he learns customs, beliefs and behaviors; in this sense, the family in welcoming the patient can make all the difference so that this subject feels supported in the face of the finitude of life, When the individual is aware that he has an incurable disease, he seeks in the family the encouragement and warmth for his anguish, suffering and support needs to face this situation. (ESPINDOLA *et al* 2018).

Particularly, the closest family members are the ones who are responsible for caring for and assisting this individual in order to observe the symptoms, take care of hygiene, food and administration of medicines; It was evidenced that the care provided to palliative patients is usually too stressful and can affect the physical and mental health of the caregiver due to excessive overload and sometimes due to the lack of social interaction and often due to the need to reconcile these care activities with the work activities of the caregiver himself. Such overload is even greater when the terminal patient is being cared for at home, as household chores are also added (DELALIBERA et al, 2018).

When patients check the attention of a caregiver who is familiar with them, they experience greater comfort and confidence, demonstrating that they are not alone to face the difficulties that the disease provides (FERREIRA *et al* , 2008). On the other hand, the humanized and empathetic care of the multidisciplinary team to the patient and consequently to the family/caregiver is very important in coping with the stressful symptoms that involve coping with the terminal illness for the patient and his caregiver (SANGALI *et al* , 2014).

The Psychology professional, when composing the multiprofessional team, due to the essence of his scientific knowledge, can offer psychic well-being to the patient, the family and the team. Therefore, the psychologist working in PC helps the patient, the family and the team to understand all the dynamics involved in life's ills; fears, anxieties, in order to alleviate these symptoms and bring a congruence to accept the finitude of life, thus improving the environment of all those who are in the process of becoming ill (REZENDE *et al*, 2014).

It is revealed that the psychologist, through the theoretical approaches that support his performance, can support the patient diagnosed with an incurable disease in order to develop the acceptance of his new life condition, providing the patient with the potential to resolve and overcome internal conflicts for a better experience until the end of life (MELO *et al* , 2013).

On the other hand, the psychologist of the multiprofessional PC team also needs to be attended by a Psychology professional who is outside this dynamic, because like all health professionals in their training they have probably not developed skills to deal with losses and when faced with the finitude of life, they feel discouraged and incapacitated, prone to the feeling of failure (REZENDE *et al* 2014 *apud* RODRIGUES *et al* 2005).

It is pointed out that the psychologist is responsible for welcoming the patient and the caregiver, ensuring that the life of both, after knowing the disease with no possibility of cure, has more quality, making them solve problems, conflicts, manifesting the emotions that emerge in the face of the proximity of the end, in this sense, the Psychology professional acts as a kind of "*conflict* mediator”; acting so that there is congruence, respect and harmony among all those involved (Porto; Lustosa, 2010).

Finally, in the PC scenario, it is necessary to create a healthy environment among all, because communication is based on respect for desires and wills, on the preservation of human dignity, subjectivity, empathy and humanization in care; in this logic, the protagonism of the Psychology professional is essential, because in line with their professional training, they are the team member who perceives the human being in all its breadth and has mechanisms to deal with all the issues that emerge from contact with human relations (MENDES *et al*, 2009).

Psychology professionals need to have effective training to deal with issues involving the care processes for patients in PC, unusual knowledge about the systematization of PC is perceived due to the lack of academic training, it is necessary to disseminate greater knowledge regarding the treatment of patients diagnosed with incurable diseases, in addition to the inclusion of this theme in the training of health professionals, It is also necessary to constantly improve this knowledge and encourage these professionals to be multipliers of the palliative dynamics. On the other hand, the strengthening of public policies that are still contemporary and little disseminated to the professionals who are part of the multiprofessional team, it is understood that with the expansion of public policies and the expansion of the theme for discussion in the training of health professionals, the care process will be achieved in a more humanized way and will promote conditions of understanding and coping so that these professionals when they are faced with patients diagnosed with incurable illness have a better psychic support. The approach to the theme of death provides clarification to professionals so that they have the management to deal with the issues involving the therapy of PC with the patient, with the family and with the team involved, demystifying this theme that is presented in such a boring and avoided way. This subject, when debated, studied and made aware, enables preparation for the professional's performance in situations in which he is faced with the terminality of life, showing that this phenomenon is inevitable, it is part of life and the process of dying is not entirely under his responsibility, because despite providing all the necessary care, having done everything possible, the time comes when the patient will leave (ALVES, *et al* 2019).

9 CONCLUSIONS

The application of PC in patients who are facing the impossibility of curing a disease and the glimpse of the terminality of life shows that there is always something to do when there is no longer an expectation of prolonging life. In this sense, the prolongation of life is shown only in postponing the suffering of all those involved in this situation without giving quality of life and dignity to the terminal patient and his family, not exalting the soothing for physical and psychic pain, the comfort and welcome that brings the condition of relief from pain and stressful symptoms, It is precisely at the moment of life when the patient is most fragile and that physical, emotional, mental, psychic and even spiritual well-being should be privileged, since he is under the diagnosis of an incurable disease.

The creation of a support network with social and psychological resources in the family environment is considered so that the main caregiver can have support and support to administer effective care when the patient is at home or even hospitalized, through this support network it is possible to rotate care, so that only one element of the family is not overloaded too much. In this sense, it is evident that the opening of discussion forums about public policies for the implementation of a support network with the availability of a multiprofessional team to establish technical support for the patient and his family member who is in home PC in order to reduce the family overload and provide support, welcome and technical assistance to all those involved, bringing security in having specialized assistance at your fingertips, through periodic clinical observation visits and specific individualized guidance.

On the other hand, the well-oriented, conscious, trained multiprofessional team in the treatment of this type of patient helps the patient and also the family in understanding and accepting this new condition of life and the caregiver together with the patient, when realizing that they have this care network, on the other hand, they provide the team with real and effective care for the terminal patient.

Due to the specificity of the terminal patient, it is necessary to listen harmoniously, to welcoming, and even when necessary to sustain silence, in this sense, the psychologist is the professional within the team who, due to his training, is better prepared to deal with such situations in order to welcome and accompany the patient, the family/caregiver and, when necessary, the members of the team itself, respecting the moment of each circumstance, acting as a conflict mediator, appeasing misunderstandings, facilitating communication in order to balance and especially support everyone in the elaboration of this experience in the best possible way.

In reality, all of us human beings have not developed the coping skills to deal with losses. We are prepared to live life, but we are not prepared to face losses in any sphere of life, whether professional, love, financial. Based on this premise, there is a denial of death on the part of health professionals in their training, as they do not receive an anthropological education, but a technical-scientific one, making the denial of death more present in the routine of these professionals, so humanized care, aimed at improving the quality of life, comfort and well-being of the patient ends up not being prioritized, because it enters into antagonism with assistance that aims only at healing at any cost.

In this sense, it is important to include specific material for PC in the graduation of all courses focused on Health, and it is evidenced here that special emphasis and greater depth should be given to the theme of PC for Psychology professionals, due to the specificity of the training of this field of knowledge, which is focused on the attention and care of human beings in all their biopsychosocial and spiritual context, applying an education aimed at dealing with the loss of the patient, prioritizing humanized care, always seeking the balance between *Curative Care* and *Palliative Care*, being aware that the most important thing is attention, respect, bioethics and empathy in welcoming, especially in cases where it is no longer possible to obtain it.

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