Historical Evolution of Comfort in Nursing Care for the End-of-Life Cancer Patients: Integrative Literature Review

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Evolution Histórica del Conforto no Cuidado de Enfermagem a Pacientes Oncológicos em Fim de Vida: Revisão Integrativa da Literatura

Evolución Histórica de la Comodidad en el Cuidado de Enfermería para Pacientes con Cáncer al Final de la Vida: Revisión Integradora de la Literatura

Nanci Soares Bizutti1; Rômulo Frutuoso Antunes2; Ruan Nilton Rodrigues Melo3; Ingrid Simsen Jensen4; Júlia Drummond de Camargo5

ABSTRACT

Introduction: End-of-life cancer patients are prone to experiencing unpleasant signs and symptoms due to the progression of the disease. Along nursing historical trajectory, care was targeted to identify, manage and evaluate the discomfort. Objective: To identify the impact of the historical evolution of comfort in nursing care for end-of-life cancer patients. Method: Exploratory and descriptive integrative literature review utilizing LILACS, MEDLINE and SciELO databases without time restraints for more comprehensive results. Results: The main impacts of nursing theories based on comfort were the valorization of the holistic model, the stimulation of the nurse-patient bond, the control of symptoms, the reduction of suffering and behaviors aligned with the patient's values. Conclusion: Comfort is mentioned in state-of-the-art historical texts, theories and nursing care practice. Nursing care to end-of-life cancer patients is guided by theories that address comfort and reduce the patient's discomfort and suffering. Key words: History of Nursing; Nursing Theory; Hospice Care/history.

RESUMO

Introdução: O paciente oncológico em fim de vida está propenso a experimentar sinais e sintomas desagradáveis em virtude da progressão da doença. O enfermeiro, ao longo de toda a sua trajetória histórica, direcionou o cuidado para a identificação, o manejo e a avaliação do desconforto. Objetivo: Identificar o impacto da evolução histórica do conforto no cuidado de enfermagem ao paciente oncológico em fim de vida. Método: Revisão integrativa da literatura de caráter exploratório e descritivo utilizando as bases de dados LILACS, MEDLINE e SciELO sem recorte temporal para maior abrangência de resultados. Resultados: Os principais impactos das teorias de enfermagem pautadas no conforto foram a valorização do modelo holístico, o estímulo do vínculo enfermeiro-paciente, o controle de sintomas, a diminuição do sofrimento e as condutas alinhadas aos valores do paciente. Conclusão: O conforto é mencionado no estado da arte em textos históricos, teorias e na prática assistencial da enfermagem. As teorias que abordam o conforto direcionam o cuidado de enfermagem ao paciente oncológico em fim de vida buscando reduzir o desconforto e o sofrimento do paciente. Palavra-chave: História da Enfermagem; Teoria de Enfermagem; Cuidados Paliativos na Terminalidade da Vida/história.

RESULTADOS

Identificar el impacto de la evolución histórica del desconforto en los cuidados de enfermería al paciente con cáncer al final de la vida. Método: Revisión integradora de la literatura de carácter exploratorio y descriptivo, utilizando las bases de datos LILACS, MEDLINE y SciELO sin marco temporal para mayor cobertura de resultados. Resultados: Los principales impactos de las teorías de enfermería basadas en el confort fueron la valorización del modelo holístico, la estimulación del vínculo enfermera-paciente, el control de los síntomas, la reducción del sufrimiento y los comportamientos alineados con los valores del paciente. Conclusión: El confort es mencionado como lo más avanzado en textos históricos, teorías y en la práctica del cuidado de enfermería. Las teorías que abordan el confort dirigen los cuidados de enfermería hacia los pacientes con cáncer al final de la vida, buscando reducir el malestar y el sufrimiento del paciente. Palabras clave: Historia de la Enfermería; Teoría de la Enfermería; Cuidados Paliativos al Final de la Vida/historia.

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INTRODUCTION

The World Health Organization (WHO) estimates that in 2020, Brazil will be the fifth country with the world’s oldest population\(^1\). This extended longevity comes together with increasing chronic non-communicable diseases (NCD) as cardiovascular, respiratory, cancers and diabetes. Currently, cancer is the second cause of death in the world and the main cause of death in 10% of the Brazilian cities\(^2\).

In 2002, WHO defined that palliative care is an approach that improves the quality-of-life of patients and their families who are facing the problems associated with life-threatening illness, by a multidisciplinary team through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual\(^3,4\).

Palliative care should be initiated since the diagnosis of a life-threatening disease while end-of-life care consists in care provided from 72 hours to one week of survival before death, focused to the quality-of-life of the patients and their families and minimizing the four dimensions of suffering elaborated by Cicely Saunders: physical, social, psychic and spiritual\(^5-7\).

The progression of the disease makes comfort measures paramount, since signs and symptoms as pain, nausea, dyspnea, fatigue, constipation, inappetence, depression, somnolence are disabling, quite often, adding complexity to the management of end-of-life cancer patients because the dimensions of suffering in face of the finitude are singular and go beyond the patient, affecting the family and the multidisciplinary team\(^5,7\).

Nursing care to end-of-life patients requires early identification and correct management of signs and symptoms in addition to patient-centered priorities and interaction with support network aligned with the therapeutic goal defined with the patient, family and healthcare team\(^5\).

Nursing to cancer patients is multifaceted with specific challenges to nurses further to their basic responsibilities. Oncologic care goes beyond medical treatment comprehending emotional, psychosocial and physical aspects. Nurses play a key role in instructing the patient about the diagnosis and treatment, providing emotional support during the course of the disease.

The approach of oncologic cancer care is patient-centered, respecting its individuality and wishes and special attention to quality-of-life, pain relief and coping should be ensured\(^8,10\).

History has shown that comfort is closely related to nursing care and is influenced by social, economic, political and religious factors. The word comfort comes from the Latin confortare, which means to strengthen, fortify. On its turn, infirm in Latin means infirmus, weak or feeble. Thus, the nurse is someone who instills strength to the infirm\(^8,7\).

In view of the quality of death in Brazil, the complexity of management of the dimensions of suffering cancer patients live in end-of-life and protagonism of nursing care, the objective is to identify the historical evolution of nurse comfort care to this patient.

METHOD

Exploratory and descriptive integrative literature review, compiling studies found in the literature separately, attempting to present the state-of-art on the theme, in addition to promoting discussions of the results and identify potential gaps. The methodology consisted in six stages: research question, search, data collection, critical analysis of the results, discussion and presentation\(^12\).

The research question followed the PICO strategy PICO (P – Population/Patient, I – Intervention, C – Control/Comparison and O – Outcome) (Chart 1). Topic C – Control/Comparison was not applied in this review because there was no control group\(^12\). The research question was: “What is the impact of the historic evolution of nurse comfort care to the end-of-life cancer patient?”

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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>P</td>
<td>Population/Patient</td>
<td>End-of-life oncologic patients</td>
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<tr>
<td>I</td>
<td>Intervention</td>
<td>Historical evolution of care</td>
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<tr>
<td>C</td>
<td>Control/Comparison</td>
<td>Not applicable</td>
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<tr>
<td>O</td>
<td>Outcome</td>
<td>Nursing care</td>
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Source: Adapted from Santos, Pimenta, Nobre\(^12\).

The second stage comprehended the search of articles indexed at the following databases: Latin American and Caribbean Health Science Literature (LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE) and Scientific Electronic Library Online (SciELO) and other dissertations utilizing the Health Science Descriptors (DeCs): “Nursing History”, “Nursing Theory”, “Comfort Care”. Due to limitations of data...
availability, the descriptors related to palliative care, oncology and end-of-life care were not applied, only those associated with historical evolution of comfort and nurse care. Full articles published in Portuguese, English and Spanish in any year were included and studies out of the scope, case reports and duplicate articles have been rejected.

In the third stage, 517 articles matched to DeCs were exported to the software Rayyan to organize and manage the data collected.

The 517 articles were reviewed by two independent reviewers in the fourth stage; 457 not meeting the inclusion criteria and 34 duplicates were rejected. The 26 remaining were reviewed once again when the articles were read in full and six out of the scope were removed. Of the 20 eligible, four were focused to end-of-life patient and 16 were considered because they correlate comfort with nurse care. From those, 17 articles, two master’s thesis and one PhD thesis were listed in a table containing the title, year, country, methodology and main results. Figure 1 portrays the flowchart of the methodology according to PRISMA15.

The historical evolution revealed that comfort is subjective, mutable, and bound to nursing. Initially, comfort was provided by women because it was believed they were docile, abnegated and gentle which made them naturally fit34. Care was empiric and intuitive with actions focused to fertility, and children’s rearing and development, support to nurses and in death. Feeding-related instructions, medicinal herbs and management were passed from generation to generation15,16. Renaissance stimulated art and science concomitantly with the dissolution of religious institutions and care-focused actions, delaying advances of nursing 35. Decay exposed the insalubrity of the environment and exclusion of least socially endowed. And at that moment, the so-called ladyship and charity sisters began visiting the infirm, bringing comfort through food supply, drugs and encouragement to those dying14-16.

Since Christianity, care was provided by deacons, and it began to be seen as charity and virtue. Comfort meant pain relief and minimizing the suffering of the poor, infirm and prisoners14-16. According to Foucault36, ensure
<table>
<thead>
<tr>
<th>Author and year</th>
<th>Study design</th>
<th>Type</th>
<th>Country</th>
<th>Objective</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kolcaba; Kolcaba, 1991</td>
<td>Analysis of concept and integrative literature review</td>
<td>Scientific article</td>
<td>USA</td>
<td>Analyze the semantics of comfort and correlate with its use in nurse practice, theory and research</td>
<td>The concept of comfort is related to nursing care since the beginning. The term is found in texts, quoted in practice, described in theories by Nightingale, Roy, Orlando, Watson and Paterson. Its definition considers nursing theory, what the individual perceives as comfort and its context</td>
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<td>Kolcaba, 1995</td>
<td>Integrative literature review</td>
<td>Scientific article</td>
<td>USA</td>
<td>Identify factors reinforcing comfort as the state-of-art of nursing care</td>
<td>The theory of comfort consolidates nursing care, valuing the holistic model, expanding the creativity and recommending the individuality</td>
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<td>Mcilveen; Morse 1995</td>
<td>Integrative literature review</td>
<td>Scientific article</td>
<td>USA</td>
<td>Describe the role of comfort in nursing care between 1900 and 1980</td>
<td>In 1900, comfort was the core of nursing practice. In 1930, comfort takes over the strategic position to reach the objectives related to nursing care. In 1960, comfort stops being the main goal. And in 1980, aspects beyond the physical context were added and initiatives to highlight emotional aspects began</td>
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<tr>
<td>Kolcaba; Fisher, 1996</td>
<td>Descriptive, exploratory and qualitative research</td>
<td>Scientific article</td>
<td>USA</td>
<td>Describe the structure of comfort-based holistic care as interdisciplinary implementation strategy of comfort in caring for the patient and family during the process of death</td>
<td>The structure of end-of-life holistic comfort includes the values of the individual, stimulates the bond among family members and promotes conducts aligned with the patient’s values avoiding life-prolonging futile interventions</td>
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<tr>
<td>Vendlinski; Kolcaba, 1997</td>
<td>Integrative literature review</td>
<td>Scientific article</td>
<td>USA</td>
<td>Describe the structure of theory of comfort care that offers definitions and a grid for the art of comfort care that are relevant to hospice nursing practice</td>
<td>The structure of comfort theory allows the evaluation of comfort by means of nursing interventions</td>
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<td>White et al., 2001</td>
<td>Descriptive study</td>
<td>Scientific article</td>
<td>USA</td>
<td>Determine end-of-life care core competencies and educational needs from practicing oncology nurses and to describe the characteristics of the respondents that are associated with selection of the leading core competencies</td>
<td>Nurses’ required competencies to manage end-of-life patients are focused to nursing interventions prioritizing comfort, which demands technical-scientific skills about palliative care, symptoms management, communication and conflicts management</td>
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<td>Mussi, 2005</td>
<td>Analysis of the literature of nursing</td>
<td>Scientific article</td>
<td>Brazil</td>
<td>Analyze the theoretical conceptions about comfort in the history of nursing and its determinants to find clues and bring light into existing theoretical inaccuracies about comfort and contradictions lived in nursing practice and teaching while promoting comfort</td>
<td>Nursing theories reinforce the subjectivity of comfort and discomfort. Institutions looking for theoretical fundaments for comfort-based nursing practice tend to direct comfort to the patient and valuing its trajectory</td>
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<td>Silva, 2008</td>
<td>Descriptive, exploratory and qualitative study</td>
<td>PhD thesis</td>
<td>Brazil</td>
<td>Conceptualized comfort in the perspective of the female nurses and patients at hospital admission, classify the characteristics attributed to the semantics of term “comfort” and identify theoretical framework that address comfort</td>
<td>Nurses of hospital admission believe comfort is related to well-being, meeting the patients’ needs and reestablishment of the clinical stability</td>
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<td>Araújo, 2013</td>
<td>Descriptive, exploratory and qualitative study</td>
<td>Master’s thesis</td>
<td>Brazil</td>
<td>Analyze the experiences of comfort of individuals in palliative care utilizing music</td>
<td>Implementation of music-therapy ensures comfort, relaxation and pain relief. In parallel, contributes to a calm environment and brings up affectionate memories and potentializing the bond nurse-patient</td>
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<tr>
<th>Author and year</th>
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<tr>
<td>Hou et al., 2014&lt;sup&gt;22&lt;/sup&gt;</td>
<td>Descriptive, exploratory and qualitative study</td>
<td>Scientific article</td>
<td>China</td>
<td>Identify nurses' knowledge of care comfort to inpatients</td>
<td>67% of the nurses working in oncology are involved in care comfort but did not acquire respective skills during their formation</td>
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<td>Moura, 2015&lt;sup&gt;23&lt;/sup&gt;</td>
<td>Descriptive, quantitative approach research</td>
<td>Master’s Thesis</td>
<td>Brazil</td>
<td>Identify how author nurses address comfort in oncology; describe factors indicated by cancer patients in outpatient chemotherapy treatment interfering in their perception of comfort; create instruments (consultation scripts and leaflets) supporting the consultation</td>
<td>Kolkaba Comfort Theory favors the implementation of the nursing process in oncology outpatient units, helping the identification, intervention and evaluation of physical, psychospiritual, sociocultural needs and environmental conditions</td>
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<td>Ponte; Silva, 2015&lt;sup&gt;24&lt;/sup&gt;</td>
<td>Integrative review</td>
<td>Scientific article</td>
<td>Brazil</td>
<td>Identify comfort measures provided by nurses found in articles published by Brazilian nurses in the light of Katherine Kolcaba Comfort Theory</td>
<td>Comfort is addressed in the theories of Nightingale, Hall, Roy, Peplau, Watson, Leininger, Paterson, Zderad, Morse and Kolcaba, that should be the result of nursing interventions. Physical comfort was predominant among the four dimensions described by Kolkaba, mainly due to the necessity of pain relief management. Sociocultural context includes the patient and its interpersonal relationships, education, religion, rituals and beliefs. Psychospiritual context addresses self-concept, emotions appearing in face of the clinical condition and faith. Environmental context reinforces the importance of a clean, calm, aired and noiseless ambient</td>
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<td>Mendes et al., 2016&lt;sup&gt;25&lt;/sup&gt;</td>
<td>Reflexive analysis</td>
<td>Scientific article</td>
<td>Brazil</td>
<td>Reflect about the theory of comfort and its philosophical-theoretical fundaments as support for nursing care to the individual, family and communities</td>
<td>Comfort-based nursing practice favors customized care and identifying signs of discomfort with interventions and continuous reassessment focused to the patient</td>
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<td>Pinto et al., 2017</td>
<td>Analysis of concept and integrative literature review</td>
<td>Scientific article</td>
<td>USA</td>
<td>Define and develop comfort-based nursing interventions</td>
<td>The concept of comfort is subjective, reinforcing the necessity of theoretical base supporting nursing care</td>
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<tr>
<td>Pereira et al., 2019</td>
<td>Analysis of concept and integrative review of the literature</td>
<td>Scientific article</td>
<td>Brazil</td>
<td>Analyzed the concept of comfort in the light of Rodgers’ evolutionary concept analysis and incorporate elements of concept analysis in the structure of nursing diagnosis “Readiness for Enhanced Comfort” (00183)</td>
<td>Initially, comfort was the central core of nursing care, interventions were targeted to provide comfort to the physical body and environment. The Great Depression led to the institutionalization of health following a medication-centered model. With new technologies, the nurse started to manipulate complex devices and improve its own management skills</td>
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<td>Cardoso et al., 2019</td>
<td>Integrative review</td>
<td>Scientific article</td>
<td>Brazil</td>
<td>Analyze scientific evidences on the use of Kolcaba comfort theory when the nursing process is being implemented</td>
<td>Kolcaba comfort theory favors the identification of discomfort, allowing the implementation of structured and patient-centered nursing process</td>
</tr>
<tr>
<td>Pereira et al., 2020</td>
<td>Literature review</td>
<td>Scientific article</td>
<td>Brazil</td>
<td>Explore the studies about comfort to end-of-life patients to determine evidence patterns in this area</td>
<td>Comfort means well-being, but end-of-life is a fragile moment to the individual, family and professionals involved. Feelings of sadness, fear and impotence pervade this moment. The nurse in charge should promote actions to bring physical, psychospiritual, sociocultural and environment comfort</td>
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<tr>
<td>Cardoso et al., 2020</td>
<td>Cross-sectional study</td>
<td>Scientific article</td>
<td>Brazil</td>
<td>Identify nursing diagnosis of older adults admitted at the intensive care units; categorize according to the dimensions of the comfort (physical, psychospiritual, sociocultural and environmental) following Kolcaba theory</td>
<td>Nursing diagnosis listed for hospitalized older adults relates with Kolcaba’s four dimensions of comfort</td>
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comfort to the infirm granted the own salvation. With the foundation of the Hospital Kaiserswerther Diakonie, the deaconesses resurfaced, tending to poor and infirm while studying theology and nursing. Florence Nightingale was among the women who have been trained and during the epidemics of cholera and after the Crimean War, she consolidated its environmentalist theory, emphasizing that unhealthy environments lead to sickening and discomfort14, 16,24.


Lydia Hall37 defined caring as a process and Ida Jean Orlando (1960) was one of the pioneer nurses who used the term “nursing process”; in her theory, nurse should ensure physical and mental comfort to the patient. Callista Roy utilizes psychological comfort to promote adaptation. Madeleine Leininger relates comfort with caring. Jean Watson considers comfort as a variable influencing development. Josephine Parteson and Loretta T. Zderad advocate that mental discomforts may reverberate in the physical. Janice M. Morse reinforces that comfort should be the final result of nursing actions. Katharine Kolcaba, in her theory of comfort, demonstrates the search for satisfaction of the needs by means of relief states, tranquility and transcendence which develop through physical, environmental, social and psychospiritual comfort15,24,30.

Currently, it is recommended that the nursing process is grounded on a theory that guides the care as nursing practice requires thorough evaluation of the individual, critical thinking and mastering the area of action38. Even if comfort has followed the historical evolution of nursing, Hou et al.22 noticed that nearly 65% of the nurses working in oncology and caring for end-of-life patients did not have specific formation in that area. The nurses at the admission unit indicated that comfort is associated with clinical stability of the patient according to the study of Silva21. Berntzen et al.31 affirmed that inpatients have some discomfort that the nursing team could overlook due to the lack of systematized approaches.

Katharine Kolcaba’s comfort theory potentialized the holistic model guiding the nurse look towards signs of discomfort of end-of-life patient through four dimensions of comfort: physical, environmental, social and psychospiritual.

This theory differs from Saunders39 reflections regarding the multidimensionality of the concept of pain, called as total pain which encompasses four dimensions of suffering and reveals the necessity of thorough evaluation and attention to these aspects.

In the study of Ponte and Silva24, the physical dimension highlighted the necessity of pain management. The environmental context emphasized the importance of ensuring a pleasant, clean, airy and noiseless ambient. The social context involves interpersonal relations while the psychospiritual raised questions in relation to self-concept and beliefs. The nurse is responsible for the actions that target the comfort in these four dimensions since end-of-life patients management is marked by feelings as sadness, fear and impotence17,18,23,29,28.

According to Araújo6, Katharine Kolcaba’s theory can warrant the required framework for the implementation of music therapy as complementary and integrative practice able to provide comfort in an environment that promotes relaxation, tranquility and symptoms relief concomitantly with the possibility of the patient...
accessing affectionate memories, strengthening the bond with family and health team.

Currently, there is material to apply this conduct by the National Policy of Integrative and Complementary Practices (PNPIC), sanctioned and implemented in the National Health System (SUS). It is possible to notice an array of options of access to and health practices that promote comfort to the patient as music therapy. A recent study published in the American Society of Clinical Oncology (ASCO) emphasized the beneficial role of music as an effective strategy in reducing stress in patients submitted to cancer treatment with chemotherapy. The present study highlights the importance of therapeutic approach of music as an invaluable tool to improve the emotional well-being of these patients along the tough journey of the treatment.

White et al. noticed that nurses caring for end-of-life patient should master the scientific-technical competencies in palliative care, patients’ rights, bioethics, communication, conflicts management, further to knowing how to identify and manage discomfort, due to the singularity of the individuals, the variability of symptoms, changes of the clinical condition, reduction of functionality and available resources. Furthermore, it should include family and health team, respecting its will and avoiding futile conducts that could cause even more suffering.

The theory of comfort needs to be explored continuously in educational settings to ensure professionals are able to incorporate in their caring practice. Mussi et al. reinforce that institutions looking for theoretical foundation for comfort-based nursing practice tend to focus the patient, valuing its journey and safety, contributing to diminish the four dimensions of suffering proactively and holistically.

CONCLUSION

Comfort is inseparable from nursing care. Nursing theories addressing comfort warrant foundation to and guide nursing actions for end-of-life cancer patients in the light of the physical, environmental, psychosocial and spiritual dimensions.

The limitations of the studies are the scarcity of articles designed for end-of-life patients. However, they contributed to the state-of-art in promoting reflections about education and dissemination of the theory of comfort as caring practice to patients in palliative care in order to ensure more comfort and quality-of-life addressed in this type of care. Therefore, scientific productions focused to end-of-life comfort and discussions during the educational formation are necessary.

CONTRIBUTIONS

All the authors contributed substantially to the study design, acquisition, analysis and interpretation of the data, wording and critical review. They approved the final version to be published.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

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None.

REFERENCES

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Recebido em 7/11/2023
Aprovado em 16/2/2024