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Original Article

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Perception of palliative care of health professionals in the hospital environment of the municipality of Pinheiro-MA

Percepção de cuidados paliativos dos profissionais de saúde no ambiente hospitalar do município de Pinheiro-MA

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Abstract
Introduction: The palliative care brought changes in the practice of professionals in health services, adding the role of caring for the dying process. However, it is a fact that, in health graduations, the approach to this topic is still insufficient and this has direct implications on the type of care offered to patients with limiting and life-threatening conditions. Objective: To assess the perception of health professionals about the Palliative care. Materials and method: Exploratory study with a qualitative approach carried out with health professionals from the hospital network in the city of Pinheiro, Maranhao. Eighteen professionals participated in the research, of which 12 nurses and 6 physicians. Data collection took place through semi-structured interviews, with the interviews being recorded and later transcribed to allow for the interpretation of data, which followed the method of thematic analysis in Bardin. Results: Professionals showed little knowledge about the subject, in addition to insecurity to deal with terminality and the guarantee of patient autonomy. In addition, there was a difficulty in accepting death by both the team and the patient and family members. Conclusion: The appropriation of knowledge about Palliative Care is essential to guarantee human dignity. Therefore, offering training and discussing this topic in the workplace is essential to guarantee the quality of life of the individual.
Keywords: palliative care; integrated health care delivery; knowledge; hospital care.

Resumo
Introdução: Os cuidados paliativos trouxeram mudanças na prática dos profissionais nos serviços de saúde, ao acrescentar o papel de cuidar do processo de morrer. No entanto, é fato

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que, nas graduações em saúde, a abordagem desse tema ainda é insuficiente e isso tem implicações diretas sobre o tipo de cuidado ofertado a pacientes com condições limitadoras e ameaçadoras de vida Objetivo: Avaliar a percepção de profissionais de saúde sobre os Cuidados Paliativos. Materiais e método: Estudo exploratório de abordagem qualitativa realizado com profissionais de saúde da rede hospitalar da cidade de Pinheiro, Maranhão. Participaram da pesquisa 18 profissionais, dos quais 12 enfermeiros e 6 médicos. A coleta de dados se deu por meio de entrevista semiestruturada, sendo as entrevistas gravadas e posteriormente transcritas para permitir a interpretação dos dados que seguiu o método da análise de temática em Bardin. Resultados: Os profissionais apresentaram pouco conhecimento acerca do tema, além de insegurança para lidar com a terminalidade e a garantia da autonomia do paciente. Além disso, verificou-se uma dificuldade na aceitação da morte tanto por parte da equipe como por parte do paciente e dos familiares. Conclusão: A apropriação do conhecimento dos Cuidados Paliativos é essencial para a garantia da dignidade humana. Portanto, o oferecimento de treinamento e a discussão desse tema no ambiente de trabalho é fundamental para a garantia da qualidade de vida do indivíduo.
Palavras-chave: cuidados paliativos; prestação integrada de cuidados de saúde; conhecimento. assistência hospitalar.

Introduce

The evolution of medical technology has brought countless benefits to the population's health. Among which, it should be highlighted, the obtaining of accurate diagnoses, as well as the early treatment of diseases with bad prognosis [1]. This technological advance, associated with the development of therapy, resulted in an increase in the prevalence of chronic diseases and in the survival of these patients. The vulnerable individual, due to his illness, is no longer the center of care and has become instrumental in order to maintain life [2,3].

In this new perspective, palliative care (PC) emerged, seeking full assistance and multidisciplinary care for the patient until the end of life, in order to minimize their discomfort and offer emotional and spiritual support to their families [2]. According to Khoshnazar and collaborators [4], PC is a philosophy of care with the objective of providing an organized treatment, in order to attenuate or ease the suffering, through early identification, adequate management of pain and other physical, mental and intellectual problems presented by the patients.

The PC also brought changes in the role of professionals in health services, adding the role of taking care of the dying process. It is noteworthy that the training of health professionals has always been focused on biological aspects, guided by the technicist method, maintaining a close relationship with the current vision mode of health care. Its practice is predominantly individual and based on fragmented interventions by different professionals for the same patient, in order to offer to the population, the greatest possible number of health services [5,6].

Thus, the lack of training in the subject ends up generating insecurity and ineffectiveness in the application of these cares. Studies show that working with these patients requires special training, including training and continuous updating on the subject. However, the current reality demonstrates that a good part of health professionals do not feel prepared to adequately care for this population [7].

Among the specific skills for performing this care, stands out knowledge about the patient's symptoms, pain control, quality of life and death and family interaction in the final phase of life. This is all essential to help the patient deal with the limitations inherent to their illness [7].

The deficiency in professional training ends up leading to the adoption of futile measures to maintain life. In relation to Brazil, there are still numerous challenges to be overcome, among which the issue of academic training stands out. Santos and collaborators [6] propose in their study, aimed at anesthesiologists, that the

training should seek to value the patient's autonomy and the development of communication skills with the patient and family. In this way, the therapy and the exercise of this care become more effective.

This study is justified because researches show that the professional environment associated with this care is still full of unprepared professionals with inadequate formation for the proper exercise of this philosophy. From the investigation of professional knowledge about PC, it will be possible to identify possible limitations in the application of these care, in order to promote discussions and encourage the development of an integrated network in favor of interdisciplinary care, sensitive to the wishes and needs of the patient and family in these spaces of care. In this sense, the aim of this study was to analyze the perception of health professionals about palliative care.

Materiais e Métodos

Sample and type of study

An exploratory and qualitative investigation was carried out at the Regional Hospital Dr. Antenor Abreu, in the city of Pinheiro, Maranhao.

Research design

The number of participants was reached through the method of "theoretical saturation", understood as the moment in which the increment of new observations does not produce a significant increase in information. Saturation was reached with 18 interviewees, of these 12 nurses and 6 doctors, working in the county's hospital network by signing an Informed Consent Form.

Inclusion and Exclusion Criteria

All health professionals who had experience and work in the Intensive Care Unit of a public hospital in Maranhao Lowland were included. Those professionals who, despite working in the sector, were on sick leave, maternity leave or vacations were excluded from the study.

Procedures

These interviews took place from May to August 2019, were stored in digital media through a recorder and later transcribed in full. Data were analyzed from the framework of Content Analysis in the thematic modality proposed by Bardin [8], where the operationalization of content analysis comprises three stages: pre-analysis; exploration of the material, or coding; treatment of results, inference and interpretation.

The data found were categorized in thematic modality. According to Minayo [9], in this modality, the construction of categories is used to determine groups of ideas about a determined concept, in an analysis that consists of discovering the center of meaning that compose a communication, whose presence or frequency mean something to the objective targeted analytical.

After categorization, the results were used to construct the themes, noting that, for Minayo [9], the notion of Theme is linked to a statement about a determined subject and can be presented by a word, phrase or abridgment.

The project was approved by the Ethics Committee for Research with Human Beings of the Federal University of Maranhao (CAAE: 03689218.3.0000.5087), in compliance with Resolution 466/2012 of the National Health Council of the Ministry of Health, which provides for guidelines and regulatory standards of the research involving human beings.

Resultados

Eighteen professionals participated in the study, of which 12 were nurses and 6 doctors. The average age of participants was 32 years. The average training time in the area was 6.5 years, while the time working at the institution was 4.5 years. The professionals

interviewed in the hospital environment brought the following thematic areas for reflection: the team's relationship with the patient and acceptance.

Team relationship with the patient

The team interviewed presented several aspects regarding the concept of PC.

> *[...]our treatment has to continue; it has to last with the objective of alleviating this patient's pain. Not only physical pain, but also spiritual pain, psychological pain, and much more.* (M02)

This testimony was the only one that included spirituality within the concept of PC. The others turned more to the terminality inherent to the patient and the relief of suffering.

> *In fact, it is the care of the patient in his terminal state. It is that way to reduce the suffering of the patient, who is already in his terminal state. We will provide the best way for the patient to reach his death, without suffering any further. Pains, lack of family... these things.* (E02)

Participants highlighted the idea that the entire team should be involved in carrying out this care. And yet, they put the need for a qualified team, and especially humanized.

> *“I believe that at this moment all professionals are important. “*(E10)
> *[...]Doctor, who has love for others, because there are some who arrive saying things that end up getting worse [...] A more human doctor. because the first one was horrible.* (E03)
> *[...]It is important to be a doctor, preferably a doctor who has a humanized vision and formation.* (M01)

Research participants showed that there is an important deficiency in addressing this issue in professional formation. Only 61% of the participants said they had been in contact with the topic at graduation, despite the fact that it was superficial contact, according to reports. When questioned about their contact at graduation, the answers were:

> *[...]Yes, I had. It was a subject of a discipline.* (E04)
> *[...]It was a mental health course, the teacher talked a lot about this topic.* (E05)

We still had reports that showed total ignorance of the subject when questioned about the patients who should receive this care. This report shows how this theme has been addressed in a deficient way.

> *[...]A patient undergoing a dressing, a patient who comes to take a test sample, which is not supposed to be done here, but he always comes to do it. Patient who comes with minor injuries.* (E01)

We can also notice, in some speeches, that the idea proposed by the guidelines appears frequently, which leads us to the lack of knowledge of the term "Advanced Will Directives" and not of the content of this tool

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> *[...]As much as I can do the last thing for the patient to live, but if his wish is for me not to intervene at that moment, I have to do his wish. But, of course, if there is no statement by the client, whether or not he wants*

> *to have the procedure, I will work to keep him alive.* (E07)
> *[...]No, with that name mostly no!* (M04)

In addition, the process of death and dying still generates a lot of discussion among professionals. Among the reports, it is clear that there is great resistance to accepting death.

> *[...]that the patient is stopping in front of me and the family member says: "no, I don't want you to do anything, because he is already terminally ill and I don't want to prolong my father's suffering." So, there were already some very delicate situations, which I as a professional was in a very boring situation. Because it's complicated for you to look at a person dying in front of you and you cannot, it's not even if you don't have power to do anything, it's just that you shouldn't do what the family member doesn't want [...] then you're in a delicate situation, it's complicated.* (E07)
> *[...], but it is very complicated for the team, we end up getting attached to the patient and we know that he will not improve, right? That unfortunately it will evolve to death.* (E11)

When questioned if the team should do everything to keep the patient alive, we had responses in favor of dysthanasia, even going against the patient's wishes.

> *[...]No way. To do everything. I do everything. Even the patient not wishing, but we have to do it, because you keep talking and he keeps looking because the eyes say everything.* (E06)
> *[...]generally this is usually done, fighting until the last moment, while the patient is breathing, we keep fighting to try and save that life. We can never leave halfway.* (E01)

Acceptance

The content of the interviews brings ideas that show how the patient and family deal with death. Many speeches reflect the difficult acceptance and fear of that moment. Some professionals dealt with the subject putting themselves in the patient's shoes, while others were unable, even if they wanted, to imagine what the patient feels.

> *It is not a question of being in the condition of a patient, it is a question of being in the condition of a human being. We are all afraid of the unknown and death is something unknown and, therefore, everyone is very afraid.* (M02)
> *It's a very heavy subject, I don't even know how to answer... It must be very difficult to accept that you no longer have a probable diagnosis in life.* (E04)
> *[...]at the beginning it has that impact, then, what happens, it matures, matures... then in the last few days it already has a certain acceptance [...]* (M05)

During mourning, the individual manifests the need to relive experiences, to value what he has lived and the presence of loved ones. The family, however, seems to have greater difficulty in accepting terminal illness, which can interfere with the patient's conduct.

> *The family does not accept it, right[...] The family, until that last moment, they want us to do something.* (E05)

Another issue that stands out is the difficulty in accepting the finitude of life in young patients, as shown in the speech below:

> *[...] but when they are young people, who can get back on their feet, come back to themselves, that's... when they have a better chance of healing. We have to do as much as possible, and the impossible to make them come back to life.* (E09)

Faith was cited by many as a support tool for overcoming this moment. It was observed in some speeches the manifestation of the appeal to the divine for healing, still within the process of denying a bad prognosis.

> *Religion, they are very attached to God. They think God will heal.* (E10)

The statements also reveal that professionals do not seem to feel able to establish a bond:

> *When you ask who wants to die, nobody wants to die. So working with the patient, the idea that he will progress to death at any time is complicated. Complicated for both the patient and the team.* (E07)

One of the interviewees, a nurse, reported a situation he had experienced as a companion:

> *Horrible. He came to my wife and asked, when she was quite lucid, talking, if she wanted to be intubated when she stopped. Without any preparation. He arrived and asked: -Look, you know there's nothing else to do for you, do you want to be intubated or not?* (E03)

Discussão

As for the thematic area "Relationship of the team with the patient", a few approached the concept proposed by the WHO, in which the objective is to improve the quality of life of patients and families in the context of a serious and life-threatening disease through prevention, relief of suffering, early identification and impeccable treatment of pain and other physical, psychological, social and spiritual symptoms and problems" [(10)].

The suffering reported by the interviewees is not only associated with the physical pain present in the disease, but rather a reflection of the entire situation experienced by the patient, it affects him intrinsically and extrinsically, and in the way he relates to the world [(11)].

This CP theme still needs a lot of adjustments within the current curriculum. Corroborating this result, a survey carried out in the city of Sao Paulo with academics showed that 83% did not receive satisfactory information about terminally ill patients during graduation [(12)].

In addition, professional formation should develop the specific skills and abilities needed to carry out this care. The more specialized and trained the team, the better the results in controlling pain and psychosocial suffering. Thus, the investment in these items becomes essential for an adequate care of patients in PC [(13)].

It is worth emphasizing that 100% of the participants denied having participated in any meeting that addressed this topic in the researched hospital. In addition, all reported not knowing the Advance Will Directives.

As for the AWD, they work as a tool for the patient to manifest their wishes at the end of their life (the manifestation must be before the end of life, as it aims to ensure that their wishes were respected). In this way, they promote the patient's autonomy and the guarantee of human dignity, while allowing, in the absence of the patient's decision-making capacity, that will be known and, if there is a health care power of attorney, it appoints a person trusted by the grantor to deliberate on its decisions [14].

Health professionals, especially doctors, are trained with an emphasis on the healing process. However, a cure is not always possible, so the professional takes on a posture of denial of death. This difficulty in dealing with the death of patients can lead to emotional consequences and difficulties at work. Thus, the professional must be remembered as an individual with their weaknesses and feelings and not in a robotic way [15].

Because of this, when the topic of dysthanasia is approached, there is so much discussion. Dysthanasia is the obsessive use of therapeutic procedures in patients in the final stage of life. The procedures are applied without real reflection on their need, bringing more harm to the patient than benefits [16]. The use of dysthanasia resides in the non-acceptance of death by health professionals and family members, who end up clinging to futile technologies to maintain the patient's life. It should be noted that the use of these technologies at the end of life does not guarantee a death with dignity [17].

As for the thematic area “Acceptance”, we noticed from the speeches that the topic is an avoided subject, despite being an everyday situation. This occurs in order to create distance and a feeling of impossibility of its occurrence. This aversion to death resides in the possibility of physical suffering, fear of loneliness, separation, the unknown, interruption of plans and dreams, the future of those who remain, in addition to the need to review their priorities and existential values [18,19].

Although the first impact on the certainty of death is one of denial, the patient can overcome his fears and finally reach acceptance, which does not mean giving up on living, but rather learning to live with his real condition. This fact demands an entire process of understanding the situation with all its consequences [19].

The mourning process leads the patient to create conceptions about the world, favoring the confrontation of mourning, as well as the reorganization of his life [11].

It should be noted that PC seek to offer support not only to the patient, but to their family, which in addition to helping emotionally, directly affects decision-making, especially when the patient has limited communication [11,16]. Therefore, the family must be aware of the patient's prognosis and be guided in the process of mourning. In this way, it is possible to avoid blaming, dysthanasia or potentialization of complicated mourning processes in the family environment. [16].

Death can be considered the last stage of the life cycle, therefore, it always seems to be related to elderly patients. When they reach this stage of life, it is expected that they have already completed their journey in life, thus the end of life seems to be more “acceptable” at this stage of life. However, the possibility of death exists since the individual's birth [19], but it is no longer accepted because young people still have a lot to conquer. The team, the family and the patient have a greater difficulty in accepting death at an early stage of the life cycle [20].

Faith helps to reduce anxiety, increase confidence and inner strength, thus, it helps to face, accept and overcome the adversities inherent to terminality. Although many place the possibility of healing in the divine figure, religiosity helps to reduce anxiety and fears, maintain hope and remain in control of the situation. In this way, it contributes to the patient's autonomy and collaboration [20,21].

In addition, the communication process between professionals and patients was highly emphasized. This process is essential to create a relationship of trust between the team and the patient, so that they feel free to express their desires, fears and values, in order to guide therapeutic conduct considering their individuality [11].

Once again, the professionals' insecurity regarding the theme is highlighted. Situations involving illness and death are associated with difficulty in communication, especially due to the professionals' personal limitations. The lack of professional preparation to deal with this moment is at the heart of the deficit arising from formation with regard to communicating difficult news [15].

Communication is essential for the execution of PC. It is considered an indispensable tool, as it allows the patient to resolve doubts, reduce anxiety and distress, be comforted and thus improve quality of life [22]. Excerpts from the speeches show the lack of attachment and empathy of the professional, which undoubtedly worked as a barrier to adequate communication (confused), therefore, provided the interviewee with a bad experience regarding PC and made the process of accepting the terminal even more difficult.

Conclusão

The reports of these professionals show that there is a great lack of PC in the hospital environment. The concepts raised by the participants, mostly incomplete, associated the theme with terminality and relief of suffering. In this context, the understanding found revolved around the control of symptoms and left aside the patient's spiritual, social and psychic issue.

This lack resides in the deficiency in the formation of these professionals. A significant portion of the participants declared that they had no contact at graduation, yet those who did were insufficient to build a solid foundation. The consequences of this bad formation were: unprepared and insecure professionals, and uncooperative patients.

In addition, the fact that no professional shows knowledge about AWD is a cause for concern, as they serve as an instrument to maintain the patient's autonomy. The need for qualification and formation of the team is clear in order to ensure the execution of the PC effectively.

Death is still a difficult topic to be dealt with today. Professionals still have their formation focused on healing and face the end of life as a failure, not as a part of the life cycle. The destigmatization of this theme is necessary, but complex. It is necessary to approach it, in a light way, in everyday life, in all social environments and, in this way, lead each one of us to reflect on how we will face it, regardless of disease or prognosis. Death is a certainty for everyone, regardless of age, so it deserves to be discussed and demystified.

Furthermore, an important coping tool is faith. Many statements were interspersed with this feeling, which seems to support overcoming adversity, as well as reducing anxiety and fear. The professionals, in their speeches, emphasize that the patient seeks in faith the strength he needs to face the moment of difficulty.

An extremely relevant point in the study was the importance of an effective communication process. Communication is the main instrument of the PC. When well done, it allows for the creation of a bond between the team and the patient and collaborates to provide adequate care. However, what we noticed was a difficulty in carrying out effective communication, a fact that resides in the bad formation mentioned above, as well as in the absence of training based on the communication of difficult news.

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