Revista MedEs
Revista Científica Estudiantil de Matanzas
MedEst. 2024: Vol.4 No.2 ISSN: 2789-7567 RNPS: 2524

MEDICAL HUMANITIES

Palliative Care: a look through history

Cuidados Paliativos: una mirada a través de la historia

Adriel Herrero Díaz [1*], https://orcid.org/0000-0002-4016-6553

Dionis Ruiz Reyes [2], https://orcid.org/0000-0003-3061-1892

[1] Medical Sciences University of Villa Clara. Faculty of Sagua la Grande. Villa Clara. Cuba

[2] Medical Sciences University of Villa Clara. Faculty of Medicine. Villa Clara. Cuba

*** Corresponding author:** adriel.hd02@gmail.com

Received: 11/09/2023

Accepted: 03/12/2023

How to cite this article: Herrero Díaz A, Ruiz Reyes D. Palliative Care: a look through history. Med. Es. [Internet]. 2024 [cited access date]; 4(2). Available in: https://revmedest.sld.cu/index.php/medest/article/view/197

ABSTRACT

Introduction: the human species with its emergence and subsequent development has had to deal with the pain of the outbreak of a disease with no possible cure and the feeling of closeness to death. Throughout history and consequently with its intellectual development, this care has been perfected, until reaching what we know today as palliative care.

Objective: describe the development of palliative care throughout history.

Method: an updated bibliographic review was carried out in relation to the topic, with a total of 14 bibliographies. Scientific articles in English, Spanish and Portuguese were used, available in databases such as: Scielo, Elsevier and in the Google Scholar search engine.

Development: palliative care consists of therapeutic action aimed at mitigating the discomfort caused by an illness in which an end other than death is not possible. Its main objective is to battle the pain suffered by patients in terminal stages. They do not seek to prolong the patient's suffering, since their objective is to alleviate suffering, based on the principles of bioethics.

Conclusions: throughout history and in accordance with different cultures and times, palliative care has undergone changes until it reaches what it is today. They represent the best therapeutic option in the face of the imminent arrival of death, providing relief to the patient during the last stage of her life.

Keywords: Bioethics; Palliative Care; Pain; Disease, History

RESUMEN

Introducción: la especie humana con su surgimiento y posterior desarrollo ha tenido que lidiar con el dolor ante la irrupción de una enfermedad sin cura posible y la sensación de cercanía de la muerte. A través de la historia y en consecuencia con su desarrollo intelectual ha ido perfeccionando esos cuidados, hasta llegar a lo que hoy conocemos como cuidados paliativos.

Objetivo: describir el desarrollo de los cuidados paliativos a través de la historia.

Método: se realizó una revisión bibliográfica actualizada, con relación al tema contando con un total de 14 bibliografías. Se utilizaron artículos científicos en inglés, español y portugués, disponibles en bases de datos como: Scielo, Elsevier y en el motor de búsqueda de Google Académico.

Desarrollo: los cuidados paliativos consisten en la acción terapéutica destinada a mitigar las molestias que causa una enfermedad en la que no es posible un final distinto a la muerte. Su principal objetivo es batallar contra el dolor que sufren los pacientes en etapas terminales. No persiguen prolongar el sufrimiento del paciente, pues su objetivo es aliviar el sufrimiento, basándose en los principios de la bioética.

Conclusiones: a lo largo de la historia y en concordancia con las diferentes culturas y épocas, los cuidados paliativos han sufrido cambios hasta llegar a lo que son hoy en día. Los mismos representan la mejor opción terapéutica ante la eminente llegada de la muerte, constituyendo un alivio al paciente durante la última etapa de su vida.

Palabras clave: Bioética; Cuidados Paliativos; Dolor; Enfermedad, Historia

INTRODUCTION

Pain and illness have been a lacerating pairing that has accompanied man throughout his entire history. Anesthesia and Analgesia are sciences as old as humanity itself. Etymologically, pain, in English, derives from the Latin poena, which means punishment, and patient derives from the Latin patior: one who endures or endures suffering or pain. This has accompanied the evolution of man as a species throughout his history. (1)

Human concern about death dates back to the origins of Homo sapiens; this represents one of the main elements that distinguishes us as human beings. Self-awareness and awareness of death are the product of an extensive process developed during a broad period of our phylogenetic history. (2)

The human being reacts to the outbreak of a disease with no possible cure and the feeling of proximity of death; generating anguish, fear and panic in most cases. Throughout history his response to these situations has been modified accordingly with his intellectual development; therefore, he has been perfecting the care received by the sick, until reaching what we know today as palliative care (PC). This is a universal issue that has generated questions of great importance and enormous complexity, given the biological, cultural, religious, aesthetic and ethical crossroads that the nature of this type of care entails. (3,4)

CP are defined as a form of therapeutic action aimed at mitigating discomfort, providing maximum well-being and comfort to the terminally ill patient, and providing emotional support to his or her family in the last phases of an illness. It is worth highlighting that this care does not aim to resolve or cure the disease. (3)

The sphere of influence of palliative action is found in those situations involved in chronicity-pain-death processes and in the mechanisms adopted to deceive pain. It is intended that the patient spend the end of his days with symptoms controlled (such as pain, nausea or dyspnea), that they pass with the greatest possible dignity, and that they are surrounded by their loved ones, in the comfort of the home or in a place as similar as possible. CPs neither speed up nor stop the dying process. They do not prolong life and neither do they hasten death. (5)

The evolution of CP has a long history, with the passage of time, they have acquired a more humanized vision, requiring more and more care for the patient that provides relief, comfort and, consequently, an increase in quality of life. , when the disease has no cure. It is true that the idea of humanized and comprehensive care for these patients is increasingly desired in society. (6)

PCs are increasingly demanding a change in their application, which acquires a perspective that holistically and comprehensively values all the needs that these patients suffer. Valuing all spheres, Bio-Psycho-Social-Spiritual, both of the patient and their families. (6)

The practice of care is as old as the existence of humanity. Since our ancestors, care has been part of society, but as time progresses, these become other types of needs to be met. It is necessary to put the evolution of CPs in context, to review the most recent history regarding this type of assistance, to be able to see its trajectory and what the transition towards this paradigm shift has been like. In such a way that you can understand what palliative care is like and how palliative care has come to be established today. (6,7)

In ancient times, in the 4th century BC, it was considered unethical to treat the sick during the dying process. Doctors were afraid of being punished for defying the laws of nature. Later in the Middle Ages, with Christian culture, in the 19th century there was still no knowledge to cure the disease, so the doctor had a caregiver role. After advances in knowledge, they began to assume a more paternalistic authoritarian role since patients were no longer in God's hand but in their own. At this point, the terminally ill ceased to have medical importance as nothing could be done for them. (6)

According to the World Health Organization (WHO), it is currently estimated that 40 million people require PC annually 78 % are people living in low- or middle-income countries. Therefore, currently, worldwide, only 14 % of people who require palliative care receive it. Some of the diseases that require palliative care intervention are neurological and oncological (34 %). The need for CP will continue to increase as a consequence of the growing burden of chronic non-communicable diseases and the population aging process. (6,7)

The need for knowledge of the history of medicine in students of Medical Sciences with a view to the training of professionals with a vast comprehensive general culture, as well as the importance that PCs have acquired today, motivated the authors to carrying out this research with the objective of describing the development of palliative care throughout history.

METHODOLOGICAL DESIGN

An updated bibliographic review was carried out in relation to the topic. The main technique for collecting information was the online search in the databases of Scielo, Elsevier and the Google Scholar search engine. A total of 14 articles were selected based on their relevance, adjustment and focus on the topic. Theoretical level methods were used such as analysis-synthesis to carry out the introduction and development, and deduction-induction to structure the conclusions. Ethical aspects were taken into account. The bases of the statements of cited materials were respected. No ethical conflicts declared.

DEVELOPMENT

In the West throughout its history, man's attitude towards death has not always been the same, being able to differentiate two very different moments in the way of living and understanding it: one prior to its hospital institutionalization in which it used to develop in the family home, which meant that even the children were present in this vital process; and another after the development of the first hospital structures (mid-20th century), in which the doctor assumes an authoritarian and paternalistic role, since the patients are no longer in God's hands, but in their own. (5)

The Paleolithic is considered the longest period in human history and in which scientific, social and cultural advances occurred most slowly. Nomadism constituted a way of life that was very unfavorable for the development of something so useless from the perspective of the mentality of primitive peoples such as the CP. It is more than likely that primitive men were not even aware of the need for this kind of attention, given the short life expectancy and, immersed as they were in day-to-day survival, the concept of chronicity. (3)

In the context of primitive cultures, they represented an activity that exceeds the strict limits of chronic incurable processes. It was within the framework of Mesolithic cultures in which care closest to or equivalent to what is understood today as palliative care began to be developed. The planning of CPs that require, by their very nature, a sequential-ritual ordering of the process, was probably not carried out until the final phases of the Paleolithic (upper or recent Paleolithic 50,000-10,000 BC). (2)

In the Middle Paleolithic, the CP are integrated, in many cases, into transition rites and even in life, transition rites to the other world are staged that, guided by the sorcerer, prepare the dying person for the journey according to the animist beliefs of each tribe. In this sense, the care that we could consider, in some way, equivalent to CP would be situated between the sphere of the folk care system (supernatural interpretation) and the sphere corresponding to the popular care system (empirical interpretation or everyday life). (3,5)

CPs develop by adopting the forms of rites of passage when, in the Middle Paleolithic, man became aware of the meaning of death and began the cult of the dead and beliefs in the afterlife. The social context and modus vivendi determined the way palliative care was organized through a double transition: from tribe to family and from nomadic to sedentary way of life. In terms of palliative care, both the folk care system (interpretation of supernatural causes and treatments) and the popular care system (natural interpretation and empirical remedies) developed in primitive cultures and continued in ancient civilizations. (3)

However, the birth of a professional system of cure and care does not appear until the Neolithic in the framework of the ancient world, and it can be affirmed that there has been a certain relationship between the social, commercial, economic, and technological development of societies with the impulse of CP. These form a fundamental part of the history of the evolution of human beings in the world, and their historical knowledge contributes to a greater understanding of the phenomenon in today's society. Cultural history and the dialectical structural model is suitable for studying the global reality of palliative care in prehistory and ancient cultures, because it seeks both the meaning of the behaviors that deal with palliative care and the characteristics that underlie the motivation of palliative care the same. (3,4,8)

In Ancient Greece (4th and 5th centuries BC), the Hippocratic tradition recommended not treating incurable and terminal patients, since these diseases were considered divine punishments, and by treating them one could challenge the gods, who had thus punished the mortal. (5,8)

There is no data to indicate that in Hippocratic medicine there was any type of specialized care for dying patients. Several centuries later, Emperor Constantine, influenced by his mother Saint Helena, legalized the Christian religion with the Edict of Milan (year 313), and Christian institutions inspired by the principles of evangelical charity began to appear, to which the name of hospitals and hospices. The Greek version of the same was the xenodochium, and under both names (hospitium or xenodochium) they appeared first in Byzantine territory, then in Rome, and finally throughout Europe. (5,9)

In the Middle Ages, hospices began to proliferate throughout Europe. Initially they were places of welcome for pilgrims, who went in search of food and accommodation, which is why they were located on busy routes, such as the Camino de Santiago in Spain (the Hospital of San Marcos in León, the Abbey of Samos in Orense, or the Castle of the Templars in Ponferrada, León). Its initial purpose was therefore charitable, and not curative. (5)

But these pilgrims sometimes came sick or dying, so they began to provide some health care. Here they were cared for as best as possible, but since science was not advanced and therapeutic resources were not abundant, although curing them was the first objective, many died without remedy, and the only thing that could be done with them was to provide them with the maximum care until their death death, focusing above all on spiritual help. They focused more on the charitable than the healing; they were not places focused only on the dying. (5,10)

In Europe, since the 4th century, Christian institutions existed and it was in the period of Constantine where they were called hospitals and hospices. In Rome, Fabiola, a disciple of Saint Jerome, founded the first hospital in the year 400 in order to care for all the pilgrims who arrived at Ostia, the port of Rome, which received people from Africa, Asia and the East. In the 12th century, Saint Bernard already used the word hospice to indicate the place where pilgrims arrived. (10)

Saint Vincent de Paul, between 1581 to 1660, created hospices throughout France for people with limited economic resources. Around the 4th century the first of many Christian institutions appears under both names, hospitium or xenodochium, first in Byzantine territory, then in Rome, and finally throughout Europe. Most hospices came to a rather abrupt end with the arrival of the Reformation. (11)

Until the 19th century, symptom relief was the main task of medical treatment, since diseases evolved following their natural history. The French doctors Bérard and Gubler summarized the role of medicine up to that point: rarely cure, often relieve, always console. The medicine of the 20th century, driven by scientific and technical progress, was consolidating itself as a more decisive discipline, concentrating its efforts on discovering the causes and curing diseases. For postmodern man, a style of forbidden, hidden, hidden death prevails; manifestations of mourning are disapproved and mourning disappears as hope is placed in the progress of science to cure the species of all evil. (2,3,4)

In the 12th century, Saint Bernard of Clairvaux (1090-1153), a French Cistercian monk, spoke of the Hospice as places for pilgrims. Later, Saint Vincent de Paul (1581-1660) promoted the creation of numerous hospices throughout France to care for people with limited economic resources. He also founded two Congregations: the Congregation of the Priests of the Mission in 1624, also known as the Pauline or Lazarist Fathers, dedicated to working with poor people from the countryside around Paris, helping them obtain food and clothing, and the Order of the Daughters of Charity in 1633, with the help of Saint Louise de Marillac. (4,5)

This last secular association established a preparation program that lasted five years, based on hospital experience and home visits. The work with the poor and sick developed by the Daughters of Charity in the Catholic world was imitated in the 19th century by Protestants. The Protestant pastor Teodor Fliedner (1800-1864) and his wife Frederika Munster, founded a society of visiting nurses (the Deaconesses of Kaiserwerth), and created a small hospital in Kaiserwerth (Prussia), which is considered the first Protestant Hospice. (2,5)

The first time that the word Hospice refers to a place dedicated to the care of the dying, we do not find it until the year 1842 in Lyon, France, date on which Mme Jeanne Garnier, with the help of two widowed friends of hers, established the Association of Women of Calvary, a confessional work that brings together lay widows presided over by a young widow, Jeanne Garnier, whose objective was to relieve and console the incurably sick. (6)

Through this association, various Hospices or Calvaries are created in various French cities. For the first time, the term hospice will be used to exclusively designate institutions dedicated to the service of the incurably ill. The Hospice built in Paris has been called Maison Medicale Jeanne Garnier since 1971, and today it continues to be a prestigious institution dedicated to the palliative treatment of patients with advanced-stage cancer. Inspired by the work of Jeanne Garnier. (2,5)

In 1874, still under the auspices of the work of the Ladies of Calvary, Aurélie Jousset created a hospice in Paris that would later be known as the Maison Jeanne Garnier foundation, which with 80 beds, is today the largest palliative care unit in France. In Ireland, Mary Aikenhead founded the Order of the Sisters of Charity in 1815 whose mission was to relieve the poor and dying. In 1870, the Order of the Sisters of Charity opened the Notre Dame hospice in Dublin and in 1905 that of St. Joseph in London for the incurably sick. (2)

In 1899, Anne Blunt Storrs founded Calvary Hospital in New York. Today it remains a prestigious institution dedicated exclusively to providing care to adult patients with advanced cancer. In 1879, Mother Mary Aikenhead, founder of the Irish Sisters of Charity, established Our Lady's Hospice in Dublin, whose main objective was the care of the dying. She took the order to England, and in London, in 1905, she founded St. Joseph's Hospice, one of the institutions where Cicely Saunders worked. Around the same time (in 1948), other Protestant homes were opened in London to care for tuberculosis patients and cancer patients. In one of these houses, St. Luke's Home for the Dying Poor, Saunders worked as a volunteer nurse for seven years. (5,6)

Between 1958 and 1965, very innovative care was developed at St. Joseph Hospice for the practices of the time, adapting it to people who medicine could not cure. Her research on morphine and pain relief confronts her with the prejudices of the time about the dependence that the regular administration of opioid analgesics could cause. Her clinical experiences thus allow her to develop the concept of global pain, describing pain under the coexistence and interrelation of multiple moral, physical, social, psychological and spiritual aspects. (2)

At the beginning of the 60s, CPs began to develop in Canada and at the end of the decade, they were also developed in Europe. In the mid-80s, countries such as Italy, Spain, Germany, Belgium, Holland, France and Poland joined. Finally, in the mid-90s, some Latin American countries did so, including Argentina, Colombia, Brazil and Chile. Currently there are around 8,000 Palliative Care services in the world, in approximately 100 different countries. (11)

In 1967, in the month of July, when the first hospice opened in Sydenham, south of London, St Christopher's, marking the official beginning of the so-called Modern Hospice Movement. It later launched the hospice movement that would give rise to what today it is known as CP that provides: total, active and continuous care of patients and their families by a multidisciplinary team. (4)

In the United States, in 1974 the first hospice in the country was opened in Bradford, Connecticut. In the mid-eighties, Medicare recognized Palliative Care as part of the medical care to be covered. (11,12)
Shortly afterwards, with Belfaur Mount, the second CP unit was opened at the Royal Victoria Hospital in Montreal, Quebec. The first University Institute for research and education in palliative care was created at the University of Ottawa in 1983. (5)

In 1980, the WHO officially incorporated the concept of PC and promoted the PC Program as part of the Cancer Control Program. A decade and a half later, PAHO (Pan American Health Organization) also officially incorporates it into its healthcare programs. The first CP Congress took place in Spain, in 1989. (4,11,13)

In the middle of the 20th century, CP emerged as a medical specialty thanks to the work of figures who forged its history: Dr. Cicely Saunders in Great Britain, Dr. Elisabeth Kubler Ross in the United States, and Dr. Balfour Mount in Canada. (11)

In October 1987, Great Britain was the first country in the world to create the medical subspecialty called Palliative Medicine, which was followed by recognition in numerous other countries such as Australia, Belgium, Austria, New Zealand, Poland, Singapore, Taiwan and Romania. . In September 2006, the American Board of Medical Subspecialties finally granted Palliative Medicine subspecialty status. (5,6,11)

By 1996, the United Kingdom managed to have 217 hospital units with a capacity of 3,215 beds, only for the terminally ill. Since 1970, three events were important in determining CP: development of the home visit, patient care in day centers, and support teams in hospitals. Since its inception, the Macmillan–Macmillan Cancer Relief Foundation promoted teams specialized in PC treatment. By 1997 there was a team of 1,500 nurses and 160 doctors who cared for 16,000 cancer patients. Another foundation is Marie Curie Cancer Care, dedicated to social support. Marie Curie nurses care for 40% of cancer patients in the United Kingdom: around 20,000 patients and have 11 hospitals. (4,6,11)

The hospice movements, according to Robert Twycross, can be compared to the medieval hospices of the late 19th century. At that time, the development of medical science and new therapeutic discoveries to cure diseases, which until then were lethal, caused doctors to make a professional change; Until then, the doctor served as a great caregiver, and with these advances, he changed to assume an authoritarian and paternalistic role, since the patients were no longer in God's hands, but in his own. (4)

Two key names in the resurgence of this CP movement are Cicely Saunders and Elizabeth Kübler Ross. Two women who, with their hard work, promoted the CP and thanks to whom today they represent a valuable resource for the terminally ill and their families.

Cicely Sander and her contributions to Palliative Care

Cicely Saunders (1918–2005), was born on June 22, 1918, in Barnet, south London. She came from a wealthy family where it was not well regarded for her to study nursing, so she began her studies at Oxford in Politics, Philosophy and Economics. In 1939, with the separation of her parents and the start of the Second World War, she studied nursing and completed her studies in 1944, at the St. Thomas's Hospital Nightingale Shcool in London. She was always an excellent nurse, but this activity was detrimental to her health, since she had back problems. The doctors advised him to perform other types of tasks; she makes the decision to enter Oxford again, this time to study social work. (2,4)

In 1947, she met David Tasman, a Polish Jew who was terminally ill with advanced cancer. David was 40 years old at that time. They fall in love, he gives more meaning to his life, since he was alone. Together they began to think that a place other than a hospital was needed to care for terminal patients, treat pain; where they were cared for with more love, helped by personnel trained to attend to other needs. (4,10)

When David dies, Cicely launches the project they had in mind. David bequeathed Saunders £500 which he would later invest in building a hospice. She carried out her work as a social worker, helping in the afternoons as a volunteer at St. Luke's Home for the Dying Poor (later called St. Lukes Hospital), a Home for the Dying run by nuns in Bayswater, London. These ideas Saunders credits as having had the greatest influence on the initial plans for St. Christopher's. Not content with dedicating the afternoons to the sick, she asked for permission to work as a nurse also at night. (2,4,10)

Dr. Barret suggests Cicely study medicine, so at 33 she enters St. Thomas's Hospital School. In 1957 she obtained a degree and a fellowship to research the treatment of pain in incurable patients, while she worked at St. Mary's Hospital and St. Joseph's Hospice in London. For seven years she has been dedicated to researching the care of terminal patients. At this time she realizes that patients use opiates on average every four hours, she begins to listen to them and take note of their needs. (3,11)

This method was applied at St. Lukes's Hospital, through training of care staff and attention to this type of patient. Its efficiency is immediately seen, which is why it begins to spread rapidly among health personnel. (12,13)

She was the first specialist in symptom management of dying patients and started the Hospice Movement in Britain. She was a fervent advocate for dying with dignity, opposing euthanasia and arguing that death can be a positive experience to which everyone is entitled. Her conviction was: you matter because of who you are. You matter until the last moment of your life and we will do everything in our power, not only so that you die peacefully, but also so that, while you live, you do so with dignity. (14)

Between 1958 and 1965 she worked and researched the care of the terminally ill at St. Joseph's Hospice, London, one of the Hospice of the Irish Sisters of Charity. Those seven years of work were crucial. (2,4,10)

In 1963 she began to publish in the medical press and was invited to give multiple conferences, especially in the United States. She observed two types of pain: physical pain and the spiritual psychological pain of death. In 1964 she developed the definition of total pain, which includes social, emotional and spiritual elements. In that same year, Saunders visited Yale University, where she gave her lecture on the concept of global care to medical students, nurses, social workers, and chaplains. From this moment on, a series of events took place that led to the Hospice Movement in the United States. In an article titled The Last Stages of Life, published in 1965, she also addressed the social treatment of death and dying and proposed a specific way of working with the terminally ill. (3,9,10,11)

In 1985 she abandoned her active participation in St Christopher's Hospice, becoming president. Her publications in the medical press are multiple, both as author and editor, highlighting: Care of the Dying (1960, 1977), The Management of the Terminal Disease (1978, 1993), Hospice: the living idea (1981), Living with Dying (1983, 1989), Beyond the Horizon (1990), Hospice and Palliative Care (1990) and several articles that discussed CP. (5, 8, 12)

She was awarded various international awards and recognitions, including the Templeton Prize, various honorary titles, the Gold Medal of the British Medical Association, and the title of Dame of the British Empire. In 2002 she established the Cicely Foundation, to promote research in CP. (10)

She died on July 14, 2005, a victim of breast cancer, in her room at St Christopher's Hospice, surrounded by the care and treatments that she herself promoted and leaving us as a legacy the importance of CP today. (10)

Elizabeth Kübler Ross

Elizabeth Kübler Ross (1926-2004), born July 8, 1926 in Switzerland, was a Swiss-American psychiatrist; she became a professor of Psychiatry at the University of Chicago. She began systematic care of the terminally ill in the United States. She proposed ways to approach her anxieties. From there came her first book On Death and Dying. In it she describes the five psychological stages in terminal patients, during the process that ends with death, where different emotions successively predominate such as: denial, isolation, anger, negotiation, depression. (12)

He introduced the notion of death as one of the stages to an entire part of the life cycle in his medical courses and has introduced his students to listening and empathy as a form of medical treatment. She is a very prolific author, she has published thirty works, several of which are best-sellers. A controversial theory: The last moments of life, presented the succession of stages gone through by the patient at the end of life (denial, anger, negotiation, depression, acceptance), stages of mourning. (2, 14)

In several of his articles, Kübler-Ross presents reflections on the denial of death in American society, where he lived and worked as a psychiatrist. In an interview, published in the Journal of the American Medical Association in 1972, he addresses more explicitly what he calls the death denial society. He proposes a change in the work of caring for the dying. Instead of looking at devices, talk to the person, observe your own reactions to the experience of dying, and learn from these patients. Following this differentiated logic, it would be possible to offer some type of care and treatment to patients. (12)

Dr. Elizabeth Kubler-Ross reaffirmed Dr. Saunders' idea, but added the concept of providing the Hospice service at home, so people would not come to the Hospice, but the Hospice would go to the people. This way of working developed by Saunders was imitated by other people in the United Kingdom, and new centers emerged that were also called Hospices. Although she did not want to create any association, the programs that emerged were included under the name of the Hospice Movement. (13, 14)

Following the care and PC models initially designed for cancer patients, today interest groups have emerged in the care of terminal patients with conditions other than cancer such as HIV/AIDS, advanced heart failure, chronic lung disease, kidney failure chronic, Alzheimer's, Parkinson's, multiple sclerosis, amyotrophic lateral sclerosis, among others. (9)

In 1969, his first works were published based on more than 500 interviews with dying patients, and it provides a new vision on the psychology of the patient and the emotional phases they go through throughout the terminal illness until death. He died on August 24, 2004. (12)

There is no doubt that PCs have evolved alongside humanity. Its implementation, development and application has gone hand in hand with the various historical, political and social processes in which humanity has been involved. Through them, Medicine has been able to elevate the treatment of the patient, having a valuable tool to apply when conventional treatments were in vain. It is valid to comment on the role of analgesics and opioids in reducing pain in these patients.

The authors consider the emergence of CP marked a before and after in terms of humanized care, enabling a new approach in medical practices for patients in the terminal stage, minimizing the anguish, pain and despair typical of these painful circumstances.

CONCLUSIONS

Throughout history and in accordance with different cultures and times, palliative care has undergone changes, until it reaches what it is today. They represent the best therapeutic option in the face of the imminent arrival of death. The current knowledge and application of this care is due to figures such as Dr. Sanders and Kübler-Ross, key figures for its development.

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STATEMENT OF AUTHORSHIP

AHD: Conceptualization, research, methodology, project administration, validation, writing the original draft, review, editing.

DRR: Conceptualization, research, methodology, validation, writing of the original draft, review, editing.

CONFLICT OF INTERESTS

The authors declare no conflict of interest.

FINANCING

The authors did not receive funding for the development of this article.