

Article

# Multidisciplinary Perceptions of Palliative Care in the ICU During the COVID-19 Pandemic: A Bioethical Reflection

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## ABSTRACT

The COVID-19 pandemic has imposed unprecedented clinical, ethical, and organizational challenges on healthcare professionals, especially in intensive care units (ICUs). This qualitative and exploratory field study aimed to understand the perception of the multidisciplinary team (physicians, nurses, physical therapists) of a university ICU on the promotion of palliative care during the pandemic, from the perspective of principled bioethics. The results revealed intense physical, emotional, and moral overload, exacerbated by a shortage of resources, lack of protocols, and insufficient training in palliative care, impacting the quality of care and the application of bioethical principles. Communication with family members was identified as a weak point, mediated remotely and lacking in connection. Shared decision-making, although valued, was compromised by practical obstacles. A restricted association of palliative care with terminality was observed, reinforcing stigmas. However, ethical virtues such as compassion and responsibility emerged, sustaining the dignity of patients. The research highlights the urgency of public and institutional policies that systematically integrate palliative care into ICUs, with ethical and technical training, advance planning, and valuing listening.

**Keywords:** palliative care; bioethics; COVID-19; intensive care unit; decision making; health communication.

## RESUMO

A pandemia de COVID-19 impôs desafios clínicos, éticos e organizacionais sem precedentes aos profissionais de saúde, especialmente nas Unidades de Terapia Intensiva (UTIs). Este estudo de campo qualitativo e exploratório objetivou compreender a percepção da equipe multiprofissional (médicos, enfermeiros, fisioterapeutas) de uma UTI universitária sobre a promoção de cuidados paliativos durante a pandemia, sob a ótica da bioética principialista. Os resultados revelaram intensa sobrecarga física, emocional e moral, exacerbada pela escassez de recursos, ausência de protocolos e capacitação insuficientes em cuidados paliativos, impactando a qualidade da assistência e a aplicação dos princípios bioéticos. A comunicação com familiares foi identificada como um ponto frágil, mediada remotamente e carente de vínculo. A tomada de decisão compartilhada, embora valorizada, foi comprometida por entraves práticos. Observou-se uma associação restrita dos cuidados paliativos à terminalidade, reforçando estigmas. Contudo, virtudes éticas como compaixão e responsabilidade emergiram, sustentando a dignidade dos pacientes. A pesquisa destaca a urgência de políticas públicas e institucionais que integrem sistematicamente os cuidados paliativos às UTIs, com formação ética e técnica, planejamento antecipado e valorização da escuta.

**Palavras-chave:** cuidados paliativos; bioética; COVID-19; unidade de terapia intensiva; tomada de decisão; comunicação em saúde.

## Introduction

The experience of working on the front lines during the COVID-19 pandemic has significantly shaped the professional trajectory and understanding of healthcare of the author of this study. In a scenario of profound



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uncertainty, intense suffering, and pressing decisions, the relevance of offering and recognizing palliative care as an intrinsic component of healthcare became indisputable, particularly in critical environments such as intensive care units (ICUs). The scarcity of material and human resources, the imposition of family separation, and the rapid deterioration of patients' clinical condition required, more than ever, an approach that prioritized dignity, compassionate communication, and the minimization of suffering.

It was in this context of health crisis that the need emerged to deepen reflection on the promotion of palliative care, understanding it not merely as a clinical response, but as a practice rooted in bioethical principles, capable of offering guidance for care in the face of finitude, vulnerability, and the complexity of the ethical dilemmas that presented themselves to professionals, patients, and their families. The COVID-19 crisis, on a global scale, sharply exposed the structural weaknesses of health systems and imposed a critical reflection on the ethics of care in extreme situations.

For a comprehensive understanding of the challenges and choices made, it is essential to contextualize the historical and epidemiological trajectory that characterized the COVID-19 pandemic and that, to a large extent, shaped healthcare practices around the world. The year 2020 began with an outbreak of respiratory infection caused by a new variant of the coronavirus, initially identified in December 2019 in the city of Wuhan, China. The rapid spread of the virus and the consequent exponential growth in the number of cases led the World Health Organization (WHO) to declare a Public Health Emergency of International Concern in January 2020 (World Health Organization 2018; 2020).

The coronavirus, first isolated in 1937 and described in 1965 due to its peculiar shape, had already been responsible for previous crises, such as severe acute respiratory syndrome (SARS) between 2002 and 2003, which caused 774 deaths, and Middle East Respiratory Syndrome (MERS) in 2012, with 858 confirmed deaths in Saudi Arabia. However, the RNA strain of the SARS-CoV-2 virus, which emerged between 2019 and 2020, had distinct characteristics: although it often manifested asymptotically or with mild symptoms (fever, dry cough, fatigue), its high transmissibility had a significant impact on health systems globally. Initially, it was believed that the virus would primarily affect the elderly and individuals with comorbidities; however, it was later observed that young people and children could also develop severe forms of the disease (Chang, Yan, and Wang 2020; Shang et al. 2020; World Health Organization 2020).

The WHO's official declaration of the pandemic in March 2020 had profound repercussions in the health sector, exposing severe limitations in terms of supplies and qualified professionals to manage the disease. In addition to the economic and social impacts, the rapid increase in cases and deaths overwhelmed health services, compromising the continuity and quality of care for the population. The imminent collapse of health systems sparked numerous ethical challenges, resulting from a shortage of technological resources, insufficient supplies, and a lack of trained professionals (Rosenbaum 2020).

Given the urgent need for intensive care and medical interventions, the pandemic has brought to light important issues related to palliative care, a field that has historically been undervalued in medicine (Braga; Ribeiro, 2025). As healthcare professionals were confronted with a growing number of critically ill patients with poor prognoses, the urgency of promoting effective and compassionate palliative care became undeniable (Figueiredo et al. 2021). Large-scale events, such as epidemics and international health emergencies, are historically accompanied by the collapse of health systems, social isolation, increased mortality, and collective suffering (Matos and Conceição 2020). In this scenario, reflecting on the presence and strengthening of palliative care during such crises is fundamental to the preservation of human dignity.

The COVID-19 pandemic has revealed, with undeniable clarity, the vulnerability of healthcare systems and the inherent fragility of human life. Since the early stages of the crisis, the need for palliative care has been evident, especially among the most affected populations: the elderly and individuals with chronic and



progressive conditions, many of whom were already eligible for this type of care. In these cases, clinical deterioration was often rapid, requiring emergency decisions in a context of great instability, scarce resources, and exhausted care teams (Matos and Conceição 2020).

Direct experience in the hospital environment during the pandemic showed that the isolation of patients from their families—often the main mediators of values, wishes, and advance directives—exacerbated the challenges related to ethical deliberation and communication. This experience raised profound concerns about how palliative care was understood, integrated, and implemented in a scenario marked by physical, emotional, and institutional limitations.

Despite the growing relevance of palliative care in contemporary clinical practice, the academic literature still had considerable gaps regarding its application in pandemic contexts and other large-scale health emergencies. There was little research addressing, from the perspective of health professionals, the obstacles and strategies related to promoting such care in intensive settings during global crises.

Given this scenario, this article, the result of a doctoral thesis from the Graduate Program in Bioethics, Applied Ethics, and Public Health, seeks to fill this gap by investigating the perception of the multidisciplinary team of an intensive care unit on the promotion of palliative care during the COVID-19 pandemic. By addressing the topic from a bioethical perspective, the study aims to deepen understanding of the challenges experienced and provide insights for improving care practices in highly complex contexts, reaffirming bioethics as an essential field for guiding humanized care in times of crisis.

Thus, the objectives guiding this investigation are: to understand the perception of the multidisciplinary team of an Intensive Care Unit (ICU) regarding the promotion of palliative care during the COVID-19 pandemic, from the perspective of Beauchamp and Childress' principles; to understand palliative care practices during the pandemic; to identify the difficulties, facilities, and challenges for the integration of palliative care in an ICU during the COVID-19 pandemic; to investigate the difficulties, facilities, and challenges in communication between healthcare professionals, patients, and family members; and to analyze decision-making practices and, in particular, whether Shared Decision Making (SDM) was used and in what way in relation to patients in palliative care.

## **Materials and Methods**

This study adopted a methodological approach that allowed for an in-depth and contextualized understanding of the experiences of healthcare professionals during the COVID-19 pandemic, focusing on the nuances of perceptions about palliative care.

### ***Study Environment***

The research was conducted in the Intensive Care Unit (ICU) of the Clementino Fraga Filho University Hospital (HUCFF), a federal public tertiary and university institution linked to the Federal University of Rio de Janeiro (UFRJ). HUCFF is part of the UFRJ Hospital Complex and is nationally recognized as for its excellence in teaching, research, and healthcare. Its operations are guided by the principles of the Unified Health System (SUS) and the ethical values and social commitment intrinsic to Brazilian public universities. Opened in 1978, the hospital was designed to accommodate hundreds of beds in various specialties, offering outpatient and inpatient care. However, due to structural, financial, and human resource constraints, it has never reached its full capacity. Currently, HUCFF has approximately 280 active beds, mostly intended for the care of adult patients with medium and high complexity conditions.



### ***Study Design***

Considering the complexity of the subject and the need to capture subjective experiences and ethical dilemmas faced in a pandemic context, we opted for field research with a qualitative, exploratory, and descriptive approach. This methodological choice is based on the premise that healthcare professionals, given their proximity to patients' suffering, have a privileged field of observation to identify meanings, perceptions, and impressions that would not be apprehensible by purely quantitative approaches (Ribeiro et al. 2014). The qualitative perspective values comprehensive listening, the institutional context, and the ethical conflicts that emerge from everyday clinical practice. In addition, data analysis was guided by the concept of reflective equilibrium, proposed as a methodological and ethical basis for analyzing these experiences, by promoting constant dialogue between normative principles, moral intuitions, and concrete situations experienced (Ribeiro 2017).

### ***Participants***

Health professionals with higher education (nurses, doctors, and physical therapists) who worked directly in healthcare during the COVID-19 pandemic were selected as inclusion criteria. Professionals who were on medical leave or maternity leave during the reference period were excluded, as well as those who were not on the front lines of healthcare during the pandemic. The number of participants was determined based on the criterion of theoretical saturation (Minayo 2017), i.e., data collection was interrupted when the interviews began to present repetitive content, without the emergence of new relevant information. When necessary, the sample size was expanded to ensure the depth and consistency of the data analysis.

### ***Data Collection***

Data collection was carried out through individual interviews, using a previously prepared semi-structured script. The interviews took place between August and October 2024, in person, in a reserved and quiet room at the hospital, ensuring privacy, comfort, and confidentiality for the participants. All interviews were recorded, with prior authorization and signature of the Free and Informed Consent Form (FICF), after detailed clarification of the research objectives. During the interviews, the researcher responsible took field notes to complement and contextualize the information obtained. The recordings were transcribed in full by the researcher herself, with a view to in-depth analysis of the content. The digital files were stored in a secure location, for the exclusive use of the researcher, in accordance with the ethical principles established by CNS Resolution No. 466/12. Each interview lasted an average of approximately 20 minutes.

### ***Data Analysis***

Thematic analysis, recognized for its wide applicability in qualitative research (Taquette and Borges 2020), was used to analyze the collected material. This technique enabled the understanding of the meanings expressed in the participants' discourses, allowing the construction of relevant categories and interpretations about the object of study. The analysis followed the model proposed by Bardin (2011), structured in three phases:

1. Pre-analysis: Organization of the material and skimming, providing an overview of the content.
2. Exploration of the material: Thematic categorization and coding of data, identifying regularities, meanings, and nuances in the narratives.
3. Treatment of results and interpretation: Construction of inferences and articulation of empirical findings with the theoretical references adopted.



The analytical categories were defined based on the recurrence and relevance of the emerging content. The material was interpreted in light of the principles of principled bioethics, as systematized by Beauchamp and Childress (2009). This approach allowed us to elucidate the perceptions, dilemmas, and strategies reported by the multidisciplinary team in promoting palliative care during the COVID-19 pandemic.

### ***Ethical Aspects***

This research was submitted for review by the Research Ethics Committees (CEP) of the Fluminense Federal University (UFF) and the Federal University of Rio de Janeiro (UFRJ), in strict compliance with Resolution No. 466/2012 of the National Health Council. The study was initiated only after obtaining the necessary approval from both institutions.

All participants were clearly and fully informed in advance about the objectives, relevance, procedures, and possible outcomes of the study. Participation was entirely voluntary, and consent was formalized by signing the Free and Informed Consent Form (FICF).

Interviews were conducted only after formal consent from participants, including specific authorization for audio recording. Confidentiality and anonymity were strictly ensured at all stages of the research through data coding and preservation of the identity of the professionals interviewed.

The transcribed material was stored in a secure digital environment, with restricted and exclusive access to the researcher responsible. All content will be kept on file for a minimum period of five years, in accordance with current ethical guidelines.

### **Results and Discussion**

Analysis of the collected data revealed a complex and multifaceted picture of healthcare professionals' perceptions of palliative care in the challenging context of the COVID-19 pandemic in a university ICU. The findings were categorized into participants' sociodemographic profiles and their perceptions of the pandemic context, with a specific focus on palliative care practices and decision-making.

#### ***Sociodemographic Profile of Research Participants***

Table 1 summarizes the sociodemographic data of the participants, organized by professional category. The analysis of these profiles allowed us to contextualize the perspectives presented in the narratives.

##### *Physicians*

The physicians interviewed had a mean age of 44.8 years, ranging from 38 to 50 years. All self-identified as white, and most were male (four men and one woman). Regarding religion, three identified as Catholic, one as Spiritist, and one as atheist. The average length of training was 20.8 years, ranging from 13 to 28 years, and the average length of service in intensive care units was 19.4 years, ranging from 7 to 27 years.

These data are partially consistent with the national study by the Brazilian Intensive Care Medicine Association (AMIB), which maps the profile of intensive care physicians. Although the average age of the physicians interviewed is slightly lower than the national average of 52 years, the length of service in ICUs is significant, indicating a consolidated professional trajectory. The predominance of males in the sample also reflects the national trend (59.8%), even though the presence of females in medicine has expanded (Cassenote et al. 2024). The ethnic and racial homogeneity, with all participants self-identifying as white, echoes the profile identified in the national census, pointing to the historical underrepresentation of black and



brown people among intensive care physicians, which suggests structural inequalities in access to medical training and specialization.

Table 1. Summary of sociodemographic data.

No.	Variable	Physicians	Physical therapists	Nurses
1	Age (average/range)	44.8 / 38–50	31.8 / 28–43	39.2 / 32–61
2	Gender	Male: 4 Female: 1	Male: 2 Female: 3	Male: 1 Female: 4
3	Race/Color	White: 5	White: 3 Brown: 1 Black: 1	White: 1 Brown: 3 Black: 1
4	Religion	Catholic: 3 Spiritist: 1 Atheist: 1	Catholic: 1 Evangelical: 2 Christian: 1 Agnostic: 1	Evangelical: 3 Christian: 1 Spiritist: 1
5	Time of education (average/range)	20.8 / 13–28	8 / 4–21	11.2 / 8–13
6	Time spent in ICU (mean/range)	19.4 / 7–27	7.8 / 4–21	5.8 / 4–10

Source: prepared by the authors, 2025.

The lower average age of respondents may be linked to contextual factors of the pandemic, where professionals under 50 years of age and outside risk groups were predominant on the front lines. Federal regulations often directed older adults and people with comorbidities to remote work (Brazil 2020), which may have influenced the composition of ICU teams and, consequently, the study sample. The diversity of religious beliefs, even with Catholicism predominating, may subjectively influence clinical practice, especially in contexts of high ethical demand, such as the definition of therapeutic goals and the communication of unfavorable prognoses (Rego, Gonçalves, and Moutinho 2020). The long period of time that the participating physicians have worked in ICUs, close to two decades, gives them valuable experience, although AMIB warns of the tendency for experienced professionals to leave the front line due to overload and the search for quality of life (Cassenote et al. 2024).

### *Physical therapists*

The physical therapists interviewed had an average age of 31.8 years, ranging from 28 to 43 years. The sample included three women and two men, most of whom self-identified as white (three), with one brown and one black. Religious diversity was greater, with two evangelicals, one Catholic, one Christian, and one agnostic. The average length of training was 8.0 years (4 to 21 years), and the average length of service in the ICU was 7.8 years (4 to 21 years).

These data indicate a younger age composition and significantly less experience in the ICU compared to the physicians in the sample, reflecting early and continuous insertion into the intensive care environment. This phenomenon can be attributed to the expansion of multidisciplinary teams in ICUs, driven by Resolution RDC No. 7/2010, which made the presence of physical therapists mandatory in these units (Brazil



2010; Alves et al. 2020). The predominance of women in the sample of physical therapists corroborates the feminization of the profession in Brazil, especially in hospital settings (Furtado et al. 2021). The greater racial diversity among physical therapists, contrasting with the homogeneity of physicians, may indicate progress in the inclusion of professionals with different profiles in intensive physical therapy.

The work of physical therapists during the COVID-19 pandemic was extremely important, encompassing respiratory support, early mobilization, and active collaboration in clinical decisions. However, studies indicate that institutional recognition and working conditions have not always matched this importance, raising concerns about the retention and well-being of these professionals in critical contexts (Furtado et al. 2023).

### *Nurses*

The participating nurses had a mean age of 39.2 years, ranging from 32 to 61 years. Four were female and one was male. Regarding race/color, three self-identified as brown, one as white, and one as black. Most identified as evangelical (three), followed by one spiritist and one Christian. The average length of training was 11.2 years (8 to 13 years), and the average length of service in the ICU was 5.8 years (4 to 10 years).

These data suggest that the nurses in the sample were in a phase of professional consolidation in intensive care. The average age and female predominance (four out of five) are in line with the findings of Gomes et al. (2024) and the national trend of feminization in nursing, which represents 85.1% of the workforce in Brazil (Machado 2017). The greater racial diversity in nursing, with a predominance of brown-skinned individuals, may indicate progress in inclusion, but racial inequalities still persist as barriers, requiring attention from public policies.

Religious diversity, with a predominance of evangelicals, suggests that spirituality may have acted as a strategy for coping with and reframing care in a highly emotionally charged environment. Spiritual care is recognized as an essential aspect of clinical nursing practice, promoting active listening and respect for patients' beliefs (Miller et al. 2023). However, it is important to consider that specific religious views may influence more conservative attitudes in end-of-life decisions, highlighting the importance of individualized and respectful dialogue for shared decision-making.

The average length of service in the ICU for nurses (5.8 years) is lower than that of physicians and physical therapists, which may be related to high turnover in the area, physical and emotional exhaustion, and poor working conditions (Gomes et al. 2024; Vincent et al. 2022). The training of these professionals is also a concern, given that more than half of Brazilian intensive care nurses have completed a *lato sensu* postgraduate course without structured practical activities, highlighting gaps in their qualifications for safe practice (Gomes et al. 2024).

### ***General Perceptions of the COVID-19 Pandemic Context***

The narratives of the professionals interviewed converged in the description of a deeply challenging experience during the COVID-19 pandemic. Three thematic axes stood out: intense physical and emotional overload, constant fear of illness and death, and the imperative need for accelerated learning in a scenario of uncertainty and instability. Although interconnected, these dimensions presented particularities according to professional category, but consolidated the pandemic as an unprecedented health crisis.



### *Doctors and the Impact of the Pandemic*

Doctors strongly emphasized the physical and emotional overload, as well as the profound psychological impacts of coping with the pandemic, characterizing it as the "greatest health crisis our generation will experience" [M4]. Daily exposure to suffering and death left lasting scars, culminating, for some, in psychological complications and demotivation to work in intensive care [M2].

The challenges included adapting to new practice requirements, such as the continuous use of Personal Protective Equipment (PPE) and changes in shift routines. Physical exhaustion was accentuated by adverse conditions, such as excessive heat and multiple layers of protection, which limited even basic needs such as going to the bathroom, as reported: "I really felt this physical overload, a lot of heat, sometimes, right? The air conditioning that didn't work properly... Those multiple layers of protection. So there was this physical aspect. Initially, I couldn't leave to go to the bathroom... even because of the limitations of the cape, (...). Intubation, extubation, pronation. So, it was a physically tiring shift. Mentally too, but physically it was very tiring." [M1]

The psychological impact was aggravated by the lack of knowledge about the disease and the absence of clear clinical guidelines, added to the weight of critical decisions in the face of the high severity and mortality of the cases. This context generated anxiety and fear of contamination and death, including of colleagues and family members: "It was a great challenge. I think for all professionals who work, especially in closed unit sectors. We had the great challenge of dealing with an unknown disease, with the power to kill, with a very high mortality rate that is really outside our norm. So it was scary, indeed. I was very afraid, for sure, and it was very painful." [M3]

These reports corroborate studies that have shown alarming prevalence rates of burnout, anxiety, and depression among healthcare workers globally, attributed to PPE shortages, work overload, allocation of unprepared teams, and fear of infecting family members (Huang et al. 2024; World Health Organization 2022). The pandemic imposed physical, psychological, and ethical challenges, transforming ICUs into environments of constant stress and trauma, where the management of life and death became routine.

In this scenario, moral distress, described by Andrew Jameton (1984) and expanded upon by Rushton (2016), became particularly evident. Professionals, aware of morally appropriate conduct, found themselves prevented from carrying it out due to institutional or structural barriers, culminating in the erosion of ethical integrity and emotional exhaustion. The scarcity of supplies, overload, and lack of institutional support amplified this distress (Caram et al. 2021; Santos et al. 2024).

In light of Beauchamp and Childress's (2009) principlism, fundamental principles were systematically compromised: beneficence and non-maleficence were restricted by precarious conditions; justice was violated by the unequal distribution of resources; and respect for autonomy was limited for both patients and professionals. This ethical and care crisis highlights the concept of vulnerable dignity (Muñoz Terron 2021), which manifests itself in human frailty and should guide care, whose absence of reception structures compromises the ethical stance of the team. The exclusion of palliative care from crisis response strategies is harshly criticized in the literature, intensifying suffering and moral suffering (Radbruch et al. 2020; Lin et al. 2020).

### *Physical Therapists and Operational Exhaustion*

The physical therapists interviewed highlighted physical and emotional exhaustion, the need for emergency learning, and the scarcity of resources. They reported extremely strenuous work routines, with long hours and an accumulation of duties, in addition to the incorporation of previously unusual behaviors.



Critical situations, such as multiple simultaneous cardiac arrests and the need to prioritize care, created ethical dilemmas in the face of high mortality. Exhaustion was compounded by scarcity and the need to make difficult choices: "Sometimes we were awake for 24, 48, 72 hours straight." [F2] "So I worked more than 100 hours a week, which was very exhausting, and I saw people dying every day, sometimes several a day, having to make choices about who to intubate, because there was only one ventilator, who to admit, because there was only one bed available..." [F4]

The emotional impact of these decisions was heightened by the intensity of the shifts and the helplessness in the face of massive losses: "During one of my shifts, 30 people died. It was kind of desperate, for example: there were five cardiac arrests at the same time, who are you going to save? Let's go with the youngest? But what about the other one? They're someone's loved ones too. What are you going to do? (...) I found myself in a real bind. The team would say, 'Let's invest in this one,' and we would invest in that one. Sometimes I would take turns, going from one cardiac arrest to another, trying to save three at the same time. (...) Many situations got out of control." [F5]

This testimony reveals the severity of the ethical dilemmas, where the scarcity of resources and high demand forced decisions based on urgency and attempts at fairness, without adequate technical or institutional support. The absence of clear ethical guidelines increased insecurity, leading to empirical and sometimes arbitrary criteria. The lack of legitimate parameters for the fair allocation of resources morally overloads frontline professionals (Sobral, Santa-Rosa, and Silvestre 2021). Although recommendations existed (Satomi et al. 2020; AMIB et al. 2021), their dissemination and application were heterogeneous.

The pandemic required accelerated technical learning, as it was "a disease that no one knew how to manage, no one understood how it worked" [F4]. The work of physical therapists expanded to include previously uncommon procedures, such as pronating patients or titrating PEEP [F3]. Despite the difficulties, the experience brought learning and scientific advances: "it was a very difficult experience, I think everyone was emotionally shaken, but in terms of experience, it was an incredible gain" [F4]. The tension between emergency learning and clinical uncertainty compromised non-maleficence, but also revealed the mobilization of virtues such as compassion, discernment, and integrity (Beauchamp and Childress 2009; Rushton 2023).

The scarcity of resources culminated in the collapse of minimum working conditions, with a lack of sedation, ventilators, and oxygen, and the replacement of experienced professionals with others without technical training, generating a "big problem" and an "increasing number of deaths due to some practices with which we disagreed" [F4, F2]. This scenario highlights the precariousness of care, violating the principles of justice and beneficence, and intensifying the moral suffering of workers.

### *Nurses and Institutional Fragility*

Nurses emphasized the initial insecurity, both due to the high risk of contamination and the fear of infecting family members [E3], as well as the misinformation and general unpreparedness of the team: "Everything was new, the disease was new, you had no perspective on it. (...) If I had to say one word, it would be this: it was very desperate" [E1]. Difficulties with biosafety protocols and lack of experience in the ICU were additional challenges, with many professionals having no previous experience in intensive care or even in the health field [E2, E5].

The most scathing criticism was directed at the recruitment of professionals for the most critical period of the pandemic, with obvious shortcomings in training: "The staff that was hired was not qualified to provide that service. (...) Any healthcare professional who was willing to work was hired. There were nursing technicians who worked outside as caregivers, manicurists. (...) And that led to many deaths." [E4]



These reports expose a scenario of improvisation and institutional insecurity, with hasty decisions and a lack of technical support. The lack of preparation and qualification compromised the ethical practice of care, violating the principles of beneficence and non-maleficence, and generating inequality in care. Justice was equally affected, as the quality of care depended on the composition of the teams. These elements reinforce the urgency of incorporating institutional strategies that value continuous training, emotional support, and spaces for ethical deliberation, forming the pillars of responsible and humane care.

### ***COVID-19 Pandemic and Palliative Care***

The interviewees unanimously perceived that palliative care during the pandemic was insufficient, often absent, or fragmented. Although there were attempts to provide it, the conditions of the pandemic and the severity of clinical cases made it difficult to consolidate a continuous, early, and structured approach. The predominant focus was on curative interventions, with little reflection and scant incorporation of palliative practices.

#### *Medical Perception of Palliative Care*

Physicians acknowledged that palliative care was limited, disorganized, and insufficient. The absence of specific protocols, rapid clinical deterioration, and the inexperience of teams were recurring obstacles. An institutional culture of "maximum investment" in interventions stood out, motivated by social pressure and the expectations of the professionals themselves: "There was no structured palliative care, no. It wasn't well accepted, right? Dying from Covid. (...) It was an era when politics and society actually had this concept that they wanted everything, everything, everything to be done. There was, in fact, a very large mobilization of society. (...) It was very excessive, right? In terms of investment. (...) But, let's establish it, let's prioritize comfort. This was not accepted. I don't remember anything structured for palliative care happening at that time, either here or elsewhere." [M1]

This account exposes a culture focused on aggressive interventions, even in the face of irreversibility, compromising beneficence and non-maleficence by prolonging suffering. The absence of criteria for the location of resources favors disproportionate conduct (Costa, Pompermayer, and Costa 2020), and the social non-acceptance of death from COVID-19 reflects the collective difficulty in dealing with terminality (Schramm 2012).

The lack of time for discussions about proportionate conduct was a significant obstacle, with the overload making it impossible to have the dialogue necessary to define therapeutic goals aligned with the prognosis [M5]. Shared decision-making requires time, listening, and understanding of the patient's values, elements that are often absent in crisis scenarios (Vidal et al. 2022). Lack of knowledge about the new disease also hindered the implementation of appropriate care, generating clinical uncertainty about the appropriate time to limit treatments [M1]. In contexts of instability, the virtue of prudence becomes fundamental for sensitive and balanced clinical decisions (Lima, Rego, and Batista 2015).

The absence of specialized teams was a significant gap [M2]. Specialized teams are essential for technical and ethical support in complex decision-making (Arya et al. 2020), and their absence compromises the early implementation of proportional conduct. The discontinuity of procedures was also widely mentioned: "I felt a bit of a lack of continuity, of a more horizontal view of the patient. It depended a lot on who was on duty, right?" [M4]. High staff turnover, due to COVID-19-related absences and emergency hiring, compromised team cohesion and longitudinal follow-up, resulting in fragmented care that was disconnected from patients' needs.



This fragmentation prevented the development of consistent therapeutic plans, which was a critical obstacle to palliative care, which requires comprehensive and coordinated follow-up. The high turnover of patients, due to rapid deterioration and high mortality, limited the planning of palliative actions, making a structured approach unfeasible [M5]. The overload and instability of the teams were directly associated with hasty decisions and the fragility of palliative practices, as reflected in the following statement: "Many seriously ill patients, so a lot of work, right? Often with the team short-staffed due to Covid leave... anyway, I think we made very hasty decisions (...) therapeutic decisions, decisions about end-of-life care, proportional care, palliative care. I think that if we had an approach based on the patient's prognosis, as an older patient with such serious illnesses... That would have been ideal, right?" [M4]

This reflection makes it clear how the overload of care led to hasty therapeutic decisions, compromising clinical deliberation and favoring automatic and disproportionate interventions, far from palliative principles (Pereira, Siqueira-Batista, and Schramm 2021). Ethical dilemmas arising from resource scarcity required decisions based on justice and equity, considering social vulnerabilities (Paura, Ribeiro, and Silva Jr. 2010), which did not occur systematically.

In addition to operational limitations, there was a profound lack of conceptual consensus on palliative care among the professionals themselves. Some perceived it as "individualized care focused on the needs of each patient" [M3] and an integral part of the "multidisciplinary round" [M4], while others expressed a critical view, associating it with "guesswork" and "little science" [M2]. These differences reveal a formative and institutional gap that compromises the safety of decisions and the equitable provision of care, violating justice, autonomy, and beneficence. The National Academy of Palliative Care (ANCP 2024) reinforces that conceptual clarity and cross-sectional integration are crucial for the consolidation of the practice.

The profile of patients considered eligible for palliative care was restricted, focusing on elderly people with comorbidities, advanced lung diseases, and multiple dysfunctions. "We knew that COVID would probably be the final outcome" [M3]. This direct association between palliative care and terminality prevents the early and widespread application of the approach, distancing it from its purpose of alleviating suffering throughout the course of serious illnesses (ANCP 2024; Radbruch et al. 2020).

### *Physiotherapists' Perceptions of Palliative Care*

Physical therapists reported a predominance of curative and emergency care, with little or no effective integration of palliative practices. The severity and pressure for immediate interventions made it difficult to reflect on comfort and quality of life: "I don't think there was even time to think about palliative care... I think I heard very little talk about this issue..." [F1]. Palliative care was only considered at the end of life, in an all-or-nothing logic, oscillating between maximum investment and therapeutic abandonment [F4]. This instability in care, without clear protocols, generated moral insecurity and compromised the quality of care (Rossi et al. 2023).

The logic of maximum care was applied regardless of eligibility for palliative care: "Everyone received, in most cases, the maximum care we could provide" [F2]. This imperative to save lives at any cost, in a scenario of scarcity and accelerated decisions, resulted in therapeutic obstinacy, prolonging the dying process and aggravating suffering. Therapeutic futility violates non-maleficence and distributive justice (Radbruch et al. 2020).

The scarcity of information about patients' medical history and the uncertain nature of COVID-19 at the beginning of the pandemic represented a significant obstacle. Many patients arrived in critical condition, sedated or intubated, making direct communication and knowledge of their limitations or previous preferences impossible [F3, F4]. The lack of knowledge about the evolution of the disease generated clinical



uncertainty and made it difficult to define prognoses, even though the severity alone justified the inclusion of palliative care. The lack of consensus among professionals about when and how to apply palliative care resulted in inconsistent care practices, varying from shift to shift: "one day the patient was receiving palliative care, the next day it was full investment" [F2]. This lack of definition compromised the consistency of care and clinical and emotional safety (Martins et al. 2022).

### *Nurses' Perceptions of Palliative Care*

Nurses reported that care during the pandemic was mainly focused on curative interventions, with palliative care only being considered in end-of-life situations [E1]. Structured practices were rarely identified [E2] and, when mentioned, were associated with isolated comfort measures or the suspension of invasive interventions, such as not performing CPR or intubation [E1, E3, E4].

This limited understanding of palliative care, reduced to analgesia and the suspension of advanced life support in terminal phases, contrasts with the contemporary conception of an early and integrated approach, which can coexist with disease-modifying treatments (ANCP 2021; Radbruch et al. 2020). This narrow view contributes to disproportionate practices and communication failures, compromising beneficence, non-maleficence, and justice.

The lack of technical preparation and inexperience of the teams also compromised the adoption of palliative measures: "The medical team was very inexperienced... They didn't really have this vision of palliation" [E3]. The rapid expansion of beds and the urgent need for manpower led to the hiring of professionals with no experience in intensive care or palliative care, affecting the ability to integrate the palliative approach from the outset. The severity and rapid progression of the disease often made comfort-centered care unfeasible: "Due to the severity, the patient did not have time for palliative treatment" [E4]. However, some reported specific initiatives of therapeutic proportionality, such as not placing the patient on mechanical ventilation [E5].

These isolated practices reveal individual efforts to align clinical decisions with bioethical principles, mobilizing virtues such as compassion, prudence, and moral responsibility. Palliative care should not be opposed to intensive care, but rather an essential part of the response to pandemics, especially when reversal of the condition is not realistic (Arya et al. 2020). The exclusive prioritization of technologies over comfort compromises therapeutic proportionality and favors obstinacy, contrary to the ethical foundations of patient-centered care.

### ***Decision-Making and Communication between Professionals and Patients/Family Members***

There was consensus among respondents that decision-making in palliative care, especially during the COVID-19 pandemic, requires a shared approach involving the multidisciplinary team, the patient (when feasible), and family members. Active listening, respect for autonomy, and anticipation of decisions were consistently valued. However, important limitations emerged, such as the fragility of communication flows, the lack of alignment among professionals, and the difficulty of incorporating palliative care principles into practice. These perceptions, although shaped by the specificities of each category, portray a scenario of overload, urgency, and ethical fragilities that compromised the quality of care and the effectiveness of communication.



### *Physicians: Dilemmas of Autonomy and Remote Communication*

The physicians interviewed emphasized that decisions about palliative care should be collegial, involving the multidisciplinary team and, whenever possible, family members: “Multidisciplinary team, nurse, physician, physical therapist, and, of course, the family. But everyone, I think everyone has to be involved” [M2]. According to the narratives, responsibility for comprehensive care should be shared by all those involved in intensive care [M5].

Although they recognized the centrality of the patient in decisions, physicians pointed out significant limitations to their active participation in ICUs during the pandemic, given that most patients were sedated, intubated, or in critical condition. This led to situations where “the patient’s wishes were overridden” [M3], or where the decision fell to the family because the patient lacked decision-making “capacity” [M1]. This reality illustrates the difficulty of applying the principle of respect for autonomy in highly complex contexts. The absence of advance directives or tools to record patient preferences made it difficult to conduct ethical procedures, resulting in disproportionate interventions. In cases of compromised autonomy, mediation by family members or directives is essential, and their absence increases the risk of decisions that are disconnected from the person’s values (Beauchamp and Childress 2009).

Anticipating discussions about palliative care was considered essential to reduce suffering and promote decisions consistent with individual values. Several interviewees argued that these conversations should take place in an outpatient setting, before clinical deterioration, to avoid disproportionate conduct [M3]. Such an early approach would not condemn patients to death, but would “cause less suffering for everyone involved” [M2]. The absence of a previously discussed and recorded care plan was a common reality, hindering ethical decisions aligned with patients’ preferences (Bradshaw et al. 2021).

Respect for autonomy, although highlighted as a central principle – “I don’t have the ability to decide what is a good life for the patient, they need to be involved” [M3] – was often overlooked due to rushed decisions, overload, and uncertainty. Physicians reported moral dilemmas between the patient’s wishes (e.g., refusing intubation) and what the team considered the best technical approach, leading to paternalistic behavior [M1, M2, and M3]. This trend was intensified by the pressure and instability of ICUs during the pandemic, favoring unilateral choices and limiting dialogue (Aredes and Modesto 2023). Conflicts between the patient’s wishes and the family’s wishes added complexity, and the absence of formal guidelines made mediation difficult [M1].

Communication with the family was one of the most fragile aspects. Restrictions on access to the units forced most contact to be by telephone, hindering bonding and emotional support [M5]. The speed of events and the irregularity of information contributed to insecurity: “It was all very fast, it was over the phone. It was uncertain, it was irregular. (...) Wow, how difficult it was to even give news over the phone” [M3]. Remote communication made mutual trust and the necessary follow-up for delicate dialogues, such as the limitation of therapeutic efforts, unfeasible. One doctor’s statement expresses the pain of this distance: “We didn’t see the family’s faces, we talked to the family on the phone, we didn’t have that full communication (...) we called some patients to say they had died (...) really thinking about palliative care in COVID was cruel because we didn’t have family nearby to participate.” [M3]

The difficulty of understanding information over the phone was recurrent [M1]. Video calls were sporadic and not systematic [M5], and initial communication was often delegated to interns or students [M2]. These barriers compromised beneficence, justice, and autonomy (García Sánchez 2020). Cultural barriers, such as resistance to accepting behavioral limitations, made dialogue even more complex over the phone [M5]. Communication was often relegated to the background in the face of technical demands, leading to self-criticism: “How we regressed in terms of intensive care, when we left the family completely away from



the patients. (...) I was an intensivist, you know? (...) I was very concerned about who I had to pronate, who I had to ventilate, who I had to intubate, you know, that sequence, and calling the family was the last thing on my mind. (...) So, I would have done that better today." [M3]

Family misinformation, amplified by distance, generated misperceptions and resistance [M5]. In palliative care, empathetic and structured dialogue is an indispensable therapeutic tool that aligns expectations and reduces distress (Ekberg et al. 2021).

#### *Physical therapists: The value of multidisciplinary*

The physical therapists interviewed were unanimous in advocating for decision-making about palliative care by a multidisciplinary team. The integrated work of different professionals was considered essential to ensure an ethical and sensitive approach, tailored to the needs of each patient: "The multidisciplinary team introduced the conversation with family members to see how far to go, what to invest in, what not to do. And also to listen to the patient" [F5]. Joint participation was seen as humanizing the decision-making process by allowing the exchange of different professional perspectives: "Each professional will bring a different perspective. If they participate, the process becomes much more humane" [F2].

This appreciation of multidisciplinary reflects a broader understanding of care, aligned with the principles of beneficence and justice. The collective construction of decisions increases their ethical legitimacy and reinforces person-centered care (Downar et al. 2016). Teamwork in palliative care constitutes an ethical commitment to attentive listening, transparent dialogue, and shared responsibility in coping with suffering, increasing therapeutic power and promoting humanized care.

The involvement of the patient in decisions, whenever they had adequate clinical and cognitive conditions, was also consensual, reiterating respect for autonomy as a fundamental principle [F3]. Although a minority paternalistic view suggested that the final decision should be made by the medical team to protect the family from the emotional burden [F1], the majority advocated a balanced composition: "It's this whole triad: the patient's will, the multidisciplinary team, and the family" [F5]. The appreciation of this tripartite model reinforces the centrality of autonomy, but the isolated paternalistic discourse points to the tension between different understandings of the role of professionals (Rego et al. 2020).

Communication with family members was one of the most fragile aspects, marked by the absence of face-to-face contact and the mediation of information by professionals who often did not participate directly in care [F3]. Health restrictions aggravated the difficulty of building bonds and mediating care [F5, F1, F3]. Staff turnover also interfered with the consistency of information, making it difficult to establish bonds and maintain communication [F4].

The exclusion of the family network from decisive moments and the impossibility of face-to-face farewells were not only operational failures but compromises of bioethical principles, depersonalizing death (García Sánchez 2020). One interviewee reflected that some emergency decisions could have been handled with more sensitivity and advance communication with family members about invasive procedures, such as intubation: "I think this care could have been taken before arriving and calling the family. For example, the patient is progressing seriously, maybe he will be intubated in the next 12 hours, call the family beforehand and talk to them." [F4]. There were reports of patients who were not informed in advance about imminent intubation, although emotional overload was recognized as a limiting factor [F4]. This tension between the ethical ideal and reality imposes the urgency of incorporating more humane and structured communication practices, even in emergencies.



### *Nurses: The Perspective of Continuous Care*

Nurses reinforced the importance of multidisciplinary action in decisions about palliative care [E5]. Nurses, due to their continuous presence at the patient's side, were identified as key players in the humanization of care, observing suffering and identifying moments to limit invasive procedures: "(...) Participation of the multidisciplinary team, including the physician, physical therapist, and nurse. Because we are the ones who care for the patient 24 hours a day, full time, because we see their suffering in bed, many days, months go by and there is no improvement, and it just keeps invading, invading, invading. I think it could already be discussed, ah, there is a poor prognosis, there will be no more surgery, the surgery will not be favorable... so, the multidisciplinary team, I think they should already come in to see if he has any chance, at the end of his life, to be close to his family and not stay at the end of his life on a tube, with PAM, with a catheter and already forgotten his origins, far away from the people he loves, I think it's everyone's dream to die at home sleeping..." [E3]

This statement highlights the central role of nurses in observing suffering and identifying futile treatment, supporting ethical decisions. A genuinely multidisciplinary approach allows for qualified listening and decisions that are sensitive to the patient. There was consensus on the relevance of family participation, especially when the patient could not express their wishes, their acceptance being "fundamental for the initiation of palliative care" [E4]. Patient autonomy was a priority if they were lucid [E1]. One professional suggested the early formalization of a legal representative upon hospital admission, in line with advance care planning [E3]. However, the nursing team faced disagreements among professionals about conduct, generating insecurity and helplessness: "This part of palliative care is kind of complicated. We treat, then the doctor says he's going to invest, the other one says no... The nursing staff is lost" [E2]. The absence of clear guidelines and specific training were obstacles (Florêncio et al. 2020).

Communication with family members was predominantly by telephone and limited. Even with attempts at standardization, the information was fragmented and inconsistent [E1, E2]. Often, contact only occurred in cases of worsening conditions or death, causing despair among families [E5, E3]. The absence of institutional and/or strategies to organize information flows and work overload prevented adequate dedication to communication [E4].

Communication difficulties extended to the multidisciplinary team itself. The continuous use of PPE impaired interpersonal recognition and nonverbal communication, which is essential in ICUs. High turnover and the absence of integration mechanisms compromised team alignment: "In the beginning, we didn't know each other... execution failed because everyone did things their own way" [E5].

In dialogue with patients, listening to their wishes and preferences was practically non-existent due to high demand and exhaustion. Decisions were guided by the urgency of the intervention, with little possibility of active listening: "I didn't get to that stage of concern, no. I was there, intubating. Things were so urgent... If you don't intubate, they can die. So, there was no communication" [E2]. Patients were already arriving in critical condition, making dialogue impossible [E4]. Even in the face of explicit refusals, suffering led to intubation [E5]. This attitude reveals a limited understanding of palliative care, assuming intubation as the only response, which compromises non-maleficence. However, refusal of intubation was seen not as a renunciation of life, but as a call for less aggressive and more humanized measures [E1], highlighting the need to strengthen the ethical and technical training of teams for care based on listening and proportionality.

### **Final Considerations**

This research, through the analysis of the perceptions of doctors, nurses, and physical therapists who worked on the front lines during the COVID-19 pandemic in a university ICU, revealed a scenario of



immense clinical, emotional, and ethical complexity. The findings highlight not only the profound physical and emotional overload experienced by professionals, but also the significant institutional limitations that prevented the guarantee of care truly centered on dignity, therapeutic proportionality, and the relief of suffering.

The absence of specific protocols for palliative care, the lack of adequate training, the high turnover of teams, and the consequent fragmentation of care practices point to a structural disorganization that directly impacted the application of fundamental bioethical principles—beneficence, non-maleficence, justice, and autonomy—the pillars of Beauchamp and Childress's (2009) principlism. The moral suffering of professionals, expressed in various narratives, emerges as a symptom of the system's failure to sustain minimum conditions for prudent decisions, interprofessional dialogue, and effective and humanized communication with patients and their families.

Shared decision-making, although conceptually valued by the interviewees, was largely compromised by practical obstacles, such as lack of time, absence of advance care planning, difficulty in promoting active listening, and lack of resources to ensure the effective participation of all involved. Critical situations, such as the absence of prior consent for intubation or the exclusion of families from crucial decisions, illustrate the erosion of respect for autonomy in the name of urgent care and pressure for interventions (Aredes and Modesto 2023).

From a conceptual point of view, there has been a persistent narrow association of palliative care with end-of-life care and the suspension of invasive procedures, highlighting gaps in training and a deep-rooted stigma that distances it from its primary function: to offer active, comprehensive, and person-centered care at any stage of a serious and life-threatening illness. The lack of an institutional culture favorable to the early and integrated introduction of this approach contributed to the adoption of practices considered futile and disproportionate, with worrying clinical and bioethical implications (Radbruch et al. 2020).

Despite the limitations imposed by the crisis, the reports also reveal the mobilization of fundamental ethical virtues, such as compassion, discernment, integrity, and responsibility. These virtues sustained the continuous effort of professionals to offer the best possible care, even in extreme conditions, preserving the dignity of patients. As Beauchamp and Childress (2009) and Rushton (2023) emphasize, these virtues are indispensable for bioethical principles to be applied with sensitivity to the context and complexity of lived reality.

In this sense, the results of this research reinforce the urgent need for institutional and educational restructuring that allows for the full integration of palliative care into health policies, especially in crisis contexts. It is imperative to train teams, establish clear ethical deliberation flows, ensure advance care planning, and value active listening as an essential therapeutic dimension. Such steps are fundamental so that intensive care does not become detached from dignity, proportionality, and respect for the uniqueness of each life (ANCP 2024; Mendis et al. 2020).

The data obtained in this investigation can guide hospital institutions in formulating guidelines that ensure the early and ethical integration of palliative care, particularly in emergency scenarios. This study stands out as one of the few qualitative studies to address the perception of the multidisciplinary team on palliative care in a university ICU during the COVID-19 pandemic, contributing significantly to the advancement of bioethics applied to clinical practice in extreme contexts.

In summary, the pandemic has exposed the intrinsic weaknesses of the healthcare system, but, paradoxically, it has also revealed the transformative power of care that, even in the face of imminent death, does not abandon human dignity. Promoting palliative care in times of health crisis is, above all, a



non-negotiable ethical commitment to recognizing human vulnerability and building care responses that transcend technicality, reaffirming, in everyday practice, the centrality of life and of the other.

Finally, it is crucial to recognize that, as this is a qualitative study conducted in a single university hospital with a limited number of participants, the results cannot be generalized to other realities. In addition, the interviews were conducted after the most critical period of the pandemic, which may have influenced how professionals reconstructed and narrated their experiences. However, the depth and richness of the narratives offer a dense and contextualized understanding of the ethical challenges experienced, contributing significantly to the debate and reflection on palliative care in crisis situations.

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