The aim of this study was to find out what medical professionals from a pre-hospital care service understand about the end of life and the non-resuscitation of chronic patients at the end of life. This was an exploratory qualitative case study, using semi-structured and open questions interviews. There were 33 doctors who demonstrated a biological understanding of death; they understood not intervening as futile and without benefit to the patient; they listed the patient’s family as a complicating element in decision-making; and recognized respect for the patient’s autonomy regarding their end-of-life decision. We conclude that the doctors facing the patient at the end of life respect the patient’s autonomy and try to do their best to minimize his suffering, even if exposed to pressure from the patient’s family to take a different course of action than the patient would like and what is necessary for the occasion of service.

Keywords: Death; Cardiopulmonary Resuscitation; Personal Autonomy; Bioethics.
RESUMO

Buscou-se saber qual o entendimento do profissional médico de um serviço de atendimento pré-hospitalar sobre a terminalidade da vida e a não reanimação de pacientes crônicos em final de vida. Tratou-se de estudo qualitativo exploratório, do tipo Estudo de Caso, por meio de Entrevistas Semiestruturadas e Abertas. Foram 33 médicos que demonstraram um entendimento biológico da morte; entendem o não intervir de forma fútil e sem benefício para o paciente; elencaram a família do paciente como elemento complicador frente à tomada de decisão; e reconheceram o respeitar a autonomia do paciente quanto a sua decisão de final de vida. Concluímos que o médico frente ao paciente em final de vida respeita a autonomia do paciente e procura fazer o melhor para minimizar o seu sofrer, ainda que exposto a pressão da família para tomar conduta diversa do que o paciente gostaria e do que se faz necessário por ocasião do atendimento.

Palavra-chave: Morte; Reanimação Cardiopulmonar; Autonomia Pessoal; Bioética.
INTRODUCTION

Although it is an important subject that concerns everyone, discussing one's own end or death is not one of the most popular topics, even though it is an inherent condition of a living being and therefore inevitable, the approach to such a relevant subject is always left for later on (Nogueira et al., 2006). The process that puts an end to a person's life begins with a pathological condition that leads to an illness, becoming ill is the indelible mark of finitude, a mark that not only affects the person, but also an entire community (Schramm, 2012). Dying is an uncomfortable fact, affecting everyone, not only the patient but those who assist him, not only the family but the doctors as well (Nogueira et al., 2006).

In a more contemporary condition, people no longer die at home, surrounded by their family and friends, they avoid accompanying the end of their loved one's life under the most diverse pretexts, and it is easier to send them to a hospital than to witness all that sequence that puts an end to the person and that, for many, is the most unpleasant experience possible. Today, in some places you can already count on a palliation team, but when this support is not available, pre-hospital care services are provided with medical professionals who are most often called upon to deal with end-of-life clinical events.

The professionals from the pre-hospital service, after having been called to assist a person in need of assistance, will define which resource will be dispatched, basic support team or advanced support, depending on the condition that was told over the phone; generally situations involving critically ill or end-of-life patients will be assisted by an advanced support team, made up of a doctor, a nurse and a driver. In addition to the team, the ambulance configured for advanced support has various equipment and medicines that make it possible to keep people in critical condition alive.

It is during the in-person evaluation that the doctor will have a real idea of the situation, both from a clinical point of view and the resources available that he might need to use to provide assistance. Here, when it comes to providing care to a seriously ill or critical patient who is already at the end of his life, another character permeates who may facilitate or hinder this care, this is the family or person responsible for him. This creates a complex scenario that is difficult to resolve for the doctor providing the care.
Therefore, we raised the following research question: what would be the point of view of the medical professional who provides pre-hospital care about the end of life and the non-resuscitation of chronic patients at their end of life? Thus, our general objective is to know the medical professional's perspective of terminality in relation to patients at the end of life in the pre-hospital setting and, as a specific objective, we aimed to identify whether the bioethical principles of non-maleficence and autonomy have been valued; valuing otherness and prudence regarding bioethical references; and valuation of orthothanasia.

METHODS

This was an exploratory study, using a qualitative methodology, with semi-structured and open questions interviews, approved by the Research Ethics Committee (CEP) under identification CAAE: 88387918.0.0000.5011.

In qualitative research the sample size is not based on a numerical strategy, so the researchers planned to interview all 45 doctors from the Mobile Emergency Medical Services, depending on their acceptance and signing of the Informed Consent form.

Individually, the research project and the Free and Informed Consent Form (TCLE) were explained. After signing the aforementioned document, participants were submitted to the questionnaire. The responses were recorded on digital media for later full analysis of the speech. A semi-structured, open questionnaire with four guiding questions was used as a data collection tool. The recordings, after being transcribed, were deleted. To ensure anonymity, the interviews were given an alphanumeric code.

The content analysis was structured in three stages: 1 – Full speech – a floating reading was made of the transcript of each interview and the most relevant points that answered the questions were highlighted, constituting the corpus of the study; 2 – Idiosyncratic Analysis – description of personal aspects of the research participant (intonations, pauses and any other manifestations captured by the audio or described in the researcher's diary); 3 – Nomothetic analysis – grouping of similarities in content observed in the interviewees' speeches, in order to identify the registration and context units, followed by semantic categorization.
There was no statistical treatment of the data, as this is a qualitative study. Only some numerical results were presented for sample characterization using an MS Excel® Software data spreadsheet. The interpretation of qualitative results was based on inference.

RESULTS AND DISCUSSION

Of the intended sample of 45 doctors, two were no longer part of the staff and one was not invited due to a conflict of interest (this is one of the researchers of this study). Of these 42 doctors who were invited, 33 signed the informed consent form and were interviewed and 9 refused to participate in the study and were therefore excluded.

In eight of the 33 interviews there was no recording, which was due to the participant's non-acceptance of having their interview recorded, but there was no negative impact to the collection of data once they had answered all the questions asked and it was possible to take notes while they spoke.

Regarding the analysis of the interviews, it became evident during this phase that some answers became repetitive, thus indicating saturation of the statements in our sample.

Content analysis were carried out based on the following questions presented below:

What do you understand about death?

For this first question, among the doctors who collaborated with the research, a repetition of responses was observed in an inferential analysis related to death at the end of life, at the end of a cycle, which takes place biologically in the absence of vital signs. The terms “end”, “end of a cycle”, “extinction”, “cessation of life and functioning of organs”, “stoppage of life” and “final process of life” were viewed as synonymous responses.

“Death is the final state of life, where all the systems of the human body shut down, they stop and you have no continuity. So taking it to the literary part, death would be the end of a cycle, of the mission in this earthly environment.”

Death raises several approaches and can be defined as the loss of vital fluids, the separation of the soul, the irreversible loss of the body's capacity for integration or the
capacity for consciousness and social integration. The way each community/social group or even an individual understands it always depends on biological, religious, social and cultural factors (Tamada et al., 2017).

According to Brêtas et al. (2006), For many years, the traditional concept of biological death was defined as the instant of cessation of heartbeats, and consequent absence of vital signs. Over time, the concept began to be modified. To Lucena et al. (2014), nowadays, biological death is seen as a process, a phenomenon and no longer as a single and precise moment or an event. Adding, clinically, to the previous concept the irreversible cessation of brain functions, which results in brain death.

The essence of death in the medical-forensic view is the activation of cathepsin, which occurs due to the absence of oxygen, that is, anoxia. The decrease in oxygen determines autolysis, that is, self-digestion and, thus, death. Initially, the cell dies, then the tissue, and then the organ; it is a cascading phenomenon. In this way, breathing, heart, circulation and the brain function stop. And he states that in the transition from life to death, of the organism as a whole, concurrent or successive intermediate stages can be recognized, they are: 1) Apparent death, a transitory state in which functions are "apparently" abolished, simulating death; 2) Relative death, effective and lasting arrest of nervous, respiratory and circulatory functions, but subject to resuscitation; 3) Intermediate death, progressive extinction of biological activities, without it being possible to recover the life of the organism in a unitary way; and 4) Absolute death, corresponds to the disappearance of all biological activity referred to the primitive organism (Santos, 1997).

In Legal Hermeneutics, the concept of death is an open concept, considered as such because its constituent elements are given by medical science, but its interpretation is legal. Law does not define what death is, nor what life is. However, it makes a distinction and analysis based on objects: death, dying and the deceased (Santos, 1997).

Understanding the concept of death from the perspective of philosophy, analyzing from Plato to Heidegger, it is observed that the philosophical tradition is full of theories and teachings about death. Plato and Epicurus had opposing ideas about death, while Plato's theory is based on the world of ideas, Epicurus's was focused on a hedonistic vision. Epicurus conceives the end of life as a process as inevitable as it is natural, described as the simple dissolution of these elementary particles – which will later come
together again, giving rise to other beings. Contrary to what Socrates and Plato believed, he justifies his conviction: "Death is a chimera: because while I exist, it does not exist; and when it exists, I no longer exist" (Epicuro, 2002). Years later, Schopenhauer presents death as the muse of philosophy and even adds Socrates’ speech recognizing philosophy as a preparation for death. Death is then a cure for the ills of life; if life is a mistake, death is the solution. For him, human individuality should not exist and the true end of life is to get rid of it. However, death is a necessity, as it annihilates man's individuality by fulfilling the main condition: ceasing to be what he is (Lobato, 2017). For Nietzsche, man experiences death in two ways, cowardly or voluntarily: "Cowardly death can be defined, in a few words, as the experience of death as a chance, the immediate effect of which is the desire to die. In this case, one wants to die because one dies. The lack of longevity in life is enough to encourage people to abandon it. Those who think like this, Nietzsche would say, are the preachers of death." (Nasser, 2008). Finally, for Heidegger (2013), man is a "being that walks towards death", having elements of conviction in living with this certainty, which leads him to worry and anguish, making him guilty of living.

Yet conceptualizing death, now through religion, Nogueira and Pereira (2006) state that initially it is important to highlight the plurality of beliefs present in global society, manifesting themselves in religious aspects that have different perspectives on death. This plurality is due to the freedom of modern society to choose and follow the religion with which it identifies. Despite this, the common point in all religions is the thought of the end of an earthly cycle that begins new cycles depending on belief: Christians may travel to heaven, Muslims to paradise, members of some variants of Buddhism believe in “the Pure Land of the West”, Afro-brazilian religions’ followers believe in returning to earth with the intention of evolution and Spiritists believe in reincarnation for the evolution of the spirit until they can ascend to the superior world and never return to Earth.

Therefore, during the analysis of the interviews, it was noticeable that there were different ways of facing death for each of the participants, regardless of the time of training, medical specialty or frequency of contact with deaths and terminally ill patients. The biological vision is the one with the highest response saturation rate among the existing visions of death.

And here in pre-hospital care, what is your point of view on death?
The objective of this question was to understand the meaning of death in pre-hospital care, considering the possibility of adoption of measures to avoid the final outcome which would be death prior to the arrival at hospital. It was noted that the meaning of death in the pre-hospital environment did not differ from the vision of death that each research subject expressed during the previous question. It was seen that the majority reported death as the end of the natural cycle of life, marked by the absence of vital signs.

“The same perspective. It's a non-answer of everything you see around you. It is a state of inertia. Dying is being inert, without movement, lifeless skin, muscles that do not contract, eyes that do not or even open, but have no life, the absence of any describable sign of life.”

Death has been delayed by advances in biotechnological resources, the introduction of specific spaces for intensive care and, more recently, the implementation of the Mobile Emergency Care Service. In emergency care, a space to fight for life, it is up to the doctor to avoid or postpone death. However, depending on the severity of the injuries, neither the agility and efficiency of emergency care nor the entire biomedical apparatus are sufficient to avoid this outcome (Aredes et al., 2018).

It was noticed that the meaning of death in the pre-hospital environment did not differ from the view that each research subject expressed during the first question, that is, the biological view of death, which is characterized by the cessation of heartbeats, and consequent absence of vital signs associated with the irreversible cessation of brain functions, resulting in brain death (Brêtas et al., 2006).

Faced with a patient who is in the final condition of his life, in a terminal situation, where he has no additional resource, regarding to healing, that can be carried out to stop his disease, that is, he has no possibility of cure or improvement. Would you intervene with diagnostic or treatment resources for this patient?

The majority of interviewees decided not to intervene, and to guarantee the greatest possible support to the patient, alleviating pain and suffering, but without interfering in the natural course of the disease.
"No. If the person is no longer likely to be cured, you are only increasing the individual's suffering. In medicine when you cannot cure, you must comfort. Provide quality of life for the individual."

According to Almeida and Melo (2019), professional care is represented by cognitive behaviors derived from practices and processes designed to restore or preserve health during life or the dying process. In some contexts, healthcare can be difficult, especially in those involving patients in the end-of-life process, due to the fragility of the individuals involved. Furthermore, professionals who care for these patients have to deal with a society that rejects and fears death and sees the professional through a single objective, which is to save lives. As a consequence, death can be seen by them as a professional failure.

According to the Federal Council of Medicine of Brazil (CFM), from the moment a patient is diagnosed at the end of life, the condition is irreversible and any extra treatment, considered ineffective or futile, should not be carried out, given that it is only a procedure that may harm the patient (Brasil, 2019). At this stage, the principle of non-maleficence assumes a privileged position over the principle of beneficence (Almeida and Melo, 2019).

Thus, orthothanasia respects death in its natural course, without artificially prolonging the end-of-life process and the patient's suffering consists of interrupting the already useless treatment, in view of an irreversible clinical condition, giving up artificial processes. It is also understood as death appropriate to the time, without disproportionate and delaying treatments (dysthanasia) and without shortening the dying process (euthanasia). The aim is to value the wishes of the sick person, treating them in a more humanized way (Almeida and Melo, 2019; Nascimento, 2018).

In the case of patients at the end of life, there is respect for self-determination, free will and the right to choose, aiming to prioritize the patient's freedom and right to have control over their life. There is no abandonment of the patient in this case, forgetfulness, mistreatment, or lack of conduct, there is no need to think about mysthanasia (Anjos, 1989). When orthothanasia is chosen, another form of care emerges as the protagonist. Curative care opens the way to palliative care (Almeida and Melo, 2019). Palliative care aims to improve the quality of life of patients who are suffering
from illnesses that threaten their lives, with procedures that seek to alleviate pain, whether organic, mental, social and/or spiritual (Freire et al., 2018).

Another possibility is the practice of euthanasia as an option. Euthanasia is based on mercy killing, one that spares a person from intense suffering, who is at the end of an illness that has no cure, or in a state of irreversible, permanent coma. It may occur intentionally, deliberately by the patient himself or at his request, or involuntarily, when carried out by another with or without his consent. The action is further classified as active and passive, where in an active way there is the act of causing death, without suffering to the patient, and passively through the absence of a medical action or interruption of an extraordinary measure, followed by the patient's death (Félix et al., 2013). However, all forms of euthanasia are prohibited by CFM, and therefore, if the doctor chooses not to perform a procedure on a patient at the end of life, using passive euthanasia, for example, he will be duly penalized.

In relation to those who prefer not to intervene, the biggest justification in this case is that this type of action, in addition to being useless, would be prolonging the patient's suffering, instead of treating it, it would be postponing suffering, practicing dysthanasia.

The term “therapeutic obstinacy” or dysthanasia is understood as the artificial prolonging of the death process, which causes suffering to the patient, through therapies in which the expected benefit does not compensate for the discomfort generated. The search for life at any cost in patients who are unable to cure, without concern for the patient's quality of life and opinion, constitutes futility (Almeida and Melo, 2019; Lima, 2015).

Despite there being saturation around the concept of not intervening in the face of inevitable death, seeking not to deviate from the need to institute palliative measures, seeking to characterize a dignified end for that individual, there were also interviewees who were in favor of intervention with resources diagnosis or treatment, even recognizing that it is a terminal condition in life.

"Yes. As long as he is alive, I try to avoid death. I am not God, but I would invest and improve the patient’s suffering.”
Those who chose to intervene reaffirmed the value of life and their duty as a doctor to maintain it. These have in their formation and conception that the cure comes from medical interventions, and doctors must follow the sole objective of saving and prolonging life.

However, according to Santos et al. (2013), being certain of death and that there are incurable diseases, demands from the doctor the price of knowing that he cannot do everything in the face of the inexorable certainties of human nature. Death, at this moment, is seen as a defeat, something insurmountable, and could be interpreted as a professional limitation (Santos et al., 2013).

There was also a third option, where the determining factor for the institution or not of therapy would be the situation of each patient, their history and the family's understanding of the patient's situation and the disease. For these professionals, the fact of not previously monitoring the patient and the obligation to make quick decisions, as in the pre-hospital setting, may influence the course of action to be taken.

“There’s no way if you don’t have access to that patient’s medical history, there’s no way to know that he really is defined as terminal, if you’re in the pre-hospital setting.”

Most interviewees observed obedience to the principle of non-maleficence as a way of guaranteeing the patient an end-of-life without greater suffering or the search for miraculous answers, allowing the natural course of the disease that insists on putting an end to the person, knowing that nothing more can be done to reverse the outcome already outlined and defined (Beauchamp and Childress, 2013).

What, for you, makes decision-making more difficult when dealing with a terminally ill patient?

According to the majority of those interviewed, family is the main complicating factor in decision-making regarding the patient at the end of life, whether through simple dialogue, lack of knowledge of the disease and the patient's prognosis, lack of prior contact, longer lasting and well established doctor-patient relationship, which is not possible in pre-hospital setting, or due to the absence of consensus in the family.

“Family pressure is very strong. Dealing with the family in an emergency situation is very complicated, because the family often doesn't understand very well what is happening, they don't accept what is happening and we are left in a situation of extreme
emotional stress. That's why we often opt for resuscitation because of this, even though we know that the patient's prognosis is bad, and even because we are in the pre-hospital environment and decision-making has to be very quick, so it's complicated.”

The patient in critical condition and his family, throughout the illness, experience situations that often lead to a displacement of reality, denial is sought most of the time; the anguish caused by the knowledge of a serious condition leads the patient to a situation of suffering and exclusion that turn poor the interactions with family and doctors (Rodrigues, 2011).

For Reis et al. (2017), family members experience different stages of adaptation, similar to those experienced by patients. At first, they may deny the fact that the disease runs in the family and over time they enter the tunnel of despair and anger, similar to what the patient thinks and goes through.

In the meantime, the participation of family members will influence the patient's condition, and may motivate aspects of refusal or acceptance regarding treatment and the disease itself (Rodrigues, 2011). Since, most of the time, information is only passed on to family members and decisions are made by them, they end up not acting upon a rational analysis of the patient's diagnosis and prognosis, but rather on an emotional basis.

In contrast, some research participants stated that they had no difficulty in taking care of patients at the end of their lives. Serving them is part of the role, even if the treatment is only palliative and aims to alleviate pain and suffering.

“That nothing, because the doctor’s role when a cure is not possible is to alleviate pain, this is something that you cannot deprive the patient of, sedation, analgesia and pain relief. I think concerning a terminal patient this is the doctor’s role.”

Other important factors mentioned and worth discussing concern the safety of the team and legal framework, or the lack of it; also the population's lack of knowledge regarding the end of life and the implementation of a palliative care protocol for management within the scope of pre-hospital, in which each case is assessed, with standard care definitions for these patients.
Dying is the only absolute certainty of life, however, the difficulty of dealing with death is inherent to human beings, since knowing oneself as mortal, and facing the finitude of life as something tangible generates fear, denial, restlessness and frustration. The non-acceptance of a chronic degenerative condition is often something experienced not exclusively by the sufferer, but also by the family. The relationship between the patient and their family members is deeply affected after diagnosis, bringing to the surface emotions that can lead to integrative or disintegrative practices for the family. And they tend to intervene and put pressure on the doctor-patient relationship and turning dialogue about therapies or their termination difficult.

Would you resuscitate a patient who has suffered a cardiac arrest, who is terminally ill, and who had previously told his family that he did not want to be resuscitated, but the family insists that you perform cardiopulmonary resuscitation?

The majority of interviewees reported respecting the patient's advance decision and decided not to resuscitate.

“If I have a minimally favorable situation, I don’t resuscitate. We do not resuscitate, because it would be a futile and useless therapy, there would be no reversal of the condition, the initial situation and, in addition, it would require a financial and even emotional cost. Resuscitation, in addition to being disrespectful to life, is also disrespectful to people.”

Cardiorespiratory arrest is characterized by the mechanical inactivity of the heart and its clinical manifestation is the absence of signs of circulation and breathing. In an attempt to reestablish the patient's spontaneous circulation, it is necessary to perform cardiopulmonary resuscitation (CPR) maneuvers, requiring them to be used rapidly and effectively (Silva et al., 2016).

Not everyone will benefit from CPR, there are patients who, due to the chronic evolution of a serious degenerative disease, at the end of life, being resuscitated after a cardiorespiratory arrest could be characterized as postponing the suffering. In many cases, the patient himself states his refusal to undergo CPR if he suffers the cessation of one or both of his vital organs, such as the heart and lungs (Silva et al., 2016). It is necessary to know how to respect the will of the individual who suffers, it is necessary to consider their autonomy (self-government, self-determination) in terms of their choices regarding
their own life, including not only their health, but their psychological integrity and their social life (Lima et al., 2015).

The Federal Council of Medicine (CFM), through Resolution No. 1995/2012, made an important contribution to protecting and valuing the individual's autonomy, especially in terms of sparing them from futile procedures that would in no way add value to their care, bringing only suffering for those who have already been carrying the burden of a terminal illness for a long time. This resolution gave voice to the patient who is able to pre-define the treatment he wishes to receive or, even, if he doesn’t want receiving any treatment at all. It is an important document and has a direct impact on the doctor who assists the patient and to the patient’s family members (Caricati and Reis, 2019).

It was noted during the analysis of the interviews that there was a significant divergence of opinions. They were divided between those in favor of not resuscitation, those who were in favor of resuscitation and those who purely conditioned their actions on what they found upon arriving at the scene, the risk of aggression or another form of hostility, for themselves and their team.

Those who chose to respect the patient's autonomy in not resuscitating justified that they would not do so because it was a desire stated, because it would not provide beneficial changes in the clinical course of the disease and it would not lead to improvements in quality of life, on the contrary, it would prolong suffering. Even so, many conditioned the action to the existence of legal support, written proof, non-resuscitation order, to protect themselves from any legal sanction, since by not resuscitating the doctor would be susceptible to family accusation of failure to provide assistance. It is important to highlight that at this moment, one must see oneself in the other, complete oneself with the other, understand the one who suffers as a complement of yourself (the doctor), that is, one has at this moment the opportunity to experience alterity, they complete each other: doctor and patient (Hossne and Segre, 2011).

The Do Not Resuscitate order (DNR) is a clear authorization from the patient or, depending on the need, the spouse, partner, representative or family members that states the willing of not undergo CPR in the event of an arrest, considering that patient already is committed of a serious and incurable illness, already in the final stage of life or under irreversible conditions of recovery. It is important to emphasize that obeying DNR order must be considered by the doctor who assists the patient at the end, after a reasonable
understanding of the situation and discussion with the clinical team about the futility of the maneuvers (Eidt et al., 2017).

“Yes, I would do CPR. Nowadays, if you don't do this, you will be seen as negligent or reckless in front of the family who doesn't have the perception that the doctor would have. So to avoid legal proceedings, I would do it. At this point I believe that if you do this resuscitation everyone will be comfortable, even if you don't achieve the desired success.”

In turn, those who decided on resuscitation state that the factors conditioning the decision are the legal implications and the role of a doctor in saving lives. For these interviewees, the verbal factor has little influence on pre-hospital conduct, so the actions taken are based on existing protocols to save lives and documentation that legally proves that what was the patient's desire. If there is no evidence of legal support, these doctors interviewed state that they would follow what the family members propose, resuscitating the patient, and leaving aside the patient's autonomous decision. Despite recognizing the will of others as dominant over the patient, here, one can understand that prudence, caution and reasoning prevailed without causing collateral damage, sparing the family from further suffering and saving themselves (doctors) from a conflict (Hossne, 2008).

**FINAL CONSIDERATIONS**

In short, the doctors we interviewed, most part, are professionals who understand death as the cessation of organic activities, a clear biological view; but not only that, they comprehend that it is useless to intervene in a patient who is at the end of life, that if there is no concrete benefit for him, treatment or examination becomes unnecessary, futile. Doctors are aware of not doing harm, they consider here the non-maleficence principle. They are doctors who take distance from the concept of dysthanasia; who respect the patient's autonomy, even if the doctor is provoked by the family to do otherwise. This doctor elaborates a judgment aiming to attend to the individual who did not want or does not want to continue suffering, he seeks a better end-of-life condition, he moves away from what is no longer useful, he chooses the concept of orthothanasia. Not only that, this doctor respects the other in their will and experiences alterity, fulfilling themselves in their suffering patients, giving value to their other face; demonstrating prudence in recognizing the concern and what to do appropriately and without exaggeration, without disregarding the patient's family.
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