



Cuidado Paliativo em situações desafiadoras: como integrar? Experiência do Brasil

Daniel Neves Forte, MD, PhD



RESEARCH ARTICLE

End-of-life care in hematological malignancies – a nationwide comparative study on the Swedish Register of Palliative Care

Ellen Skåreby¹, Per Fürst^{2,3}, Lena von Bahr^{4,5*}

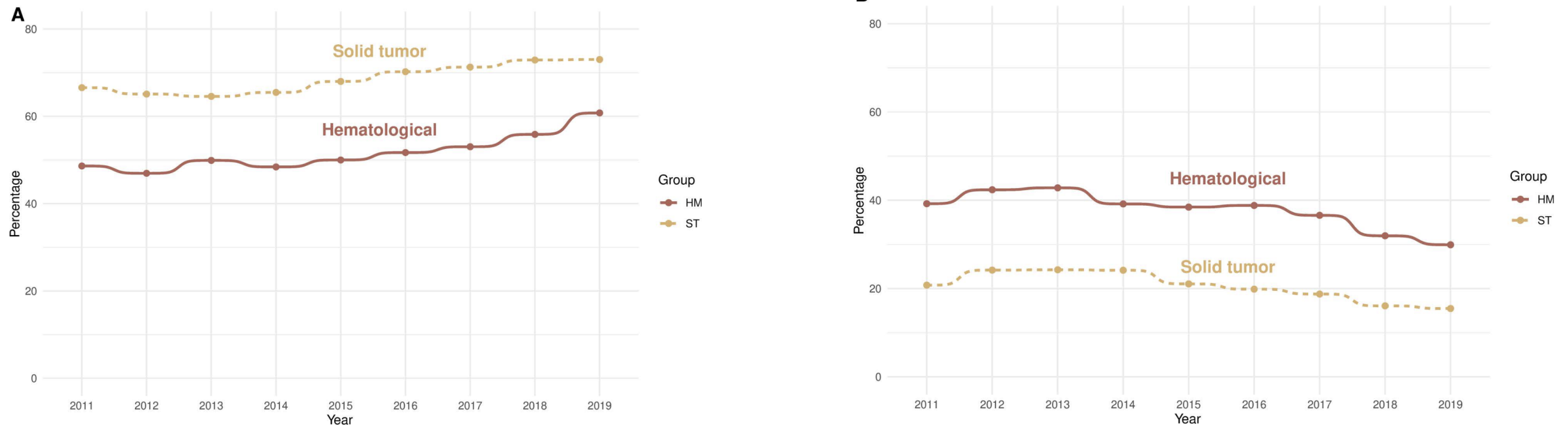
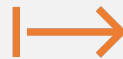
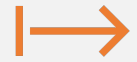


Fig 3. Trends over time; 3a: SPC access, 3b: Deaths in emergency hospital.

Visão estratégica: 4 pilares



Visão estratégica: 4 pilares



Complementaridade



Pilar 1: complementaridade

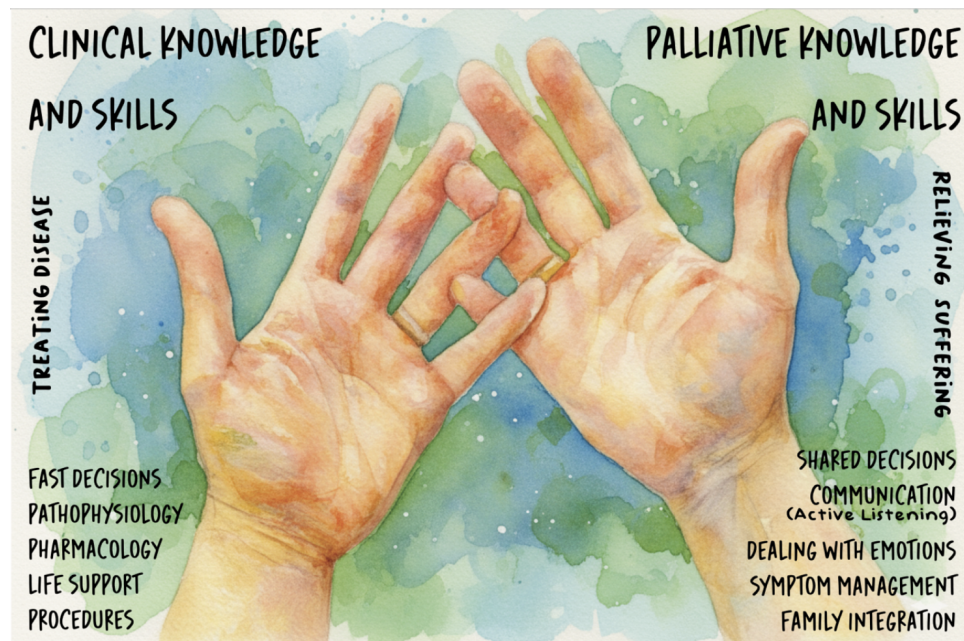


Figure 1 - The two-hands metaphor: clinical and palliative care knowledge and skills are like two hands; when used together in a coordinated way, they lead to less distress and better outcomes than when used in isolation.

Image generated with artificial intelligence (both Microsoft Copilot™ and Gemini™) based on prompts and a photograph by Fernanda Bono Fukushima, with further editing by the artist.

Critical Care Science
<https://doi.org/10.62675/2965-2774.20260301>

VIEWPOINT

Foundational principles for young intensivists to drive better outcomes: palliative care

Daniel Neves Forte¹, Edison Iglesias de Oliveira Vidal², Nancy Kentish-Barnes³

Pilar 1: complementaridade

Haematological Malignancies in Older People 4

Palliative care of patients with haematological malignancies: strategies to overcome difficulties via integrated care

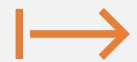
Ulrich Wedding

**Lancet Healthy Longev 2021;
2: e746–53**

Published Online

	Disease trajectory	Types of disease	Suggestion for start of palliative care involvement	Reference
Indolent lymphoma, and chronic lymphocytic leukaemia	Low symptom burden, long course of the disease and low mortality	Indolent lymphoma, and chronic lymphocytic leukaemia	Symptomatic progress	E Jawahri et al (2020) ³³
Multiple myeloma	Intermediate symptom burden, intermediate course of the disease and mortality	Multiple myeloma	Intermittent addition, based on reporting of patient-reported outcomes	Ramsenthaler et al (2019) ³⁴
Chronic graft versus host disease	High symptom burden, intermediate course of the disease and mortality	Chronic graft versus host disease	Integration at the time of diagnosis	El-Jawahri et al (2018) ³⁵
Acute myeloid leukaemia	High symptom burden, high mortality	Acute myeloid leukaemia	Early integration at the time of diagnosis	El-Jawahri et al (2021) ³⁸
Aggressive lymphoma	High symptom burden, high mortality	Aggressive lymphoma	Integration at the time of recurrent or refractory disease or when non-curative treatment is initiated	Odejide et al (2020) ³⁶

Visão estratégica: 4 pilares



Complementaridade



Identificação de fragilidade



Pilar 2: Identificação de fragilidade

Intensive Care Med
<https://doi.org/10.1007/s00134-025-08054-1>

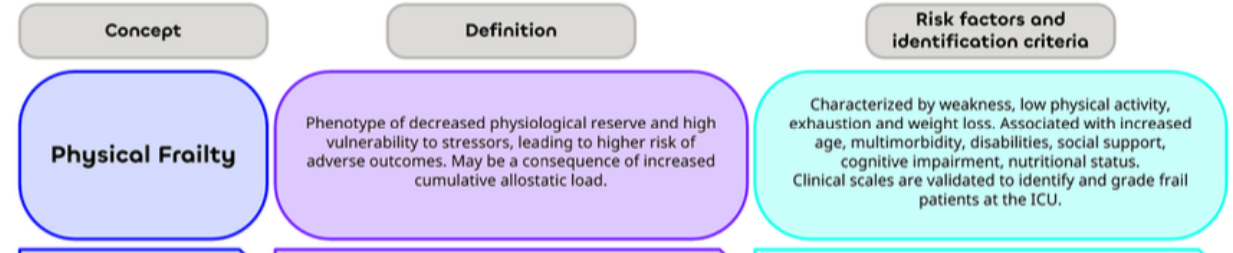
WHAT'S NEW IN INTENSIVE CARE

Allostatic overload as the pathophysiological basis for integrating palliative care in the Intensive Care Unit



Daniel Neves Forte^{1,2*}, João Gabriel Rosa Ramos^{3,4} and Otavio T. Ranzani^{5,6}

© 2025 Springer-Verlag GmbH Germany, part of Springer Nature



REVIEW ARTICLE

C. Corey Hardin, M.D., Ph.D., *Editor*

Frailty in Older Adults

Dae Hyun Kim, M.D., Sc.D., M.P.H., and Kenneth Rockwood, M.D.

	Fit	Prefrailty	Frailty	End-Stage Frailty
Frailty Score	Fried frailty phenotype, 0 points Deficit-accumulation frailty index of <0.10 Score on Clinical Frailty Scale, 1–3	Fried frailty phenotype, 1 or 2 points Deficit-accumulation frailty index of 0.10 to <0.20 Score on Clinical Frailty Scale, 4	Fried frailty phenotype, 3 or 4 points Deficit-accumulation frailty index of 0.20 to <0.55 Score on Clinical Frailty Scale, 5–7	Fried frailty phenotype, 5 points Deficit-accumulation frailty index of ≥ 0.55 Score on Clinical Frailty Scale, 8 or 9

N Engl J Med 2024;391:538-48.
DOI: 10.1056/NEJMr2301292

CUIDADOS PALIATIVOS E FRAGILIDADE

Cartilha para o Profissional de Saúde

Organização

Comitê de Geriatria e Gerontologia da Academia Nacional de Cuidados Paliativos

Parceria

Comitê de Nutrição da Academia Nacional de Cuidados Paliativos



Escala Clínica de Fragilidade*



1. Muito Ativo - Pessoas que estão robustas, ativas, com energia e motivadas. Essas pessoas normalmente se exercitam regularmente. Elas estão entre as mais ativas para a sua idade.



2. Ativo - Pessoas que não apresentam nenhum sintoma ativo de doença, mas estão menos ativas que as da categoria 1. Frequentemente se exercitam ou são muito ativas ocasionalmente, exemplo: em determinada época do ano.



3. Regular - Pessoas com problemas de saúde bem controlados, mas não se exercitam regularmente além da caminhada de rotina.



4. Vulnerável - Apesar de não depender dos outros para ajuda diária, frequentemente os sintomas limitam as atividades. Uma queixa comum é sentir-se mais lento e/ou mais cansado ao longo do dia.



5. Levemente Frágil - Estas pessoas frequentemente apresentam lentidão evidente e precisam de ajuda para atividades instrumentais de vida diária (AIVD) mais complexas (finanças, transporte, trabalho doméstico pesado, medicações). Tipicamente, a fragilidade leve progressivamente prejudica as compras e passeios desacompanhados, preparo de refeições e tarefas domésticas.



6. Moderadamente Frágil - Pessoas que precisam de ajuda em todas as atividades externas e na manutenção da casa. Em casa, frequentemente têm dificuldades com escadas e necessitam de ajuda no banho e podem necessitar de ajuda mínima (apoio próximo) para se vestirem.



7. Muito Frágil - Completamente dependentes para cuidados pessoais, por qualquer causa (física ou cognitiva). No entanto, são aparentemente estáveis e sem alto risco de morte (dentro de 6 meses).



8. Severamente Frágil - Completamente dependentes, aproximando-se do fim da vida. Tipicamente incapazes de se recuperarem de uma doença leve.



9. Doente Terminal - Aproximando-se do fim da vida. Esta categoria se aplica a pessoas com expectativa de vida < 6 meses, sem outra evidência de fragilidade.

Pontuando fragilidade em pessoas com demência

O grau de fragilidade corresponde ao grau de demência. Sintomas comuns na demência leve incluem esquecimento dos detalhes de um evento recente, apesar da recordação do evento em si, repetindo a mesma pergunta/história e afastamento de eventos sociais.

Na demência moderada, a memória recente está muito comprometida apesar de aparentemente lembrar bem de fatos do passado. Quando solicitadas, elas são capazes de fazer o cuidado pessoal.

Na demência severa, elas não conseguem realizar cuidados pessoais sem ajuda.

* 1. Canadian Study on Health & Aging, Revised 2008.

2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 113:489-495.

©2009. Version 1.2_EN; ©2018. Version 1.0_Port. All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada. Permission granted to copy for research and educational purposes only.

The Journal of frailty & aging 2020
Clinical Frailty Scale: Translation and Cultural Adaptation Into the Brazilian Portuguese Language

SYSTEMATIC REVIEW

The impact of frailty on intensive care unit outcomes: a systematic review and meta-analysis

John Muscedere^{1,6*}, Braden Waters², Aditya Varambally³, Sean M. Bagshaw⁴, J. Gordon Boyd¹, David Maslove¹, Stephanie Sibley¹ and Kenneth Rockwood⁵

© 2017 The Author(s). This article is an open access publication

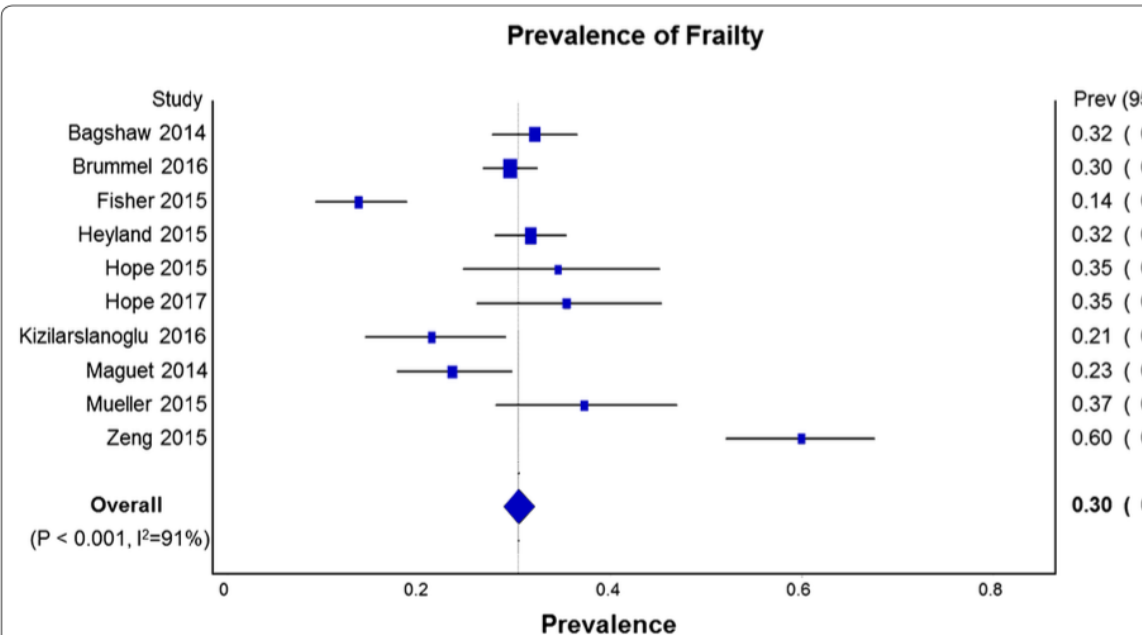
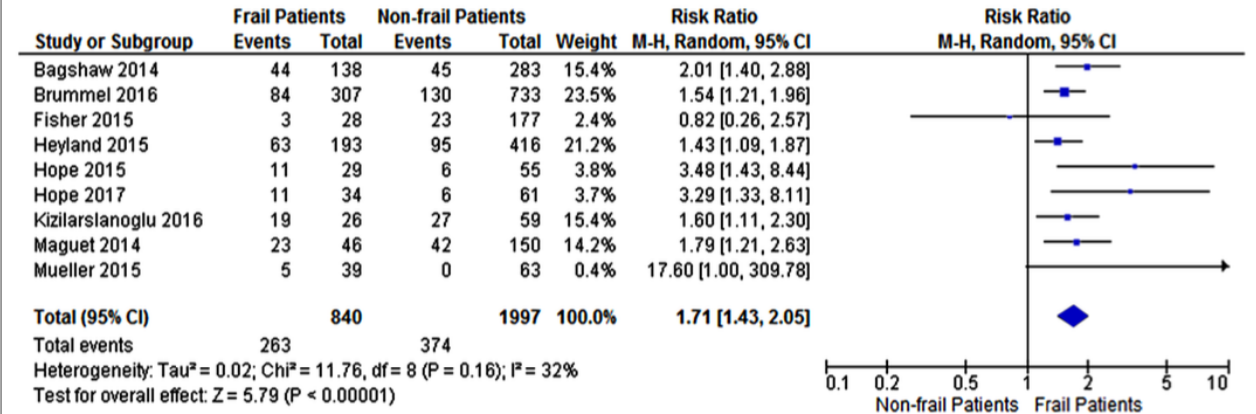


Fig. 1 Prevalence of frailty in the included studies using all measures of frailty

Daniel Neves Forte 2026

a Hospital Mortality



b Long-term Mortality

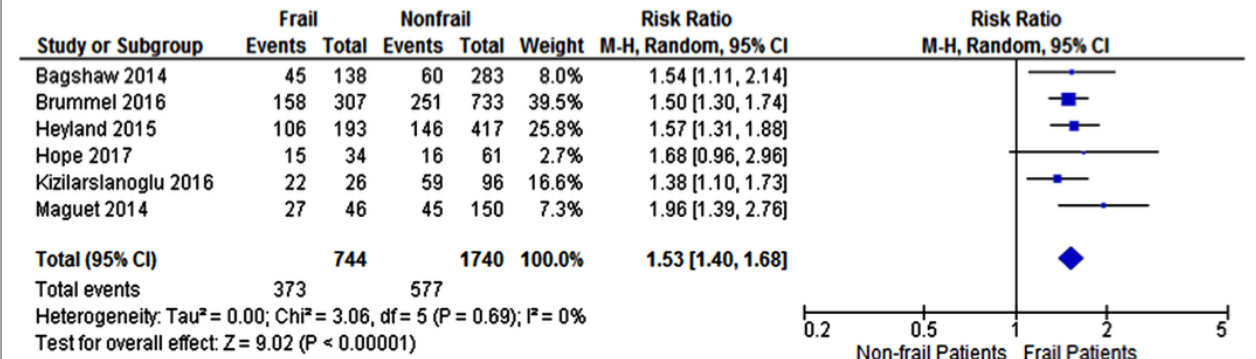


Fig. 2 Forest plot of the risk ratio for hospital and long-term mortality (>6 months) in frail and non-frail patients using all measures of frailty

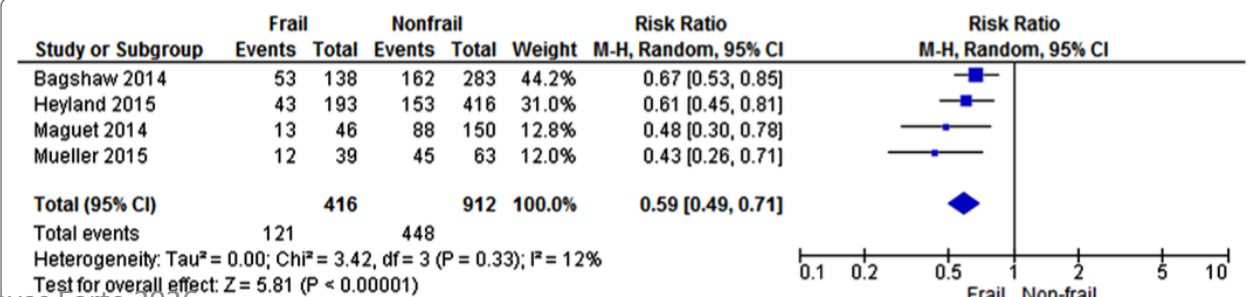


Fig. 3 Forest plot of the risk ratio for discharge home in frail and non-frail patients

Pilar 2: Identificação de fragilidade

Intensive Care Med
<https://doi.org/10.1007/s00134-025-08054-1>

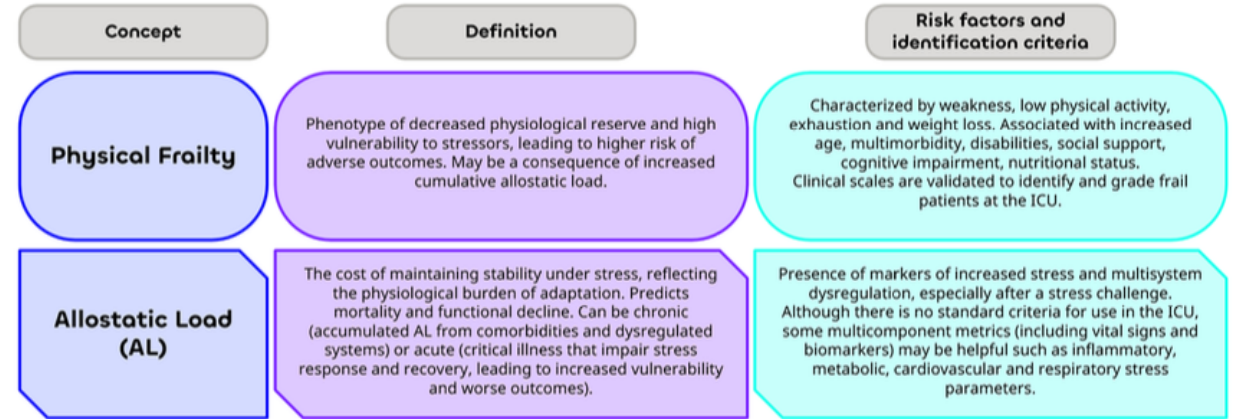
WHAT'S NEW IN INTENSIVE CARE

Allostatic overload as the pathophysiological basis for integrating palliative care in the Intensive Care Unit



Daniel Neves Forte^{1,2*}, João Gabriel Rosa Ramos^{3,4} and Otavio T. Ranzani^{5,6}

© 2025 Springer-Verlag GmbH Germany, part of Springer Nature



Pilar 2: Identificação de fragilidade

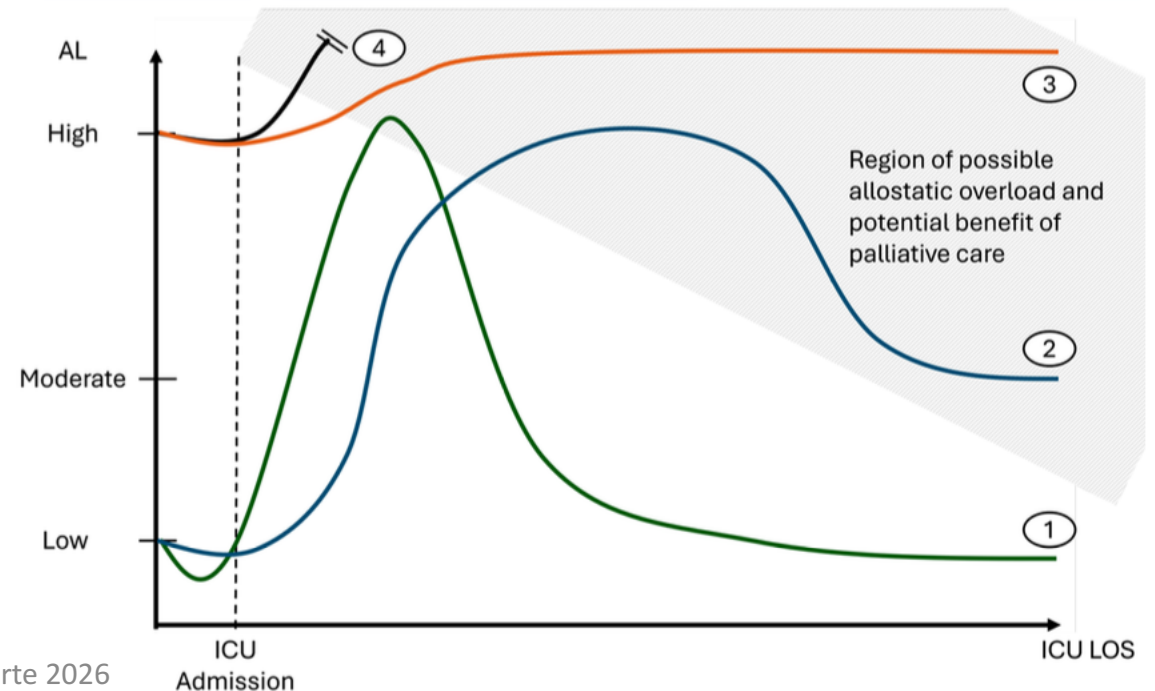
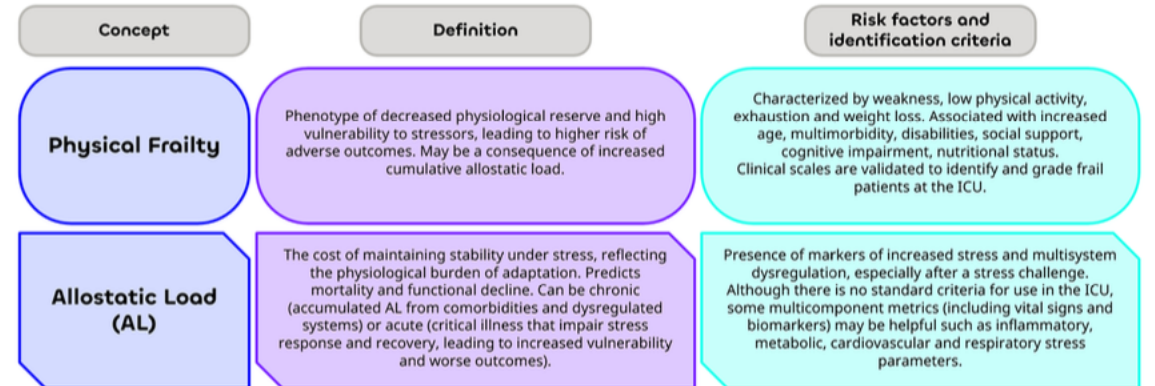
Intensive Care Med
<https://doi.org/10.1007/s00134-025-08054-1>

WHAT'S NEW IN INTENSIVE CARE

Allostatic overload as the pathophysiological basis for integrating palliative care in the Intensive Care Unit

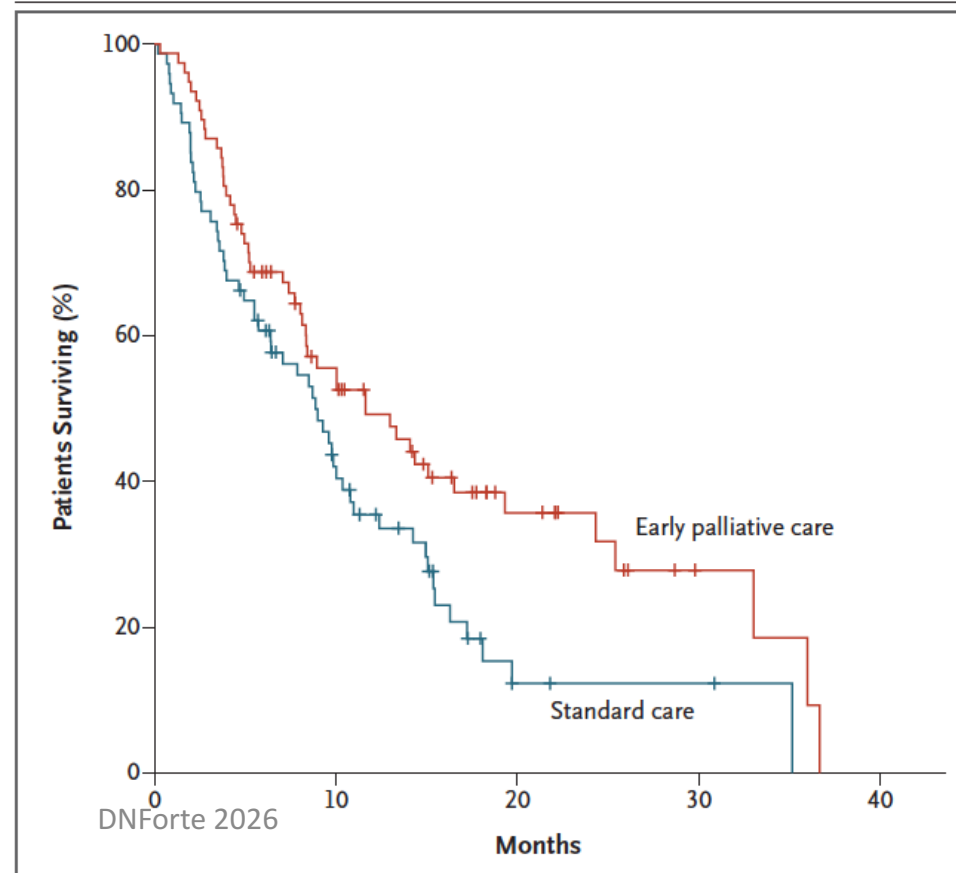
Daniel Neves Forte^{1,2*}, João Gabriel Rosa Ramos^{3,4} and Otavio T. Ranzani^{5,6}

© 2025 Springer-Verlag GmbH Germany, part of Springer Nature



ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer



Early Palliative Care in Advanced Non-Small Cell Lung Cancer Patients: A Meta-Analysis

American Journal of Hospice
& Palliative Medicine®
2025, Vol. 42(11) 1109–1119
© The Author(s) 2024
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/10499091241300530
journals.sagepub.com/home/ajh



Jie Liu, MB^{1,2}, Wei Cheng, PhD², Jie Du, MM¹, and Yamin Li, PhD³

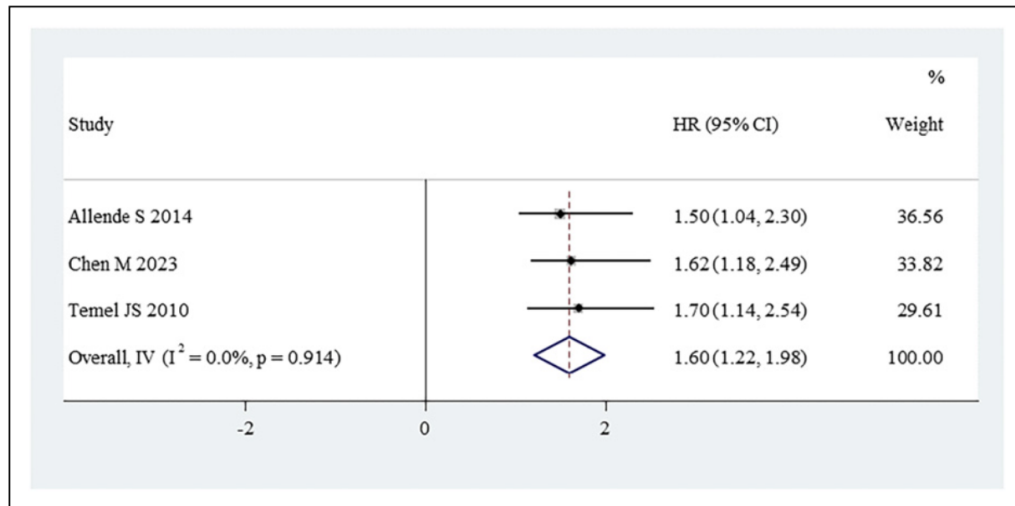


Figure 3. Forest plot of meta-analysis for overall survival.

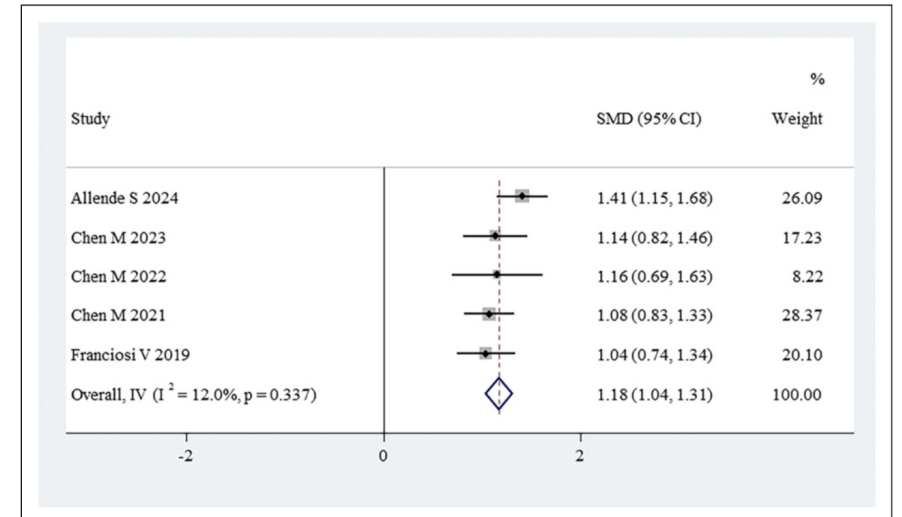
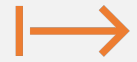


Figure 4. Forest plot of meta-analysis for quality of life.

Visão estratégica: 4 pilares



Complementaridade



Identificação da fragilidade




Processo de decisão estruturado



Pilar 3: Processo de decisão estruturado



A bioethical framework to guide the decision-making process in the care of seriously ill patients

Daniel Neves Forte^{1,4*} , Fernando Kawai² and Cláudio Cohen³

BMC Medical Ethics (2018)

Table 1 Summary of the Decision-making framework

Step# and guiding ethical principle	Main focus	Goals	Method	Practical objectives
1st step: Ethics of Accuracy	The body and its biology: the diseases and treatment options	To be accurate in diagnosis, prognosis, and success and failure rates of possible treatments.	Evidence-based practice, probabilistic and scientific reasoning	To Present: a) A correct diagnosis and the phase of the disease. b) A probable prognosis, i.e., how the majority of patients with that phase of the disease will evolve over time. c) The absolute risk reduction, the relative risk reduction, the number needed to treat. The potential adverse effects as well as costs and inconveniences of treatments. Uncertainty is addressed through estimation of confidence intervals and the disclosure of the potential limitations of generalization of evidence in that specific case.
2nd step: Ethics of comprehension	The person and biography: patient's values and views of suffering.	To comprehend and be empathetic to the patient's suffering, respecting the other as an end in itself. The emphasis here is to listen, to be present and to learn about biography, not to act, to change or to fix it.	Empathic communication	To learn about the patient's understanding, views, life values, perceptions of suffering and treatment preferences.
3rd step: Ethics of situational awareness	The healthcare multidisciplinary team	To apply the scientific evidence developed in populations to the specific situation of the patient, conciliating evidence based treatments with the patient's values and biography.	Clinical judgement and effective team communication	A team proposal of which would be considered: a) the acceptable evidence based treatment, taking on consideration the scientific view only b) The best or recommended treatment following both the scientific evidence while also respecting the patient's biography and wishes. c) The potentially inappropriate treatments following scientific evidence and the patient's biography and wishes. d) The futile or unacceptable treatments, considering exclusively the scientific basis.
4th step: an ethics of deliberation	The patient-provider relationship	Establishing rapport and building consensual patient-provider goals of care, ensuring that the patient's values will be respected and scientifically acceptable practices will be used.	Deliberation and person-centered communication	To have an honest and empathic communication about diagnosis, prognosis and then, to establish consensual goals of care for the best and worst scenario. After the setting of GOC, specific treatments within the Step#3 proposal are deliberated between patient and physician, reaching a new consensus about which treatments might or might not be employed to reach the desired goals.

REVIEW

The trajectory of very old critically ill patients



Bertrand Guidet^{1*}, Helene Vallet², Hans Flaatten³, Gavin Joynt⁴, Sean M. Bagshaw⁵, Susannah K. Leaver⁶, Michael Beil⁷, Bin Du⁸, Daniel N. Forte⁹, Derek C. Angus¹⁰, Sigal Svirri¹¹, Dylan de Lange¹², Margaret S. Herridge¹³ and Christian Jung¹⁴

© 2024 Springer-Verlag GmbH Germany, part of Springer Nature

Table 1 A four step process to decide when and how to limit or suspend life sustaining treatments (LST)

Biological: the disease and possible treatment options	To be accurate in diagnosis, prognosis, and success and failure rates of possible treatments	Evidence-based practice, probabilistic and scientific reasoning	To present: (a) A correct diagnosis and the phase of the disease (b) A probable prognosis, i.e., the best- and worst-case scenarios and their chances based on current evidence
Biographical: the person and their values	To comprehend and be empathetic to the patient's suffering. To be respectful. The emphasis here is to listen, to be present and to learn about biography, not to act, to change or to fix it	Empathic communication	To learn about the patient's understanding, coping strategies, life values, perceptions of suffering and treatment preferences
Situational awareness: the current situation, who are the stakeholders and what are the potential outcomes?	To align evidence based treatment with the patient's values and preferences	Clinical judgement and effective team communication	An inter-professional and multidisciplinary team proposal of what would be considered: (a) The best or recommended treatment (b) The acceptable treatment, based on scientific evidence only (c) The potentially inappropriate treatment based on scientific evidence and the patient's wishes (d) The futile or unacceptable treatment
Goal of care: consensus building and sharing decision-making	To achieve a consensual goal of care	Effective and empathic communication. Providers learn about patient's values and preferences, patient/families learn about diagnosis, prognosis and treatment proposals	(a) To achieve a consensual goal of care, between provider and patient / surrogate (b) A shared decision made to start, stop or maintain LST follows. For instance, if the shared goal of care is symptom control and allowing a natural death, then a decision to withdrawal LST can be shared

REVIEW

The trajectory of very old critically ill patients



Bertrand Guidet^{1*}, Helene Vallet², Hans Flaatten³, Gavin Joynt⁴, Sean M. Bagshaw⁵, Susannah K. Leaver⁶, Michael Beil⁷, Bin Du⁸, Daniel N. Forte⁹, Derek C. Angus¹⁰, Sigal Sviri¹¹, Dylan de Lange¹², Margaret S. Herridge¹³ and Christian Jung¹⁴

© 2024 Springer-Verlag GmbH Germany, part of Springer Nature

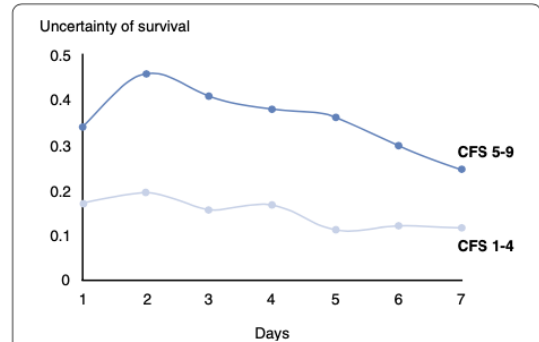
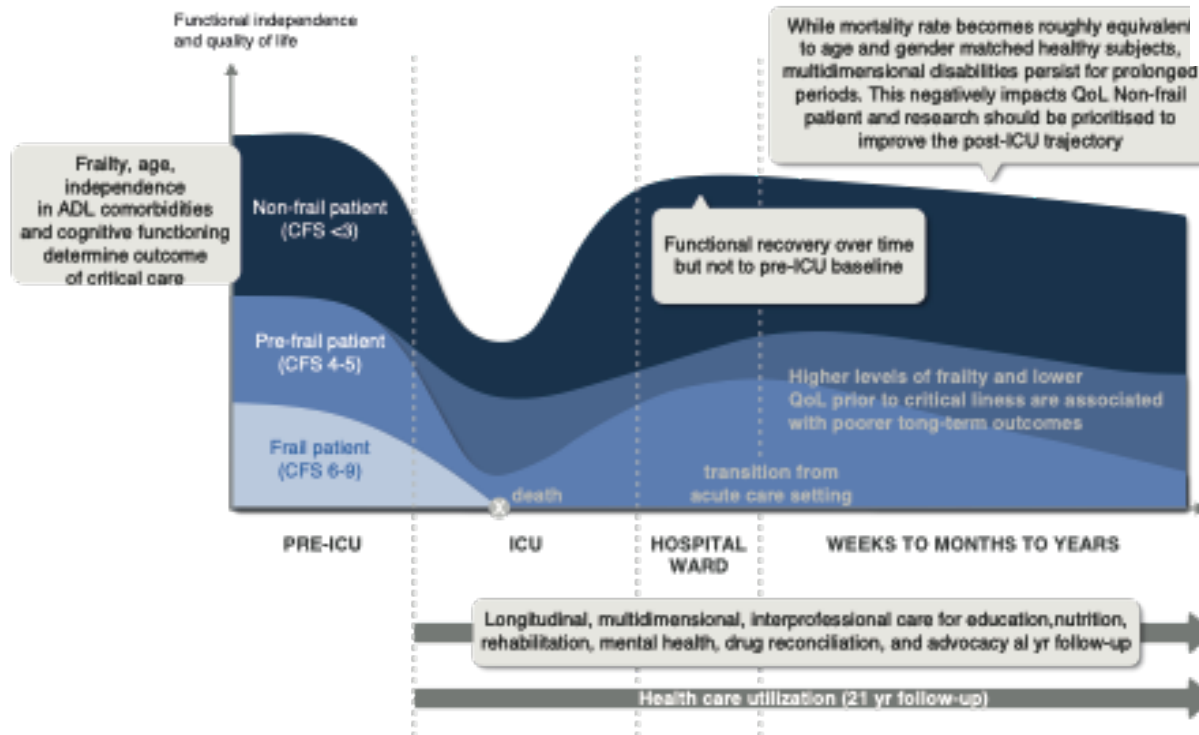
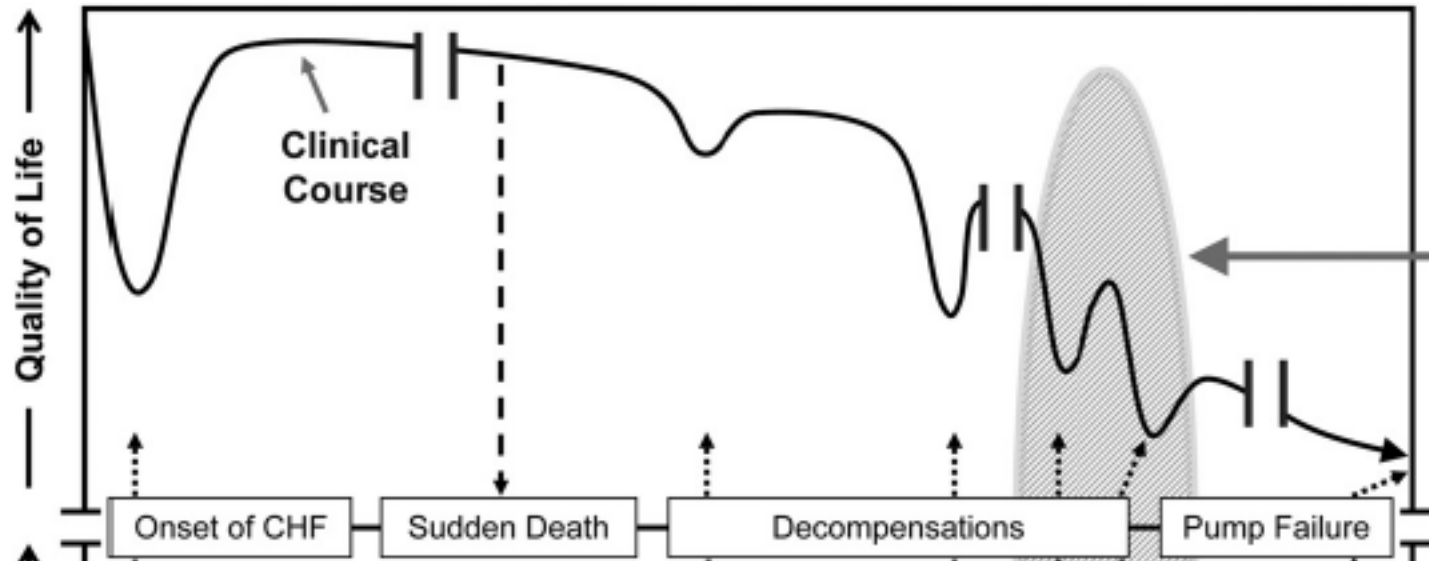


Fig. 3 Evolution of uncertainty about survival during the first week in ICU for very old patients according to frailty. Comparison of patients without (CFS 1–4) and with frailty (CFS 5–9) in the VIP2 study cohort. Uncertainty is depicted as the entropy of binary outcomes (survival vs non-survival) and ranges from 0 (minimum) to 1 (maximum uncertainty). Note for frail patients it takes at least 5 days to reduce the uncertainty about survival compared to that on admission



Circulation April 17, 2012

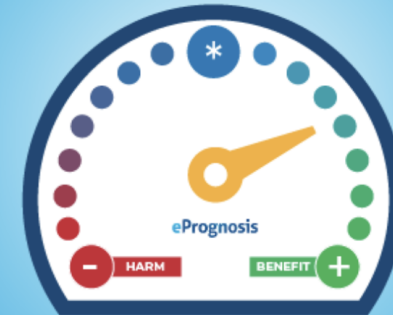
WHAT WOULD YOU LIKE TO DO?



**PROGNOSTIC
CALCULATORS**



**TIME TO
BENEFIT**



**CANCER
SCREENING**

NEW AND MOST USED PROGNOSTIC CALCULATORS



MD+ CALC

Log in SIGN UP

Search "QT interval" or "QT" or "EKG"

- Popular
- Newest
- Favorites
- Specialty
- Guidelines
- All

- Creatinine Clearance (Cockcroft-Gault Equation)**
Calculates CrCl according to the Cockcroft-Gault equation.
- CKD-EPI Equations for Glomerular Filtration Rate (GFR)**
Estimates GFR in CKD patients using serum creatinine, cystatin C, or both.
- CHA₂DS₂-VASc Score for Atrial Fibrillation Stroke Risk**
Calculates stroke risk for patients with atrial fibrillation, possibly better than the CHADS₂ Score.
- Mean Arterial Pressure (MAP)**
Calculates mean arterial pressure.
- ASCVD (Atherosclerotic Cardiovascular Disease) 2013 Risk Calculator from AHA/ACC**
Estimates 10-year risk of heart disease or stroke to guide management strategies.

Original Investigation | Caring for the Critically Ill Patient

FREE

Cite Permissions Metrics

Development and Validation of the Sequential Organ Failure Assessment (SOFA)-2 Score

Otavio T. Ranzani, MD, MSc, PhD^{1,2,3}; Mervyn Singer, MD⁴; Jorge I. F. Salluh, MD, PhD⁵; [et al](#)

» Author Affiliations | Article Information

JAMA

Published Online: October 29, 2025

2025;334;(23):2090-2103.

doi:10.1001/jama.2025.20516

Calculadora SOFA-2
v3.0 Install App
Calculadora interativa baseada em Ranzani et al. (JAMA, 2025)

Neurológico 0 pts
Escala de Coma de Glasgow (GCS)
GCS 15 (ou sinal de positivo, pu)

Respiratório 0 pts
Métrica de Oxigenação
PaO₂:FiO₂ >300 mmHg (>40 kP)

Cardiovascular 0 pts
PAM (Pressão Arterial Média)
PAM ≥70 mm Hg
Norepinefrina (µg/kg/min)
Ex: 0,1
Epinefrina (µg/kg/min)
Ex: 0
 Outro vasopressor ou inotrópico?
 Suporte mecânico cardiovascular? (ECMO-VA, BIA, etc)

Hepático **Renal** **Hemostasia**

www.sofa2.app

REVIEW

The trajectory of very old critically ill patients



Bertrand Guidet^{1*}, Helene Vallet², Hans Flaatten³, Gavin Joynt⁴, Sean M. Bagshaw⁵, Susannah K. Leaver⁶, Michael Beil⁷, Bin Du⁸, Daniel N. Forte⁹, Derek C. Angus¹⁰, Sigal Svirri¹¹, Dylan de Lange¹², Margaret S. Herridge¹³ and Christian Jung¹⁴

© 2024 Springer-Verlag GmbH Germany, part of Springer Nature

Table 1 A four step process to decide when and how to limit or suspend life sustaining treatments (LST)

Steps and its focus	Objective	Method	Practical objectives
Biological: the disease and possible treatment options	To be accurate in diagnosis, prognosis, and success and failure rates of possible treatments	Evidence-based practice, probabilistic and scientific reasoning	To present: (a) A correct diagnosis and the phase of the disease (b) A probable prognosis, i.e., the best- and worst-case scenarios and their chances based on
Biographical: the person and their values	To comprehend and be empathetic to the patient's suffering. To be respectful. The emphasis here is to listen, to be present and to learn about biography, not to act, to change or to fix it	Empathic communication	To learn about the patient's understanding, coping strategies, life values, perceptions of suffering and treatment preferences
Situational awareness: the current situation who are the stakeholders and what are the potential outcomes?	To align evidence-based treatment with the patient's values and preferences	Clinical judgement and effective team communication	An inter-professional and multidisciplinary team proposal of what would be considered: (a) The best or recommended treatment (b) The acceptable treatment, based on scientific evidence only (c) The potentially inappropriate treatment based on scientific evidence and the patient's wishes (d) The futile or unacceptable treatment
Goal of care: consensus building and sharing decision-making	To achieve a consensual goal of care	Effective and empathic communication. Providers learn about patient's values and preferences, patient/families learn about diagnosis, prognosis and treatment proposals	(a) To achieve a consensual goal of care, between provider and patient / surrogate (b) A shared decision made to start, stop or maintain LST follows. For instance, if the shared goal of care is symptom control and allowing a natural death, then a decision to withdrawal LST can be shared

REVIEW

The trajectory of very old critically ill patients



Bertrand Guidet^{1*}, Helene Vallet², Hans Flaatten³, Gavin Joynt⁴, Sean M. Bagshaw⁵, Susannah K. Leaver⁶, Michael Beil⁷, Bin Du⁸, Daniel N. Forte⁹, Derek C. Angus¹⁰, Sigal Svirri¹¹, Dylan de Lange¹², Margaret S. Herridge¹³ and Christian Jung¹⁴

© 2024 Springer-Verlag GmbH Germany, part of Springer Nature

Table 1 A four step process to decide when and how to limit or suspend life sustaining treatments (LST)

Steps and its focus	Objective	Method	Practical objectives
Biological: the disease and possible treatment options	To be accurate in diagnosis, prognosis, and success and failure rates of possible treatments	Evidence-based practice, probabilistic and scientific reasoning	To present: (a) A correct diagnosis and the phase of the disease (b) A probable prognosis, i.e., the best- and worst-case scenarios and their chances based on current evidence
Biographical: the person and their values	To comprehend and be empathetic to the patient's suffering. To be respectful. The emphasis here is to listen, to be present and to learn about biography, not to act, to	Empathic communication	To learn about the patient's understanding, coping strategies, life values, perceptions of suffering and treatment preferences
Situational awareness: the current situation, who are the stakeholders and what are the potential outcomes?	To align evidence based treatment with the patient's values and preferences	Clinical judgement and effective team communication	An inter-professional and multidisciplinary team proposal of what would be considered: (a) The best or recommended treatment (b) The acceptable treatment, based on scientific evidence only (c) The potentially inappropriate treatment based on scientific evidence and the patient's wishes (d) The futile or unacceptable treatment
Goal of care: consensus building and sharing decision-making	To achieve a consensual goal of care	Effective and empathic communication. Providers learn about patient's values and preferences, patient/families learn about diagnosis, prognosis and treatment proposals	(a) To achieve a consensual goal of care, between provider and patient / surrogate (b) A shared decision made to start, stop or maintain LST follows. For instance, if the shared goal of care is symptom control and allowing a natural death, then a decision to withdrawal LST can be shared

REVIEW

The trajectory of very old critically ill patients



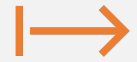
Bertrand Guidet^{1*}, Helene Vallet², Hans Flaatten³, Gavin Joynt⁴, Sean M. Bagshaw⁵, Susannah K. Leaver⁶, Michael Beil⁷, Bin Du⁸, Daniel N. Forte⁹, Derek C. Angus¹⁰, Sigal Svirin¹¹, Dylan de Lange¹², Margaret S. Herridge¹³ and Christian Jung¹⁴

© 2024 Springer-Verlag GmbH Germany, part of Springer Nature

Table 1 A four step process to decide when and how to limit or suspend life sustaining treatments (LST)

Steps and its focus	Objective	Method	Practical objectives
Biological: the disease and possible treatment options	To be accurate in diagnosis, prognosis, and success and failure rates of possible treatments	Evidence-based practice, probabilistic and scientific reasoning	To present: (a) A correct diagnosis and the phase of the disease (b) A probable prognosis, i.e., the best- and worst-case scenarios and their chances based on current evidence
Biographical: the person and their values	To comprehend and be empathetic to the patient's suffering. To be respectful. The emphasis here is to listen, to be present and to learn about biography, not to act, to change or to fix it	Empathic communication	To learn about the patient's understanding, coping strategies, life values, perceptions of suffering and treatment preferences
Situational awareness: the current situation, who are the stakeholders and what are the potential outcomes?	To align evidence based treatment with the patient's values and preferences	Clinical judgement and effective team communication	An inter-professional and multidisciplinary team proposal of what would be considered: (a) The best or recommended treatment (b) The acceptable treatment, based on scientific evidence only (c) The potentially inappropriate treatment based on scientific evidence and the patient's wishes
Goal of care: consensus building and sharing decision-making	To achieve a consensual goal of care	Effective and empathic communication. Providers learn about patient's values and preferences, patient/families learn about diagnosis, prognosis and treatment proposals	(a) To achieve a consensual goal of care, between provider and patient / surrogate (b) A shared decision made to start, stop or maintain LST follows. For instance, if the shared goal of care is symptom control and allowing a natural death, then a decision to withdrawal

Visão estratégica: 4 pilares



Complementaridade



Identificação da fragilidade



Processo de decisão estruturado



Comunicação baseada em neurobiologia

VIDEOS IN CLINICAL MEDICINE

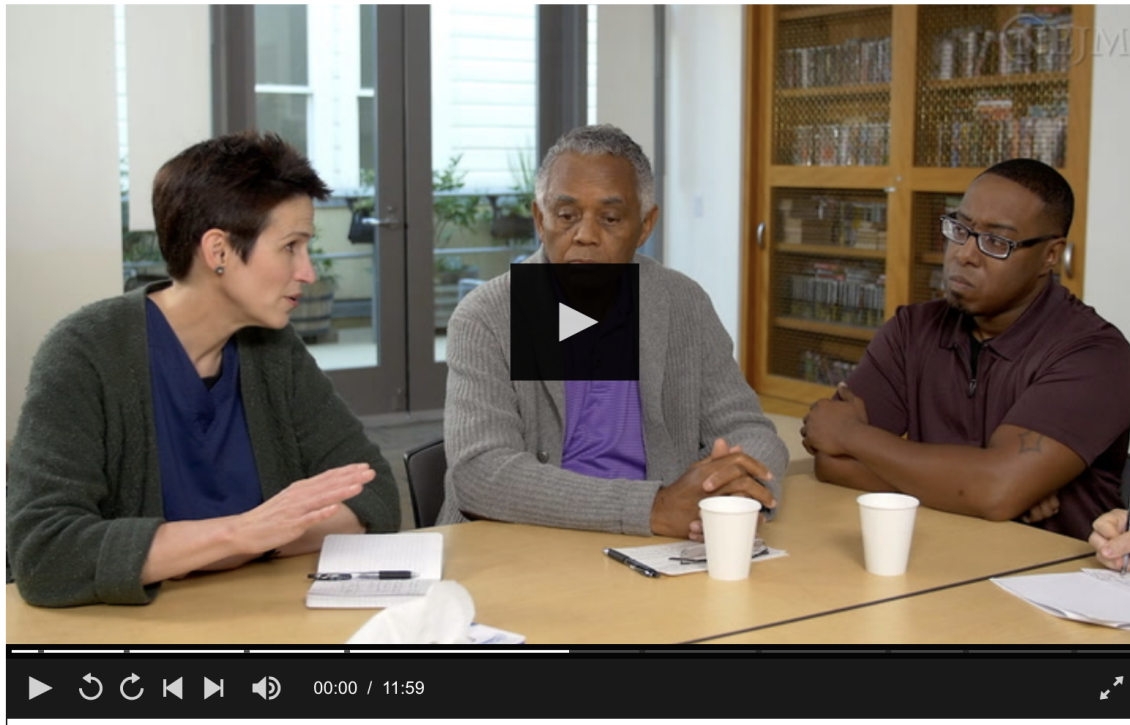
Family Meetings on Behalf of Patients with Serious Illness

Eric Widera, M.D., Wendy G. Anderson, M.D., Lekshmi Santhosh, M.D., M.A.Ed., Kanako Y. McKee, M.D., Alexander K. Smith, M.D., M.P.H., and James Frank, M.D.

- ≡
- 🔖
- PDF
- 🔗
- ©
- ⋮

Video **Figures/Media**

Metrics



September 10, 2020

N Engl J Med 2020; 383:e71

DOI: 10.1056/NEJMvcm1913056

Editors

Julie R. Ingelfinger, M.D., Editor

ADVERTISEMENT

What will you learn today?

New strategies for enhancing health care delivery

NEJM GROUP

LEARN MORE →



The hierarchy of communication needs

**a novel communication strategy rooted in neurobiology developed
in a Brazilian COVID-ICU and high mistrust settings**

Daniel Neves Forte, MD, PhD, Mark Stoltenberg, MD, MPH, MA, Sabrina Correa da Costa Ribeiro, MD, Ingrid Maria (Mia) Olsen de Almeida, MD, Vicki Jackson, MD, MPH, Bethany-Rose Daubman, MD.

Open camera or QR reader and
scan code to access this article
and other resources online.



ORIGINAL ARTICLE

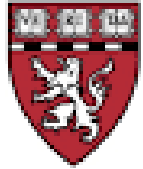
Open Access

The Hierarchy of Communication Needs: A Novel Communication Strategy for High Mistrust Settings Developed in a Brazilian COVID-ICU

Daniel Neves Forte, MD, PhD,^{1,2,*,**} Mark Stoltenberg, MD, MPH, MA,^{3,4,**} Sabrina Correa da Costa Ribeiro, MD,¹
Ingrid Maria (Mia) Olsen de Almeida, PsyD,² Vicki Jackson, MD, MPH,^{3,4} and Bethany-Rose Daubman, MD^{3,4}



MASSACHUSETTS
GENERAL HOSPITAL



HARVARD
MEDICAL SCHOOL



GLOBAL HEALTH SERVICE AWARDS

The Global Health Services Awards were established to accelerate the impact of those already dedicated to global health; to recognize people whose goal is to inspire, advance and improve clinical care for underserved populations; and to emphasize the importance and benefits of global collaboration in healthcare. All MGH employees and global partners are eligible for an award under this program.

2024 RECIPIENTS

Excellence in Research and Innovation Award



Gugu Shazi

Africa Health Research Institute
Professional Nurse, Autopsy Study Program Coordinator

Excellence in Clinical Education and Mentorship Award



Daniel Neves Forte, MD

Hospital Sírio-Libanês, Brazil
Intensive Care Physician



Kathleen Corey, MD, MPH

Harvard Medical School
Associate Professor of Medicine

Excellence in Global Disaster Response and Humanitarian Action Award



Lianet Vazquez, MD

Massachusetts General Hospital
Resident Physician



Medo





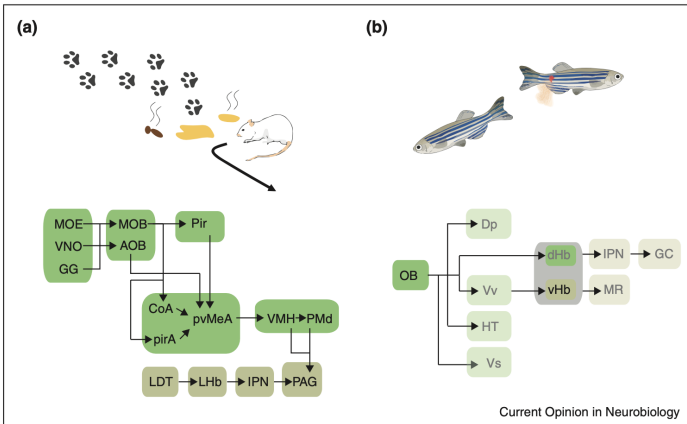
Available online at www.sciencedirect.com

ScienceDirect

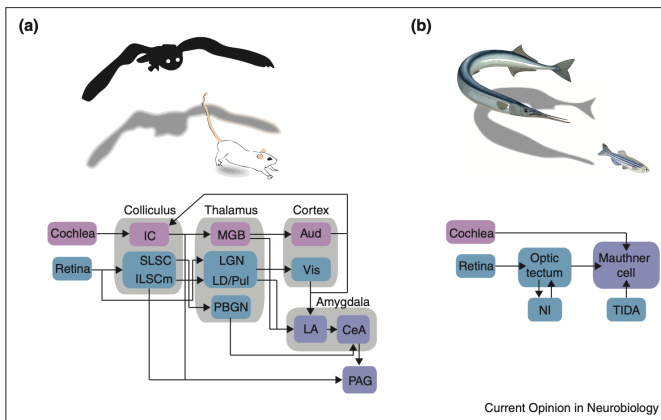
Current Opinion in
Neurobiology

Is there anybody out there? Neural circuits of threat detection in vertebrates

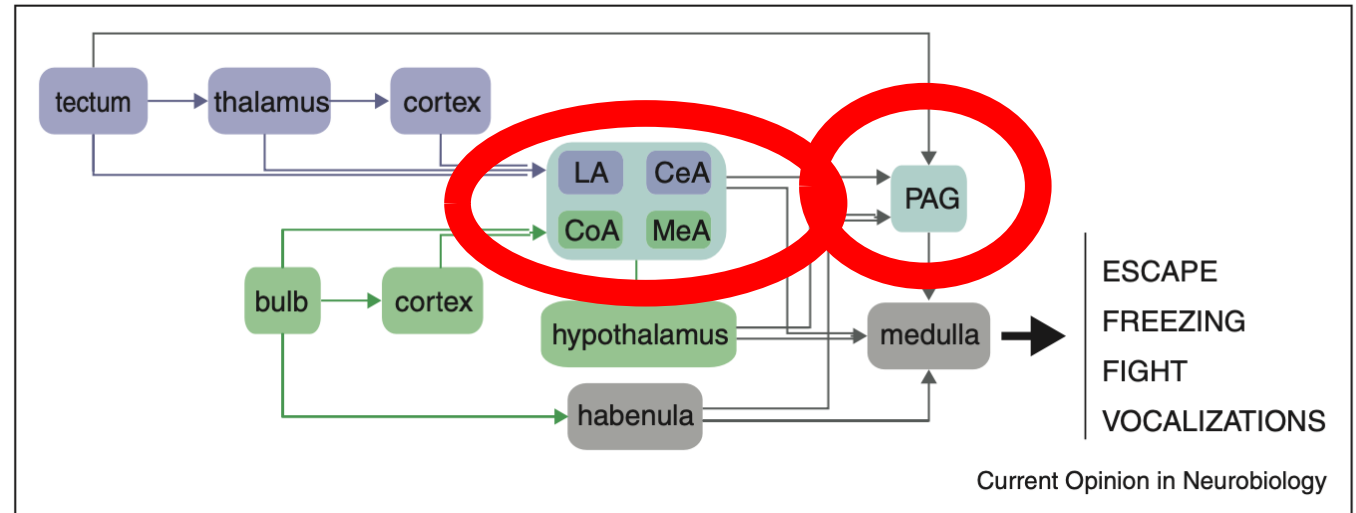
Ana G Pereira and Marta A Moita



Current Opinion in Neurobiology



Current Opinion in Neurobiology



Current Opinion in Neurobiology

Consolation as possible expression of sympathetic concern among chimpanzees

Teresa Romero^{a,b,1}, Miguel A. Castellanos^c, and Frans B. M. de Waal^{a,1}

12110-12115 | PNAS | July 6, 2010 | vol. 107 | no. 27

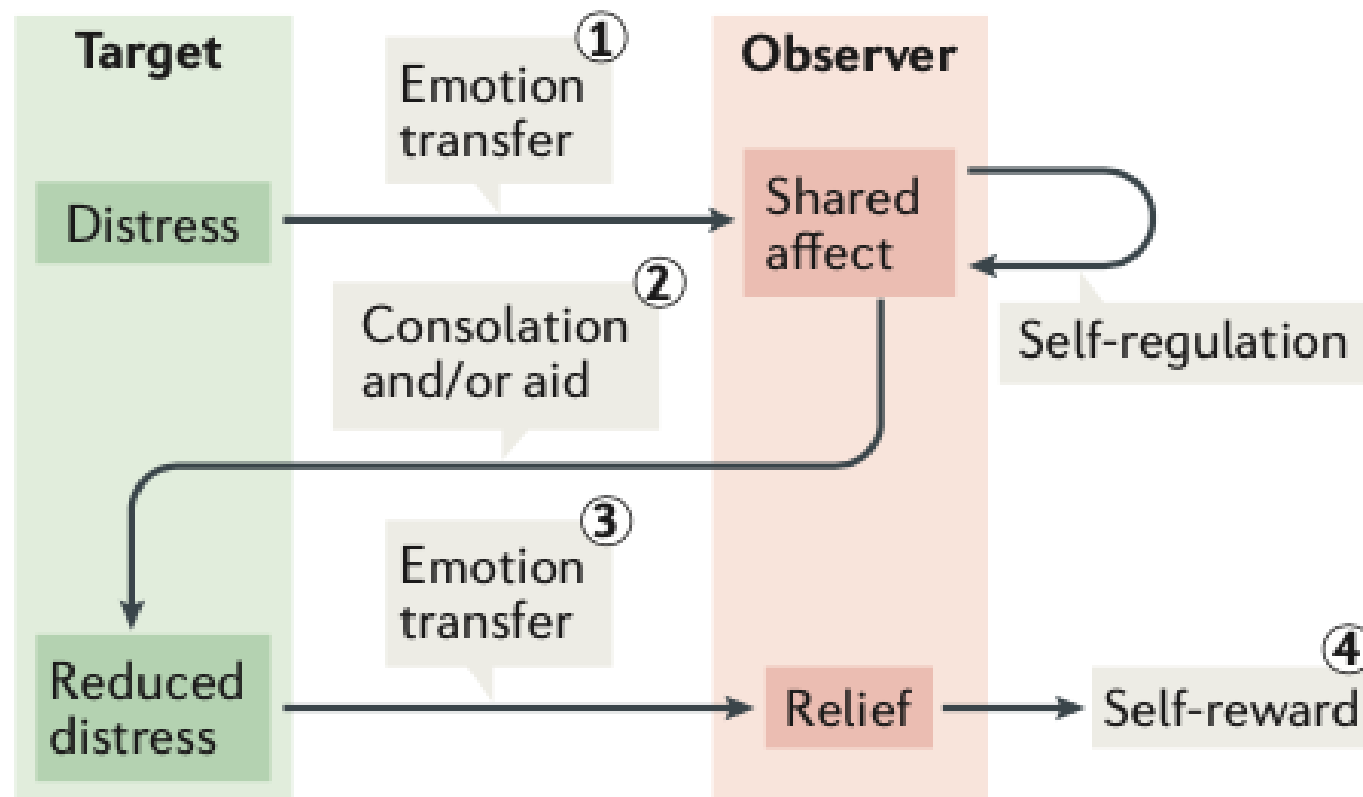
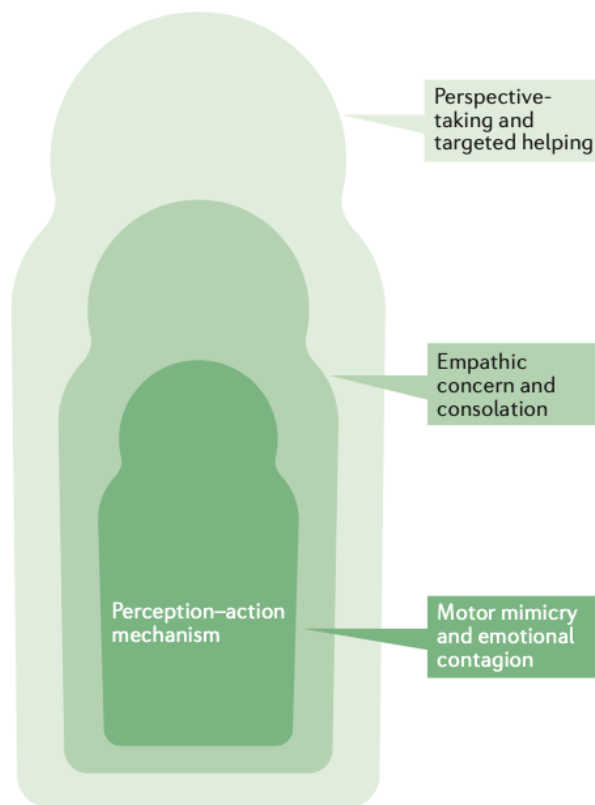


Fig. 1. Chimpanzees spontaneously console distressed individuals by means of friendly body contact. Loudly screaming after having lost a fight against a rival, an adult male (right) is approached by a juvenile who puts an arm around him. Photograph by Frans de Waal.

Daniel Neves Forte 2026

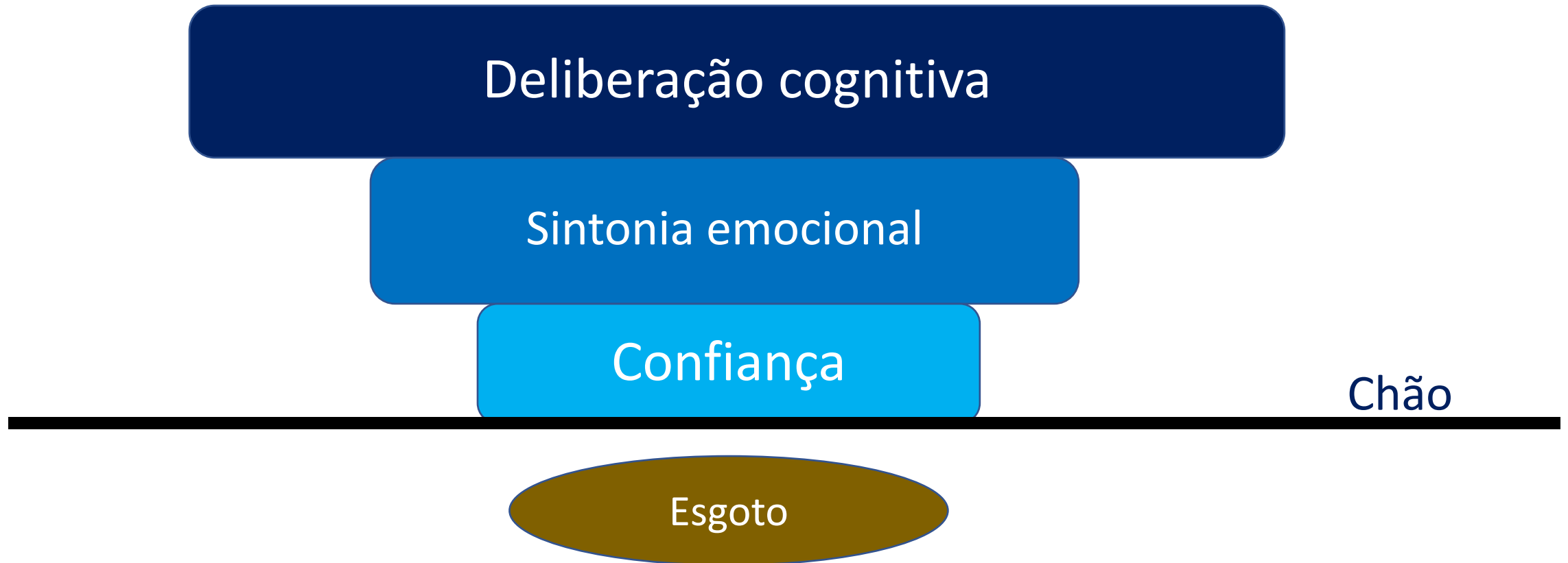
Mammalian empathy: behavioural manifestations and neural basis

Frans B. M. de Waal^{1*} and Stephanie D. Preston^{2*}



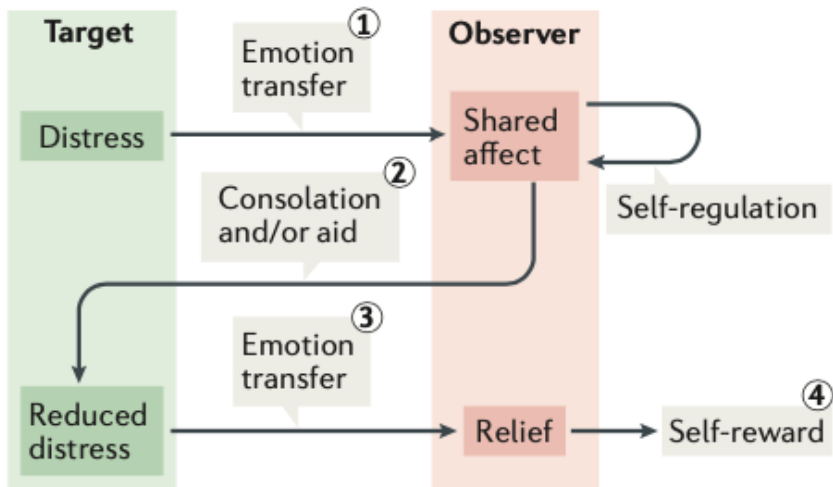
Daniel Neves Forte 2026

Hierarquia das necessidades de comunicação

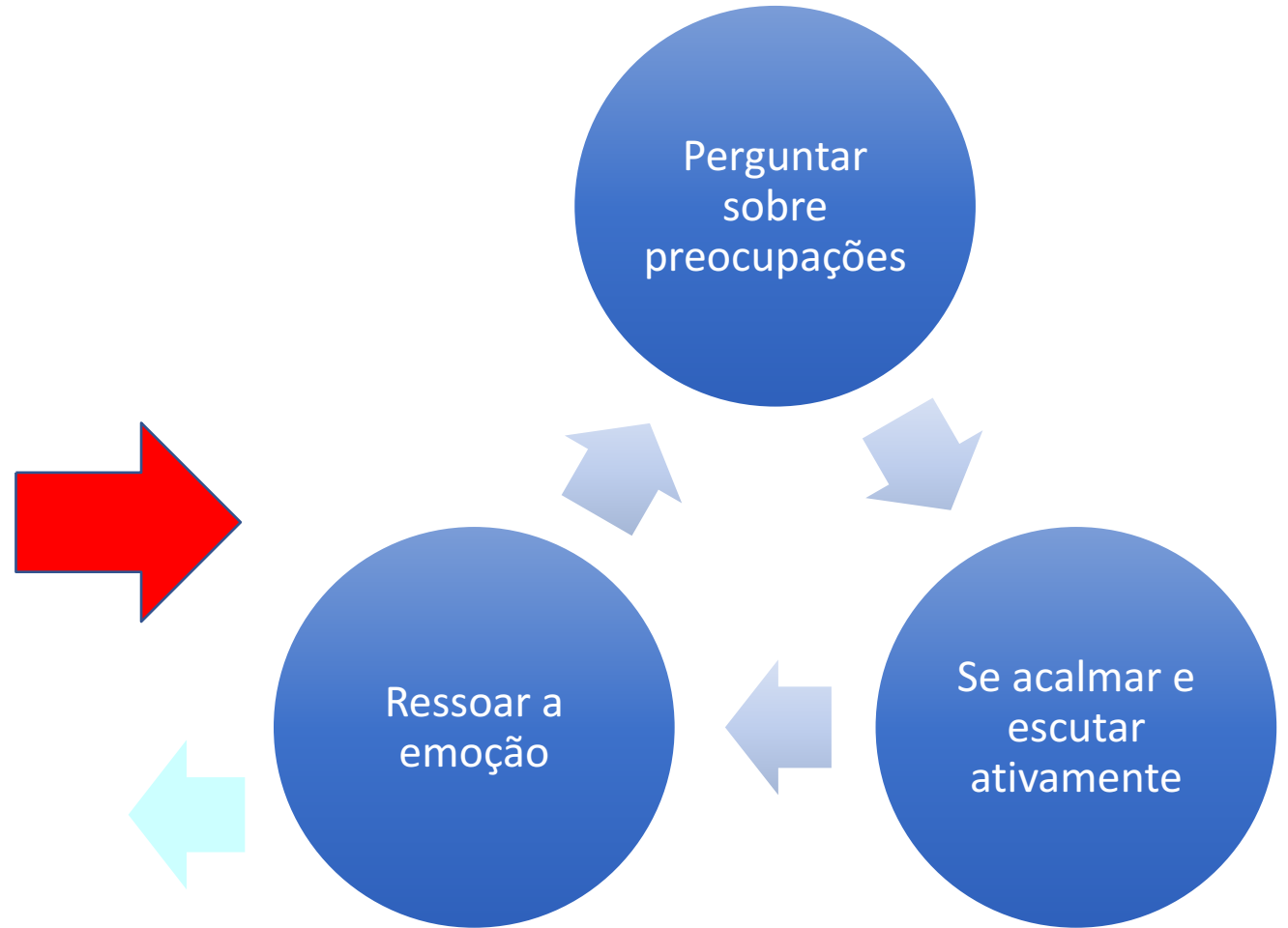


Mammalian empathy: behavioural manifestations and neural basis

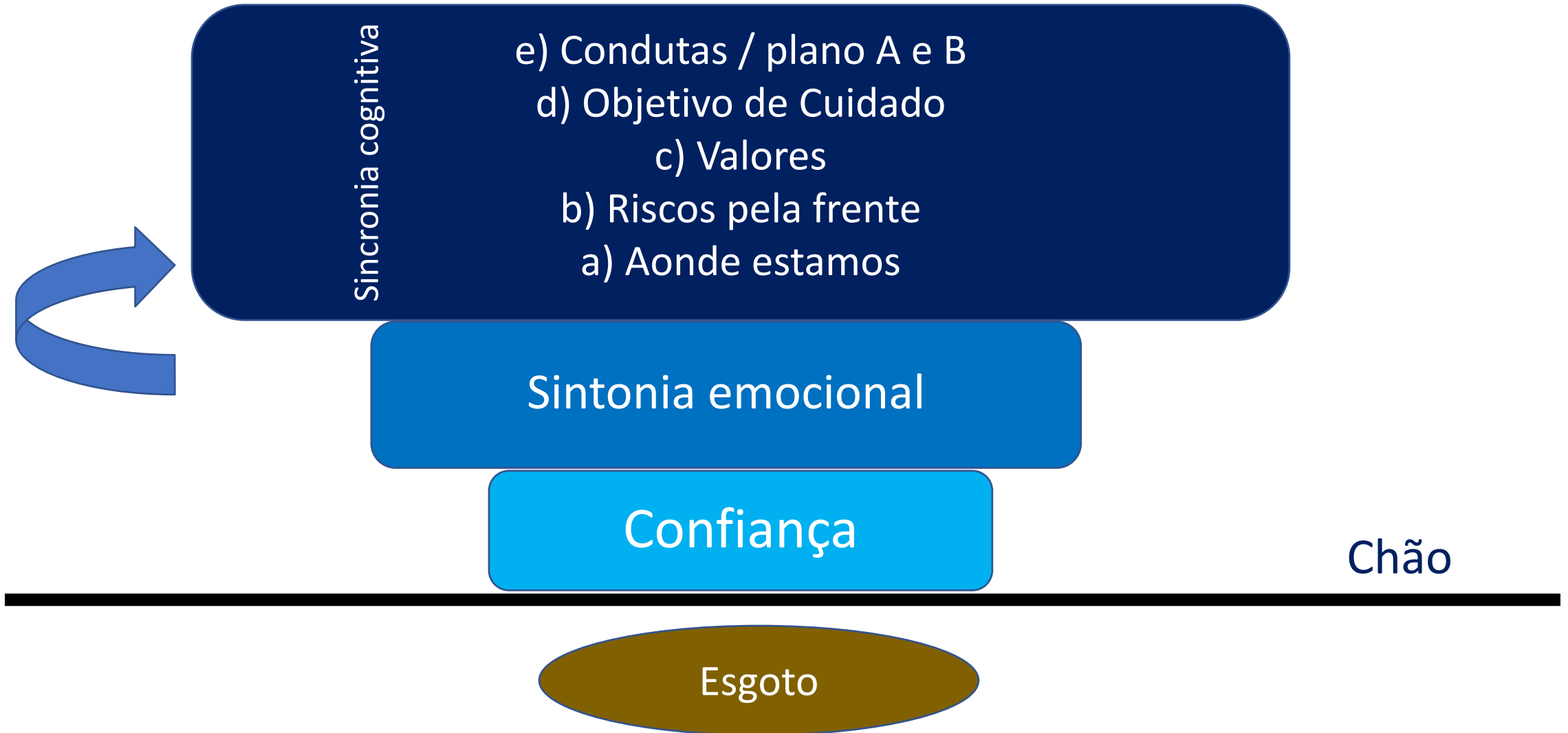
Frans B. M. de Waal^{1*} and Stephanie D. Preston^{2*}



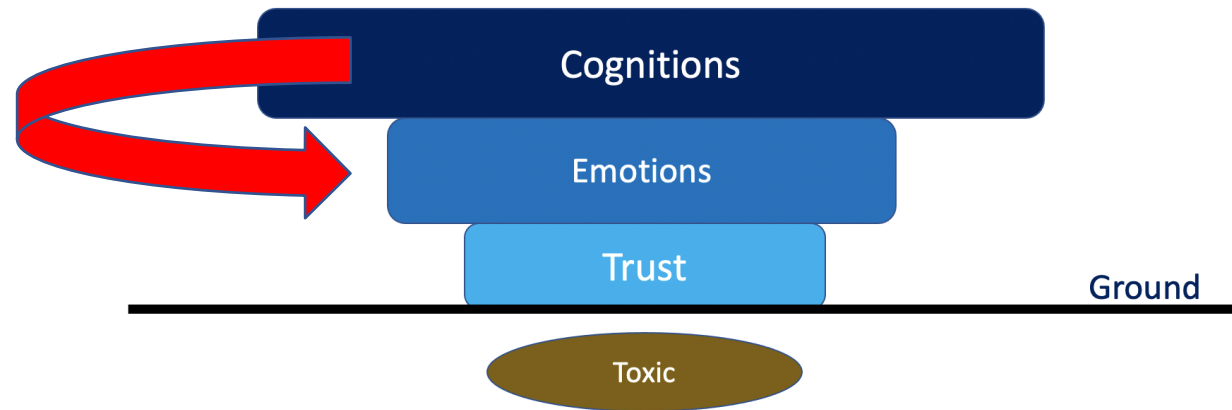
Sintonia emocional em 3 etapas



Hierarquia das necessidades de comunicação



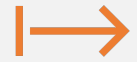
Hierarquia das necessidades de comunicação



**VOLTE UM NÍVEL
QUANDO
EMOCOES
INTENSAS OU
DESCONFIANÇA
SURGIREM**



Visão estratégica: 4 pilares



Complementaridade



Identificação da fragilidade



Processo de decisão estruturado




Comunicação baseada em neurobiologia

RESEARCH

Open Access

The use of bioethical decision-making framework in the ICU of a public Brazilian hospital: a retrospective observational case series



Daniel Mendonça Dantas¹, Fabrício Ferreira Lipi¹, Sofia Carolina Cantuario de Oliveira¹,
Matheus Parra Barcelos de Mendonça¹, Juliana Blassioli Suyama¹, Gabriel Lehvy Cantarin Gonçalves¹,
Bernardo Ramos De Godoy¹, Vivian Meloni Bagini¹, Victor Moitinho Mariano¹, Ludhmila Abrahão Hajjar² and
Daniel Neves Forte^{2*} 

RESEARCH

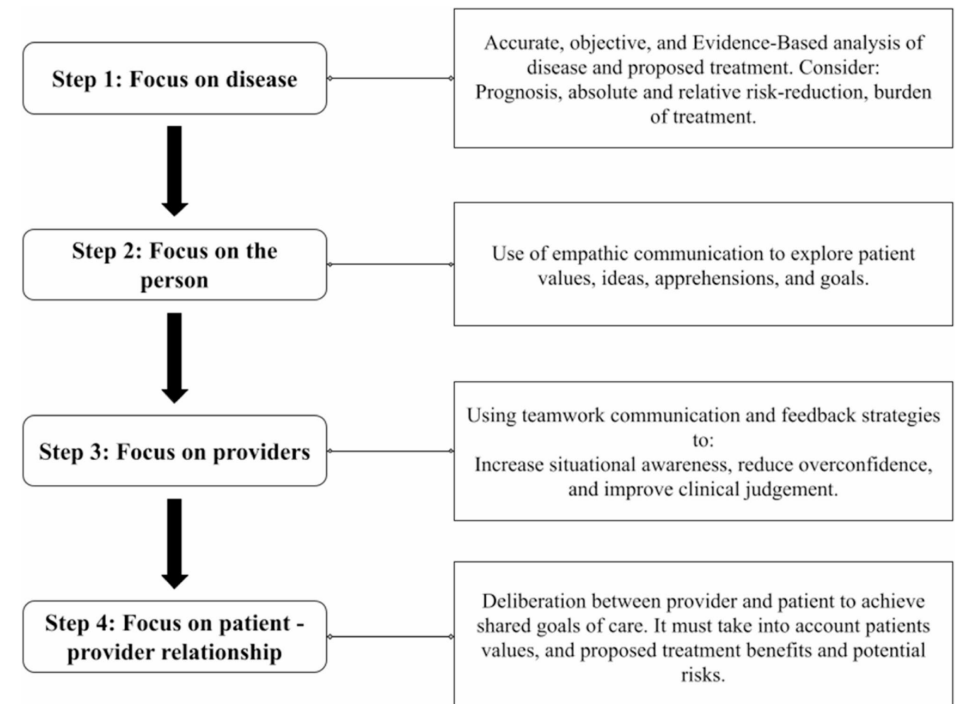
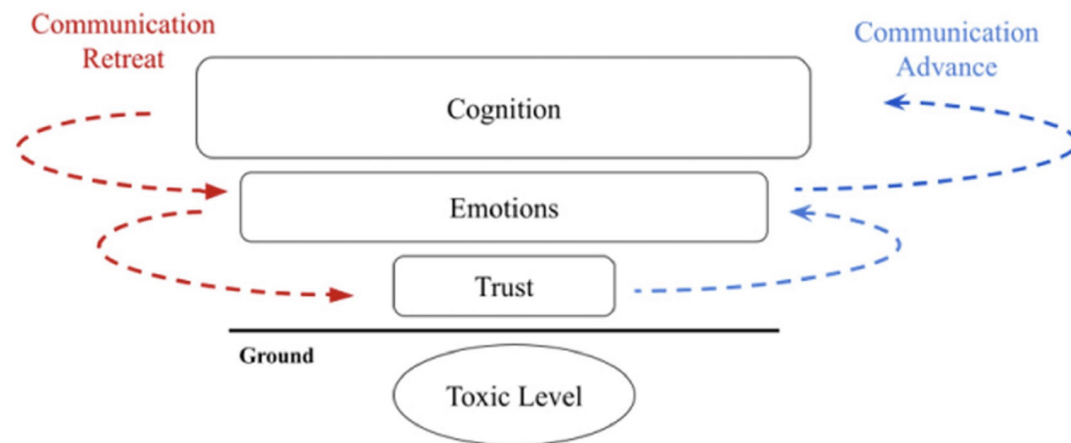
Open Access



The use of bioethical decision-making framework in the ICU of a public Brazilian hospital: a retrospective observational case series

Daniel Mendonça Dantas¹, Fabrício Ferreira Lipi¹, Sofia Carolina Cantuario de Oliveira¹, Matheus Parra Barcelos de Mendonça¹, Juliana Blassioli Suyama¹, Gabriel Lehvy Cantarin Gonçalves¹, Bernardo Ramos De Godoy¹, Vivian Meloni Bagini¹, Victor Moitinho Mariano¹, Ludhmila Abrahão Hajjar² and Daniel Neves Forte^{2*}

Fig. 1 Bioethical framework for decision aid in critically ill patients from ref 4 Forte DN. et al., (2018) [4] A bioethical framework to guide the decision making process in the care of seriously ill patients. BMC Med Ethics



RESEARCH

Open Access



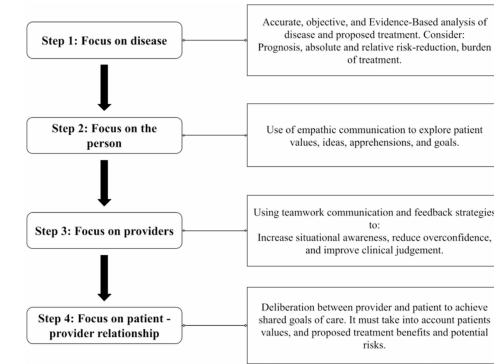
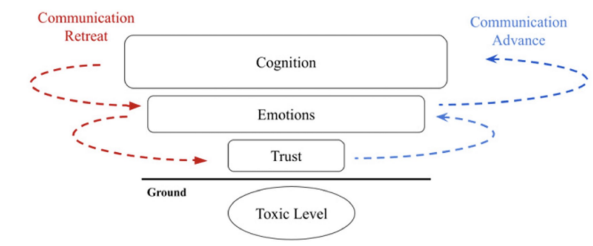
The use of bioethical decision-making framework in the ICU of a public Brazilian hospital: a retrospective observational case series

Daniel Mendonça Dantas¹, Fabrício Ferreira Lipi¹, Sofia Carolina Cantuario de Oliveira¹, Matheus Parra Barcelos de Mendonça¹, Juliana Blassioli Suyama¹, Gabriel Lehvy Cantarin Gonçalves¹, Bernardo Ramos De Godoy¹, Vivian Meloni Bagini¹, Victor Moitinho Mariano¹, Ludhmila Abrahão Hajjar² and Daniel Neves Forte^{2*}

Table 3 Value-based decisions and outcomes

Category	Total (N=40)	Percentage
Section 1 - Value-based clinical decision		
Any LST modification based on the patient's value ^a		
Yes	17	42,5%
No	23	57,5%
Withdraw of LST		
Yes	3	7,5%
No	37	92,5%

Fig. 1 Bioethical framework for decision aid in critically ill patients from ref 4 Forte DN, et al., (2018) [5] A bioethical framework to guide the decision-making process in the care of seriously ill patients. BMC Med Ethics



A) Co-occurrence of Patient Values and Withholding

