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Dignity at the End of Life: Perceptions among Primary Health Care Professionals

Dignidade no final da vida: percepções de profissionais da Atenção Primária à Saúde

Dignidad al final de la vida: percepciones de profesionales de la Atención Primaria de Salud

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Abstract

Objective: To understand how Primary Health Care professionals perceive dignity at the end of life. **Methods:** Qualitative research conducted between October and November 2022 with 12 Primary Health Care professionals from five basic health units in southern Brazil, adults with a minimum service period of three months. Professionals on leave or vacation during data collection were excluded. The discourses were obtained from the transcription of semi-structured interviews and analyzed through John Creswell's Content Analysis by developing codes, subcategories, and categories. The research was approved by the Research Ethics Committee (Opinion no. 5.651.793). **Results:** Two subcategories emerged. The first addressed transformations at the end of life related to dignity, encompassing biopsychosocial, spiritual, and economic changes, loss of autonomy, and frailty. The second explored the meanings attributed to dignity, relating them to transcendence, palliative care, comfort promotion, and appropriate control of signs and symptoms, linked to the possibility of dying at home. **Conclusion:** Dignity was understood as respect for patients' autonomy and wishes. Although challenges to promoting it at the end of life remain, palliative care and the home environment are recognized as essential for providing comfort and preserving dignity.

Descriptors:
Terminal Care. Respect. Right to Die. Health Personnel. Primary Health Care.

Whats is already known on this?
In bioethics, dignity is discussed and conceptualized in connection with the enhancement of autonomy. In healthcare delivery, particularly within primary care, there is still limited professional preparedness to implement it in the context of life's finitude.

What this study adds?
It highlights Primary Health Care professionals' perceptions of dignity, associated with the principles of palliative care, which are essential for preserving autonomy and respecting individual wishes, thereby improving the quality of end of life experience.

Resumo

Objetivo: Compreender as percepções de profissionais da Atenção Primária à Saúde sobre a dignidade no final da vida. **Métodos:** Pesquisa qualitativa, realizada entre outubro e novembro de 2022, com 12 profissionais da Atenção Primária à Saúde de cinco unidades básicas de saúde do Sul do Brasil, adultos, com tempo mínimo de serviço de três meses. Excluíram-se os profissionais em afastamento laboral ou em férias durante a pesquisa. Os discursos foram extraídos da transcrição de entrevistas semiestruturadas e submetidos à Análise de Conteúdo de John Creswell, pela criação de códigos, subcategorias e categorias. Pesquisa aprovada pelo Comitê de Ética em Pesquisa (Parecer n.° 5.651.793). **Resultados:** Foram criadas duas subcategorias, a primeira sobre transformações no final da vida relacionadas à dignidade, considerando modificações biopsicossociais, espirituais e econômicas, perda de autonomia e debilidade. Na segunda apresenta-se os significados de dignidade, relacionando-os ao transcendente, aos cuidados paliativos, à promoção de conforto e adequado controle de sinais e sintomas, associados à possibilidade de morrer em casa. **Conclusão:** A dignidade foi compreendida como respeito à autonomia e às vontades dos pacientes. Embora persistam desafios para promovê-la no final da vida, os cuidados paliativos e o ambiente domiciliar são reconhecidos como fundamentais na oferta de conforto e preservação da dignidade.

Descritores:

Assistência Terminal. Respeito. Direito a Morrer. Pessoal de Saúde. Atenção Primária à Saúde.

Resumen

Objetivo: Comprender las percepciones de los profesionales de la Atención Primaria de Salud sobre la dignidad al final de la vida. **Métodos:** Investigación cualitativa, realizada entre octubre y noviembre de 2022, con 12 profesionales de la Atención Primaria de Salud de cinco unidades básicas de salud del sur de Brasil, adultos, con un mínimo de tres meses de servicio. Se excluyó a los profesionales que estaban de baja laboral o de vacaciones durante la investigación. Los discursos se extrajeron de la transcripción de entrevistas semiestructuradas y se sometieron al Análisis de Contenido de John Creswell, mediante la creación de códigos, subcategorías y categorías. Investigación aprobada por el Comité de Ética en Investigación (Dictamen n.º 5.651.793). **Resultados:** Se crearon dos subcategorías, la primera sobre las transformaciones al final de la vida relacionadas con la dignidad, considerando las alteraciones biopsicosociales, espirituales y económicas, la pérdida de autonomía y la debilidad. En la segunda se presentan los significados de la dignidad, relacionándolos con lo trascendente, los cuidados paliativos, la promoción del confort y el control adecuado de los signos y síntomas, asociados a la posibilidad de morir en casa. **Conclusión:** La dignidad se entendió como el respeto a la autonomía y los deseos de los pacientes. Aunque substistan los retos para promoverla al final de la vida, los cuidados paliativos y el entorno doméstico se reconocen como fundamentales para ofrecer confort y preservar la dignidad.

Descriptores:

Cuidado Terminal. Respeto. Derecho a Morir. Personal de Salud. Atención Primaria de Salud.

INTRODUCTION

End of life refers to the phase of illness marked by progressive organic and functional decline, refractory symptoms, and limited prognosis. At this stage, comfort must be prioritized through relief of suffering and through delivery of palliative care (PC), an approach intended to improve quality of life among individuals who live with life-threatening conditions and among their relatives.[1-2]

PC rests on strategies centered on relief of physical, psychosocial, and spiritual symptoms.[3] An international expert consensus recommends early provision, starting at diagnosis of life-threatening conditions and extending to bereavement support for relatives.[4]

The need for PC is globally high; each year, an estimated 40 million individuals die with unmet palliative care needs.[3] In 2017, about 56.8 million individuals required PC worldwide, and nearly half were in their last year of life.[5] In Brazil, in 2019, this number exceeded 885,000 individuals, indicating substantial mortality with unrelieved suffering, and only in 2024 was the National Palliative Care Policy (PNCP) approved.[6-7]

PNCP highlights the strategic relevance of Primary Health Care (PHC) in structuring PC within healthcare networks. One of its guidelines is PHC strengthening, which positions this level as coordinator of care and assigns responsibility for PC delivery in both health services and home settings.[7]

PHC constitutes the main gateway to health services in Brazil and, through actions by the multidisciplinary team, offers essential care for individuals, families, and communities aimed at health promotion and recovery of health. Within this scope, professionals follow individuals with chronic conditions and provide support for physical, emotional, spiritual, and social demands consistent with PC principles.[8]

Implementation of PC in PHC, although essential for comprehensive, longitudinal follow-up of individuals with chronic conditions, encounters significant barriers. These include scarce resources, insufficient professional training regarding its principles, and cultural resistance to care for patients at the end of life, which directly affects care delivery and dignity.[8]

Dignity can be defined as an absolute value that qualifies the human person and is grounded in safeguarding a virtuous existence. This valuation allows individuals to be regarded as dignified by virtue of a human essence that enables deliberate, conscious decision-making and expression of wishes, either personally or through those who hold responsibility for them.[9]

Worldwide, dignity was recognized in 1948 by the Universal Declaration of Human Rights as an attribute or right inherent to all individuals, who are considered equally free.[10] In Brazil, the Federal Constitution guarantees dignity by prohibiting subjection of any individual to torture or to degrading, inhuman practices, since each person is acknowledged as a rights-bearing subject.[9] Thus, protection of dignity encompasses rights such as health, assistance, life, respect, freedom, and equality, given that human beings are considered superior to all other living beings due to conscience and rational capacity.[10]

Within this perspective, support for a dignified life implies recognition and appreciation of each person's individuality, with respect for their values and assurance of active participation in decisions about personal care. At the same time, support for a dignified death implies an end of life with minimal or no suffering, preservation of autonomy, and respect for the person's biography.[11]

Therefore, understanding finitude as a natural process aligns with the bioethical principle of non-maleficence, since avoidance of potentially inappropriate, futile interventions expresses respect for the person by not subjecting them to treatments that generate undignified conditions of existence.

In this context, critical reflection by health professionals on their own beliefs and cultural background becomes crucial, since these must not be confused with those held by the person receiving care or by their relatives. This attitude may facilitate shared decision-making at the end of life, grounded in dignity and in personal wishes as starting points for care planning.[3]

It is therefore necessary to envision care practices that preserve dignity for individuals at the end of life, including those who receive care at home. The aim is to strengthen attention to finitude and incorporate a renewed perspective on this process into clinical practice, in order to improve care quality and preserve dignity at the end of life.

In light of these considerations, this article aims to understand how Primary Health Care professionals perceive dignity at the end of life.

METHODS

This qualitative study was conducted between October and November 2022. The research method was described based on the Consolidated Criteria For Reporting Qualitative Research (COREQ) guideline, in its translated and validated Portuguese version.[12] Semi-structured interviews were conducted with twelve health professionals working in five Basic Health Units (BHUs) recognized as Family Health Strategy (FHS) units in a city in southern Brazil.

The interviewer was female, an undergraduate nursing student at the time of data collection, with experience in qualitative research through prior involvement in a scientific initiation project. For this study, at least three interviews were conducted under supervision of the advisor, a PhD-prepared nurse and university faculty member, in order to ensure proper data production.

Participants were selected through non-probability sampling, specifically snowball sampling.[13] The first participant was a key informant approached in person, who worked at the setting where the first author of the article was completing a mandatory curricular internship. After the first interview, this participant was asked to indicate another PHC professional, who needed to be based at a unit recognized as a FHS facility, and so on consecutively. The final setting, comprising five BHUs, was justified by the sampling technique adopted and by achievement of data saturation.

Inclusion criteria were: being a health professional aged at least 18 years, having verbal communication abilities, and having worked in the service for at least three months, a period considered sufficient for familiarization and for practice within the health service alongside patients with life-threatening conditions. Exclusion criteria were professionals who were on leave or on vacation during data collection.

Professionals indicated from other BHUs were contacted and invited through a messaging application, during which the first author introduced herself, explained the research objectives, and expressed interest in conducting the interview. In total, 22 professionals were eligible and invited to participate. Among them, ten refused to participate, nine nurses and one community health worker (CHW), who justified their refusal due to excessive demand and workload. Thus, 12 professionals took part in the study.

After acceptance, interviews were scheduled according to professionals' availability and took place in person in private rooms within the health units. Interviews were conducted in participants' workplace, in a private setting with the researcher, and were audio-recorded with a device that captures, stores, and allows later analysis of sound records; interviews lasted between 12 and 50 minutes, and recordings were destroyed after transcription. No interview had to be repeated, and no field notes were produced.

A protocol was used to guide the interviews, including questions about care for individuals with severe, advanced conditions with risk of death, namely: In cases involving patients with severe, advanced conditions and risk of death, what do you perceive that the illness affects in physical, psychological, social, and spiritual terms? What does dignity mean to you? In cases involving patients with advanced conditions, close to death, what do you believe dignity is? What do you consider a dignified death? In your professional practice, what do you consider a factor that facilitates care actions that promote dignity for these patients? And what do you consider a factor that hinders care actions that promote dignity for these patients? Can you describe care actions that the team carries out to promote dignity for patients in these conditions who are followed by your team?

Qualitative data analysis followed the steps proposed by John Creswell.[14] These steps comprise organizing and preparing data, reading collected data, performing detailed analysis and coding, grouping codes into categories, reporting information in narrative form, and interpreting or extracting meanings from the results through researcher inference.[14]

After each interview, the first author transcribed the material into a text document, which ultimately totaled 95 pages and was reviewed by the advisor, the second author of this article. Transcriptions preserved participants' individuality, with all expressions reported, and only slang, filler expressions, and repeated words removed to facilitate comprehension. The documents were anonymized, stored in cloud storage, and remained accessible only to the first author and the study advisor. Transcripts were not returned to participants. Data saturation was discussed, and when repetition across responses was identified, data collection was brought to an end.

Documents were organized in a Google document-management platform and coded by the first author under supervision and agreement with the advisor, using Atlas.ti in its free version, available for

student use for five days. The software was selected due to its functions and user-friendly features, which enable document import and code organization for category construction.[15]

A total of 21 codes were created and assigned to 237 excerpts from participants' interviews. These codes supported construction of four subcategories and two categories, which emerged from data and thematic proximity. This article focuses on one category for presentation of the findings: Perceptions of dignity among Primary Health Care team professionals. Table 1 summarizes the codes used to define the subcategories within the thematic category presented.

Chart 1. Presentation of category, subcategories, and codes. Pelotas, RS, Brazil, 2022.

Codes	Subcategories	Category
Disease-related changes	Transformations at the end of life and their relation to dignity	**Perceptions of dignity among Primary Health Care team professionals**
Physical changes		
Psychological changes		
Social changes		
Spiritual changes		
Feeling of care		
Dignity for oneself	Meanings of dignity	
Patients' dignity		
Mention of God		
Palliative care		

Source: authors (2026).

Regarding study results, feedback was provided to the Municipal Center for Management of Collective Health Education (NUMESC) through presentation and executive summary, which was also sent to study participants.[16] The research adhered to Resolution No. 466 of December 12, 2012, with approval from the Research Ethics Committee through Opinion No. 5.651.793 and participant consent via signature of the Free and Informed Consent Form (FICF).

RESULTS

Among the 12 female participants interviewed, five were nurses, four were physicians, two were nursing technicians, and one was a community health worker (CHW). Participants ranged in age from 30 to 55 years. Professional experience at BHUs varied between eight months and 20 years. All had PHC experience, and regarding palliative care specialization, two nurses were pursuing postgraduate specialization, one physician had contact with the topic during medical school, and the CHW had participated in palliative care training conducted by students at the service.

The following sections present the constructed subcategories: Transformations at the end of life and their relation to dignity and Meanings of dignity.

Transformations at the end of life and their relation to dignity

This subcategory encompasses disease-related changes and their relation to dignity, which emerged spontaneously in narratives during interviews, without predetermined order. These changes were linked to the physical dimension, such as body alterations and functional capacity loss; the psychological dimension, involving emotions, thoughts, and mental health; the social dimension, encompassing interpersonal relations, work, and daily life changes; the spiritual dimension, related to beliefs, values, and search for meaning; as well as the feeling of care.

Participants described the impact of transformations stemming from advanced disease on daily life among individuals at the end of life, highlighting challenges and limitations experienced. They also emphasized feelings involved in care delivery and associated end of life with severe, advanced conditions, particularly cancer. Some statements also revealed surprise at cancer diagnosis, perception of disease as linked to frailty, and loss of resilience.

> The majority of these conditions that can lead to death, these diagnoses, is cancer. [...] Physically, the person becomes extremely debilitated [...] those with severe disease [...] constantly think, especially in the early moments after diagnosis, that they will die. (Interviewee 10)

> [...] what causes it most is cancer, which is the most severe condition I have. [...] (Interviewee 5)

> [...] we had a patient who passed away 15 days ago [...] she came to the BHU last year complaining of diarrhea alternating with normal stools, we requested a colonoscopy and it revealed intestinal cancer, we referred her to CERON [Center for Radiotherapy and Oncology], she underwent treatment and surgery, and she was doing super well, then she didn't survive. (Interviewee 7)

Difficulty accepting terminality in young individuals was noted, along with embarrassment experienced by those who become dependent on care.

> There are situations of more terminal end-of-life status, which we accept more easily. There are younger patients in terminal state due to certain conditions, for example cancer, which we have many cases of here in the unit, in our territory. That's harder, right? (Interviewee 11)

> [...] I think the worst for the patient is being bedridden, depending on someone else to eat, bathe, change diaper; I think that's embarrassing [...] sometimes it's not even advanced age, because there are young patients in that situation too. (Interviewee 8)

Physical changes mentioned included loss of autonomy, general frailty, and difficulties performing basic and instrumental activities of daily living.

> They start losing autonomy, generally when they can no longer perform daily life activities alone... go to the bathroom, dress, put on shoes, take a bath. (Interviewee 12)

> [...] when there is this type of patient, usually they no longer speak. (Interviewee 3)

> Many cannot eat, have difficulty with elimination, evacuating; many need catheters, and we also change catheters in this type of patient. There is pain, many complain of pain even when medicated, including with morphine. (Interviewee 11)

Psychological changes highlighted emotional distress, patients' difficulty expressing feelings, and limitations in assessing psychological status and establishing communication.

> There are cases of people who cannot [communicate] because of stroke sequelae, so they cannot communicate to say how bad they feel, how scared they are..., but when people are in full consciousness they say they do not want to die, do not want to leave

> their relative, their child, grandchild. It's quite complicated to support someone when you know there is not much you can say to comfort them, right. (Interviewee 11)

Social changes provoked by disease included reduced sociability and compromised economic conditions and needs.

> [...] it ends up generating some depression too, they no longer want contact, sometimes not even with relatives, right. With friends, going out... I always say "put the chair, let's go out, let's get some sun," but it really causes significant decline. (Interviewee 7)

> Social issues too, like how the family sees you... "I was an active person in my community, my church, wherever, in my family group I am no longer, I am dependent, confined to my home, walk with difficulty, with crutch assistance." (Interviewee 12)

Participants reported that patients' and relatives' economic conditions influence treatment, support provided, and symptom control.

> [...] Families with more abundant financial resources can often provide better support for the patient. (Interviewee 4)

> Also, I think it complicates a lot because it demands money, everything. Food issues, if specific nutrition is needed, diapers, mattress, home accommodation; many need higher hospital beds, if they cannot borrow one, which is sometimes difficult, [...] so some people do not have medicine, money to buy it. When you have money everything becomes easier, at least in that sense, you need something, you go there and alleviate, provide comfort [...]. (Interviewee 11)

Additionally, difficulties addressing spiritual aspects with patients were expressed.

> Ah, I think the fear of dying, right? For everyone, with religion or not, it's complicated; I think those with religion can rely more on something, have support and hope. (Interviewee 9)

> Worse that I lack knowledge even to know about these issues, because I had little contact with it and the patients I had do not talk about it, do not have it, so it's hard to assess. (Interviewee 3)

Meanings of dignity

This subcategory addresses themes related to dignity for oneself, illustrating how individuals perceive their own value and respect, as well as patients' dignity, associated with how they are treated in the health care context. It also covers mention of God, spirituality, and beliefs as sources of meaning and support, along with palliative care, understood as practices aimed at promoting comfort, relieving suffering, and enhancing quality of life in the face of disease.

> For me, dignity is being able to face each stage of your life in a healthy way, both physically, psychologically, spiritually. It is having the right to live and die under at least reasonable conditions. To live life's moments in peace. To have a life... you can have a simple life, with few material resources, but if you have peace and the minimum for survival, to meet basic needs, and be able to die with dignity, with

> health assistance, family by your side, the treatment you need, I think that's dignity [...] (Interviewee 2)
>
> [...] I think it's being respected in your body, social issues, psychological [...] It's having the minimum you need to survive, having a dignified life. Not just to survive, right, but to have a good life, a pleasant life, something like that. To be respected, not need to beg for anything... not just survive, right, but an existence with some meaning, some significance. (Interviewee 9)
>
> [...] now I will address palliative care... it's that function of impeccable pain and symptom treatment. [...] So I think speaking of dignity near death, we have to relieve pain. After that, relief of [other] symptomms. (Interviewee 12)

Control of signs and symptoms was also involved, along with access to basic living conditions such as food, services, and health professionals.

> I think it's not feeling pain, always being well hygienic, basic needs met, having comfort, regardless of death or life, being treated with respect, following all human rights issues [...] not using the person as a test, as sometimes happens in hospital where they "try to intubate." (Interviewee 3)
>
> Regarding disease, dignity is being well attended by a physician, by a health professional, whether at a BHU [basic health unit], emergency department, UPA [Emergency Care Unit], outpatient clinic, not waiting hours in a chair, having a bed when needed... [...] I think dignified care involves the professional's attitude of respecting you, not judging you... and also service infrastructure [...] If at home, having a proper place to sleep, eat, have food, bathe, have someone to care. (Interviewee 9)

Dignity was further linked to the possibility of dying at home, absence of suffering, non-abandonment, respect for autonomy, and preservation of self-perception.

> [...] relatives we see, "Ah, leave at home? Die at home?" I think the most dignified death for a patient with no prospect of changing the outcome is to be comfortable with family, with people they know... [...] I believe that environment must be much more dignified. [...] Not so much the patient, but relatives still have this idea that everything must be done, they do not realize that not always that is dignified, right, and the person goes to ICU, alone. (Interviewee 10)
>
> Dignity more like is the person not dying alone. We know cancer also consumes those nearby, but it's just not being abandoned and alone... simply not having anyone by your side to provide comfort and support. Having the dignity of having someone who can be there with you in your last days is always good. (Interviewee 5)
>
> I understand it as death without pain, with as little suffering as possible, because some things you cannot minimize to the point the person has no pain, no discomfort, no anxiety. But I believe in minimizing as much as possible pain, discomfort, anguish, that the person understands and can remain serene in that phase when they perceive themselves, as much as they can perceive, no return [...]. (Interviewee 11)

> We do not yet use advance directives here, but we try to make a gentlemen's agreement with the family. [...] They do not want [to know about prognosis], have hope of cure even facing very severe disease. (Interviewee 12)

Finally, some professionals mentioned God, either through patients' statements or in their own accounts.

> They have hope they will be cured, it's God, all that. (Interviewee 12)

> [...] thank God she managed to recover, but she had to undergo treatment. (Interviewee 5)

DISCUSSION

Results indicate that end of life is understood as a period of profound transformations, marked by suffering, loss of autonomy, and proximity to death, with physical, psychological, social, and economic impacts for patients and families. In this context, dignity was understood as preservation of autonomy, comfort, and pain control, as well as assurance of care that enables dying without suffering, preferably at home and alongside family members.

This study identified professionals' difficulty addressing and following individuals with advanced conditions in PHC, particularly those affected by cancer. As a complex condition with unpredictable prognoses and distinct progression patterns, it poses challenges for professionals at this care level, as well as for patients and their relatives.[17]

Interviewed professionals reproduced the social maxim that end of life is more acceptable during older adulthood. Consistent with this finding, research conducted with nursing professionals in an intensive care unit revealed that terminality is more alarming in young individuals, with age acting as a factor that triggers more thoughts and reflections on acceptance difficulties in these cases.[18] This understanding reveals how age functions as a moral marker of death, naturalizing terminality in older adulthood and rendering end of life in young individuals socially more disturbing.

Recurrent mentions emerged regarding impaired physical mobility, physiological elimination, and reduced capacity to perform basic life activities. These changes are believed to directly impact autonomy and, consequently, patient dignity. In this regard, research investigating the effect of personal autonomy loss on dignity-related distress suggests that reduced autonomy increases suffering and loss of existential meaning for the patient, consequently affecting dignity perception.[19]

Promotion of dignity starts with recognition of individual autonomy. For autonomy to be effectively exercised, choice options must exist regarding what benefits the individual most, whether biological, social, or psychological in nature. When autonomy is reduced, protecting it becomes a duty, ensuring that the person's opinions and choices are considered, provided they cause no harm to others.[20]

This research also revealed professionals' fragility regarding support for patients with impaired communication, mainly due to difficulty accessing their expressions, emotions, and wishes. Consistent with these findings, research identified that patients cared for by palliative care teams face communication challenges.[21] To enhance and/or enable communication with compromised patients, health professionals must seek alternatives such as gestures, writing, drawings, or specific codes, in order to improve this exchange and consolidate patient understanding of their health context.[22]

Furthermore, interviewees perceived that disease provokes changes in self-recognition among those affected and generates uncertainties about their social role. Literature agrees that, from diagnosis of severe, advanced disease, changes occur in living patterns that lead the person to confine themselves to their home, largely due to discouragement and functional decline. However, this symptom must not be ignored, and social support can be facilitated through support groups and strengthening of personal relations, contributing to symptom management and assistance with routine activities during illness.[23]

Beyond that, provision of comfort in this research was directly related to patients' financial situation. Access to material resources, medications, and services depends on socioeconomic conditions, which determine promotion of dignity and end-of-life quality. Research indicated that factors such as low educational level and worse socioeconomic conditions directly relate to physical capacity loss and functional decline among older adults, with reduced access to health services as a decisive factor.[24]

Additionally, low income and low educational level are social health determinants linked to reduced survival and increased late diagnoses, impairing dignity maintenance during end of life.[25]

In relation to spiritual issues, direct influence exists between beliefs and how disease will be faced, but in some cases difficulty arises in discussing the topic due to reluctance to enter patients' singular aspects. Consistent findings show that addressing religiosity and spirituality can be challenging for health professionals, not only due to scarce assessment models, professional training and preparation, but also due to available time and workload overload.[26] Nevertheless, health professionals must support patients and relatives based on beliefs, particularly when existential crises inherent to the end-of-life process intensify.[27]

Additionally, resort to God as a transcendent source of support and sustenance, as observed in this study, aligns with research conducted with patients receiving palliative care in an oncology unit, which identified that most interviewees had religion and that belief in a higher being, faith maintenance, and religious practices served as key pillars for facing severe disease, providing more meaning to life and greater comfort.[28]

This research further demonstrated that care and dignity meaning are influenced by the interplay between personal and professional experience. Narratives revealed that caring for someone dying is challenging, particularly in PHC given its responsibilities, and is not routine at this care level. In contrast, research with home care professionals showed perception of natural, beautiful death, where patients can remain close to family and receive social and spiritual support; professionals demonstrated availability to assist with decision-making and provide clarifications, although difficulty was acknowledged in dealing with finitude, considered easier when the person understands their prognosis.[29]

In this study, the term dignity was associated with respect for the minimum each person needs for survival, as well as respect for rights to fair treatment each deserves. The State plays a determining role in promoting people's dignity by, or ideally implementing, social, political, economic, and cultural strategies that qualify the dying process and death. Thus, enabling dignity allows provision of humanized conditions during illness so that the person feels comfortable experiencing a dignified death.[30]

Dignity was also related to palliative care, family support, appropriate pain control, dying at home, and avoidance of invasive practices that prolong suffering. Palliative care is characterized by individualized, humanized care aimed at relieving suffering, viewing the individual beyond disease, with focus on quality of life promotion through multidisciplinary action.[31] In this research, activation of this care type occurred precisely due to its proposal to address suffering in its multidimensional dimension.

In relation to dying at home, this possibility directly depends on a structured home care network and action by specialized palliative care teams, whose absence often makes this experience unfeasible or inappropriately transfers responsibility exclusively to the family. Additionally, some situations prevent patient permanence at home, including family incapacity to follow the dying process to the end, difficulty maintaining home permanence agreements, lack of available resources to ensure comfort, and bureaucratic issues after patient death at home.[31, 32]

Family and friend support at the final life moment proves central to maintaining patient dignity, particularly when understood as not feeling abandoned and not dying alone, meanings highlighted in this research. Authors state that strengthening support networks is fundamental and serves as an illness coping strategy that assists the patient in addressing physical and emotional issues.[33] Moreover, presence of trusted persons who collaborate in comfort promotion, combined with professional preparation to support those involved, optimizes care and allows patients to experience reduced suffering burden.[34]

Consistent findings from research with oncology patients receiving palliative care through home hospitalization service showed that, among end-of-life wishes, remaining close to family stood out, aiming to make final days more fulfilling. Death was also seen as separation, generating anguish; thus, support for these individuals is essential to facilitate farewells, reduce loneliness, and ensure dignity.[35]

Therefore, this study offers important contributions to deepening knowledge about meanings attributed to dignity at end of life by Primary Health Care professionals. Narratives emphasized valuing dignity maintenance during finitude, with focus on respect for individuality, autonomy preservation, sign and symptom control, non-abandonment, and importance of enabling patient permanence in their home environment.

In this regard, practical implications of findings point to the need to qualify and strengthen care practices in PHC, with emphasis on promoting dignity at end of life. Effective integration of palliative care into primary care actions is highlighted, along with valuing care at home, investment in professional

training and continuing education, and improvement of public policies that sustain a care network capable of responding to end-of-life demands.

Conversely, limitations during study development must be acknowledged, including the small number of participants, which may have limited diversity of viewpoints on dignity at end of life. Additionally, conducting research in a restricted setting with specific resources limits generalizability of findings to other realities with different structural and organizational contexts. Thus, this research encourages other investigators to conduct future studies involving more professionals from diverse settings, with the central aim of understanding which actions to promote dignity at end of life are feasible based on presented dignity perceptions.

CONCLUSION

This research enabled understanding of perceptions about dignity at end of life from the perspective of health professionals working in PHC. Promotion of dignity at end of life presents challenges in this context. Results indicate that the final life phase constitutes a process of significant transformations in patients' physical, psychological, spiritual, and social aspects.

These transformations may entail suffering, marked by autonomy loss and consequent dependence on others. Furthermore, emotional distress, difficulties expressing feelings, and communication challenges also contribute to changes in perceived dignity, both for affected individuals and for health professionals and relatives regarding them.

Preeminence was found for respect toward patients' decisions and protection of their autonomy. Within this scenario, palliative care assumes relevance by enabling patients to find comfort and achieve dignified terminality in their home environment. For realization of this goal, increasing the number of qualified professionals capable of providing respectful care to this population becomes imperative. Therefore, finitude must receive greater investigation in subsequent studies to deepen knowledge about this experience within Primary Health Care.

CONTRIBUITIONS

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REFERENCES

1. D'Alessandro MPS, Barbosa LC, Anagusko SS, Maiello APMV, Conrado CM, Messias AA, editores. Manual de cuidados paliativos. 2ª ed. São Paulo: Hospital Sírio-Libanês; 2023. Acesso em: 25 dez. 2025. Available from: https://biblioteca.cofen.gov.br/wp-content/uploads/2023/10/manual-de-cuidados-paliativos-2a-edicao.pdf.

2. World Health Organization (WHO). Palliative Care. 2020. Acesso em: 23 dez. 2025. Available from: https://portal.ct.gov/-/media/departments-and-agencies/dph/government-relations/palliative-care-agenda-and-minutes/2018-working-def-of-palliative-care.pdf.

3. Vidal EIO, Kovacs MJ, Silva LM, Sacardo DP, Bersani, ALF, Di Tommaso ABG, et al. Posicionamento da ANCP e SBGG sobre tomada de decisão compartilhada em cuidados paliativos. Cad Saúde Pública [Internet]. 2022; 38(9):1-10. DOI: 10.1590/0102-311XPT130022.

4. Radbruch L, Lima L, Knaul F, Wenk R, Ali Z, Bhatnaghar S, et al. Redefining Palliative Care- A New Consensus-Based Definition. J Pain Symptom Manage [Internet]. 2020; 60(4): 754-764. DOI: 10.1016/j.jpainsymman.2020.04.027.

5. Ministério da Saúde (BR). Sociedade Beneficente Israelita Brasileira Albert Einstein. PlanificaSUS: Manual de Cuidados Paliativos na Atenção Primária à Saúde. São Paulo: Ministério da Saúde, 2023.

6. Rodrigues, LF, Silva JFM, Cabrera M. Cuidados paliativos: percurso na atenção básica no Brasil. Cad Saúde Pública [Internet]. 2022; 38(9): 1-8. DOI: 10.1590/0102-311XPT130222.

7. Ministério da Saúde (BR). Portaria GM/MS nº3.681, de 7 de maio de 2024. Institui a Política Nacional de Cuidados Paliativos - PNCP no âmbito do Sistema Único de Saúde - SUS, por meio da alteração da Portaria de Consolidação GM/MS nº 2, de 28 de setembro de 2017. Brasília: Ministério da Saúde; 2024.

8. Costa ACX, Firmiano VR, Milagres AO, Lopes JC, Maciel JDV. Cuidados Paliativos na Atenção Básica: Um Olhar para a Humanização. Cedigma [Internet]. 2025; 3(5):27-31. DOI: https://doi.org/10.5281/zenodo.14927701.

9. Silva RS. Dignidade humana. 1ª ed. Enciclopédia jurídica da PUC-SP. Campilongo CF, Gonzaga AA, Freire AL, coordenadores. Tomo: Direitos Humanos. São Paulo: Pontifícia Universidade Católica de São Paulo, 2022. Acesso em: 8 jun. 2025. Available from: https://enciclopediajuridica.pucsp.br/verbete/507/edicao-1/dignidade-humana.

10. Organização das Nações Unidas (ONU). Declaração Universal dos Direitos Humanos. 1948. Acesso em: 23 dez. 2025. Available from: https://www.unicef.org/brazil/declaracao-universal-dos-direitos-humanos.

11. Zanlorenzi AC, Utida ARS, Perini CC. Aspectos bioéticos relacionados aos cuidados de fim de vida: uma revisão integrativa. Rev latinoam bioét [Internet]. 2023; 23(1):27-43. Acesso em: 23 dez. 20258. Available from: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-1536508.

12. Souza VR dos S, Marziale MHP, Silva GTR, Nascimento PL. Tradução e validação para a língua portuguesa e avaliação do guia COREQ. Acta paul enferm [Internet]. 2021; 34:eAPE02631. DOI: https://doi.org/10.37689/acta-ape/2021AO02631.

13. Bockorni BRS, Gomes AF. A amostragem em snowball (bola de neve) em uma pesquisa qualitativa no campo da administração. Receu [Internet]. 2021.; 22(1): 105-117. DOI: https://doi.org/10.25110/receu.v22i1.8346.

14. Creswell JW. Projeto de pesquisa: métodos qualitativo, quantitativo e misto. 3ª ed. Porto Alegre (RS): Artmed; 2010.

15. Atlas ti. Scientific Software Development GmbH. 2025. Acesso em: 25 dez. 2025. Available from: https://atlasti.com/free-trial-version?utm_source=google&utm_medium=search_paid&utm_campaign=atl_all_go_b2c_acq_brand&utm_content=atl_all_go_b2c_acq_brand_high_intent&utm_ad=775477870446&utm_term=atlas.ti%20download&matchtype=b&device=c&GeoLoc=9102297&placement=&network=g&adset_id=186344881816&ad_id=775477870446&kw=atlas.ti%20download&cpn=23043727632&gad_source=1&gad_campaignid=23043727632&gbraid=0AAAAApc8-YAPbbjDKrRgWUKS3S_u7OBQ_&gclid=CjwKCAiA3rPKBhBZEiwAhPNFQHVnzfvEyGgXmOG39NQ82VT9-feS2X9wa4lcEiHJZFoLL_FW-VwF8RoCj3QQAvD_BwE.

16. Universidade Federal de Pelotas (UFPEL). Dignidade no final de vida: experiências dos profissionais das equipes da atenção primária em saúde- Resumo executivo. 2023. Acesso em: 25 dez. 2025. Available from: https://wp.ufpel.edu.br/francielefrc/files/2024/04/resumoexecutivonataniele.pdf.

17. Temporão JG, Santini LA, Santos ATC, Fernandes FMB, Zoss WP. Desafios atuais e futuros do uso da medicina de precisão no acesso ao diagnóstico e tratamento de câncer no Brasil. Cad. Saúde Pública [Internet]. 2022; 38(10):1-15. DOI: https://doi.org/10.1590/0102-311XPT006122.

18. Hammerschmiedt CM, Morais G, Machado M, Neto AFES, Abrocesi S. Sentimentos dos profissionais da equipe de enfermagem frente ao processo de morte e morrer. Delos [Internet]. 2024; 18(63):1-14. DOI: 10.55905/rdelosv18.n63-059.

19. Bovero A, Botto R, Mellano E, Gottardo F, Berchialla P, Carletto S, Geminiani GC. Loss of Personal Autonomy and Dignity-Related Distress in End-Of-Life Cancer Patients. Am J Hosp Palliat Care. 2024; 41(2):179-186. DOI: 10.1177/10499091231166373.

20. Terrón JMM. Vulnerable Dignity, Dignified Vulnerability: Intertwining of Ethical Principles in End-of-Life Care. Int J Environ Res Public Health [Internet]. 2021; 18(482):1-12. DOI: https://doi.org/10.3390/ijerph18020482.

21. Dias C, Rodrigues IT, Gonçalves H, Duarte I. Communication strategies for adults in palliative care: the speech-language therapists' perspective. BMC Palliat Care [Internet]. 2024; 21;23(1):49. DOI: 10.1186/s12904-024-01382-x.

22. Santos KLD, Camacho ACLF, Silva FR, Melo ER. Comunicação da enfermeira em cuidados paliativos: um relato de experiência. Rev Recien [Internet]. 2023; 13(41):170-176. DOI: https://doi.org/10.24276/rrecien2023.13.41.170-176.

23. Brito TRP, Penido GSG, Silva JG, Fava SMC, Nascimento MC. Factors associated with perceived social support in older people with cancer. Geriatr., Gerontol. Aging. [Internet]. 2021; 15:e0210004. DOI: http://dx.doi.org/10.5327/Z2447-212320212000104.

24. Figueiredo AEB, Ceccon RF, Figueiredo JHC. Doenças crônicas não transmissíveis e suas implicações na vida de idosos dependentes. Ciênc Saúde Colet [Internet]. 2021; 26(1):77–88. DOI: https://doi.org/10.1590/1413-81232020261.33882020.

25. Santos APFB, Quintella LP, Sousa ACB, Cardoso FS, Martins AG, Cerqueira JDM. Determinantes Sociais na Sobrevida dos Pacientes com Câncer de Cabeça e Pescoço. REVISA [Internet]. 2024; 13(4):991-1000. DOI: https://doi.org/10.36239/revisa.v13.n4.p991a1000.

26. Alch CK, Wright CL, Collier KM, Choi PJ. Barriers to addressing the spiritual and religious needs of patients and families in the intensive care unit: a qualitative study of critical care physicians. Am J Hosp Palliat Care. [Internet]. 2020; 38(9):1120-1125. DOI: 10.1177/1049909120970903.

27. Badanta B, Rivilla-García E, Luchetti G, Diego-Cordero R. The influence of spirituality and religion on critical carenursing: An integrative review. Nurs Crit Care [Internet]. 2022; 27:348–366. DOI: 10.1111/nicc.12645.

28. Bradford KL. The nature of religious and spiritual needs in palliative care patients, carers, and families and how they can be addressed from a specialist spiritual care perspective. Religions (Basel) [Internet]. 2023; 14(125):1-22. DOI:10.3390/rel14010125.

29. Perboni JS, Oliveira SG, Cordeiro FR. Health professionals' subjectivation towards end of life and death in home care service. Rev Bras Enferm [Internet]. 2022; 75(2):e20210684. DOI: https://doi.org/10.1590/0034-7167-2021-0684.

30. Martí-García C, Fernández-Férez A, Fernández-Sola C, Pérez-Rodríguez R, Esteban-Burgos AA, Hernández-Padilla JM et al. Patients' experiences and perceptions of dignity in end-of-life care in emergency departments: A qualitative study. J Adv Nurs [Internet]. 2023; 79, 269–280. DOI: https://doi.org/10.1111/jan.15432.

31. World Health Organization (WHO). Integrating palliative care and symptom relief into primary health care: a WHO guide for planners, implementers and managers. Geneva: World Health Organization; 2018.

32. Sørstrøm AK, Ludvigsen MS, Kymre IG. Facilitating planned home death: A qualitative study on homecare nurses' experiences of enablers and barriers. J Adv Nurs [Internet]. 2025; 81:340–352. doi: 10.1111/jan.1617.

33. Saarinen J, Mishina K, Soikkeli-Jalonen A, Haavisto E. Family members' participation in palliative inpatient care: An integrative review. Scand J Caring Sci [Internet]. 2023; 37:897–908. DOI : https://doi.org/10.1111/scs.13062.

34. Carvalho JMG, Sanguino GZ, Murilho JAT, Oliveira LE, Da Luz MS, et al. Assistência recebida na Atenção Básica: perspectiva de pacientes em cuidados paliativos oncológicos e suas famílias. Rev Enferm UFPI [Internet]. 2025; 14: e5336. DOI: 10.26694/reufpi.v14i1.5336.

35. Sartor SF, Thofehrn MB, Borel MGC, Monteiro TBM, Martins CL, Arrieira ICO. Attitudes of cancer patients in palliative care towards death in the context of home care. Rev. Enferm. UFPI [Internet]. 2021;10(1):1-8. DOI: https://doi.org/10.26694/reufpi.v10i1.803.

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