

Palliative care: the speech medical residents

Cuidados paliativos: discurso de médicos residentes

Abdon Moreira Lustosa¹, Fernando Dutra², Márcia Adriana Dias Meirelles Moreira³, Carla Braz Evangelista⁴, Marcella Costa Souto Duarte⁵, Ana Aline Lacet Zaccara⁶, Fernando André Costa de Souza⁷

DOI: 10.5935/2238-3182.20150072

ABSTRACT

Introduction: palliative care is provided by a multidisciplinary team that consists of Nursing, Psychology, Physiotherapy, Social work, and Medicine. Although this type of therapy is essential for patients outside of the healing possibilities, it is evident that these caring procedures are little disseminated in medical courses resulting in lack of knowledge by newly graduated doctors. **Objectives:** to investigate the medical residents' speech about the goals of palliative care. **Methods:** this was an exploratory research with a qualitative approach. The study included 19 medical residents in the area of anesthesia and surgery at a hospital in João Pessoa-PB. The empirical material was analyzed qualitatively by the collective subject speech technique. **Results:** it was possible to identify the following core ideas from the speeches of participants: palliative care aimed at improving the quality of life of patients with incurable diseases and at terminal stages; this care seeks to provide comfort and dignity to the patient without therapeutic possibility of cure; they provide relief from symptoms, pain, and suffering for the terminally ill patient. **Conclusions:** resident physicians understand that the palliative care aimed at improving the quality of life through symptom relief and pain control, through which experiencing and monitoring the process of illness is possible with respect and dignity, preventing unnecessary suffering and providing preventive intervention.

Key words: Internship and Residency; Education, Medical; Palliative Care; Palliative Medicine; Critical Illness.

RESUMO

Introdução: os cuidados paliativos são realizados por equipe multiprofissional da qual fazem parte a Enfermagem, Psicologia, Fisioterapia, Serviço Social e a Medicina. E apesar dessa modalidade terapêutica ser indispensável a pacientes fora das possibilidades de cura, evidencia-se que esses cuidados são pouco divulgados nos cursos de Medicina, o que contribui para falta de conhecimento dos médicos recém-formados. **Objetivos:** investigar o discurso de médicos-residentes acerca das finalidades dos cuidados paliativos. **Métodos:** trata-se de pesquisa exploratória, com abordagem qualitativa. Participaram do estudo 19 médicos-residentes da área de anestesia e cirurgia de um hospital de João Pessoa-PB. O material empírico foi analisado qualitativamente, mediante a técnica do discurso do sujeito coletivo. **Resultados:** a partir dos discursos dos participantes, foi possível identificar as seguintes ideias centrais: os cuidados paliativos visam a melhorar a qualidade de vida do paciente com doença incurável e em fase terminal; são cuidados que buscam propiciar conforto e dignidade ao paciente sem possibilidade terapêutica de cura; e cuidados que propiciam alívio de sintomas, dor e sofrimento do paciente terminal. **Conclusões:** os médicos residentes entendem que os cuidados paliativos visam à melhoria da qualidade de vida, mediante o alívio dos sintomas e o controle da dor, por meio

Submitted: 2014/05/05

Approved: 2015/07/24

Institution:
The federal University of Paraíba – Campus I
Bioethics Studies and Research Center of the
Health Sciences Center
João Pessoa, PB – Brazil

Corresponding Author:
Abdon Moreira Lustosa
E-mail: abdonmoreira@gmail.com

do qual é possível vivenciar e acompanhar o processo do adoecimento com respeito e dignidade, prevenindo o sofrimento desnecessário e intervindo preventivamente.

Palavras-chave: Internato e Residência; Educação Médica; Cuidados Paliativos; Medicina Paliativa; Estado Terminal.

INTRODUCTION

Assistance to patients outside the therapeutic possibilities of cure has been the subject of discussion among specialists.¹ The application of new care modalities that meet the needs of these individuals, focused on improving the quality of life and relief of pain and symptoms in the physical and emotional spheres, are indispensable for providing care to these patients.² Therefore, the philosophy of the palliative care practice appears to be appropriate to this situation because they are targeted to patients for whom there is no possibility of cure resulting from a progressive disease in irreversible stage that no longer responds to curative treatments making the care process the priority treatment.³

Palliative care is applied by interdisciplinary and multidisciplinary teams composed of medical professionals, social workers, nurses, psychologists, physiotherapists, occupational therapists, nutritionists, and others in the administrative sector and religious support. In this care model, all professionals are relevant for fostering care and providing comfort to patients.^{4,5}

The philosophy of palliative care alerts to the need to individualize care better positioning health services with regard to patients suffering from incurable diseases, enabling the promotion of essential care to individuals undergoing terminal diseases.² Thus, it becomes vital to guide the society to providing directed care for these patients, avoiding their exclusion from receiving assistance.¹

However, despite the increase of scientific literature on the subject, Brazilian medical schools have directed little attention to the subject. This fact is reflected in the absence of disciplines, mandatory or optional, focused on the teaching of the philosophy of palliative care in the course curriculum.⁶

The knowledge of doctors is becoming increasingly fragmented, which offers the feeling of a growing power in the disease process and death and makes future physicians become outstanding professionals in the science of healing, however, unprepared to monitoring and assisting the patient who cannot be cured. From this perspective, the psychosocial and spiritual aspects

of the patient are little valued when facing the disease, although they are the most obvious dimensions before incurable diseases and proximity of death.⁷

The philosophy of palliative care, when addressed during the training of medical students, provides better therapeutic resources when healing is possible and the best care resource when healing is not possible.⁷ Within this scope, it is essential that the teaching of palliative care be inserted in the curricula of health courses and during the professional practice to ensure that patients are assisted in an ethical, holistic, and humane manner.¹

Following this line of thought, the current Code of Medical Ethics (CEM) enhances the presence of the doctor as the counselor and patient's partner, from not only a biological approach but essentially humanistic. In order to fulfill this goal, the professional of Medicine must be able to assist the patient considering him as an integral being, holder of feelings, desires, and autonomy that ensure dignity for life and when its end approaches.^{8,9}

The focus on palliative care highlights the most relevant aspects addressed in this Code. The Federal Council of Medicine (CFM) emphasizes this approach for assistance to patients with chronic and irreversible disease excluding the abandonment of patients in these cases.¹⁰

The need to know the medical view about the palliative care emerges in Brazil based on the understanding that the deficit in education in palliative care brings negative consequences to doctors and patients associated with the stimulus in spreading this approach promoted by CFM.

Considering the relevance of the theme and the small number of studies on palliative care in the medical field, this study is based on the following question: what is the understanding of medical residents about palliative care? To answer the proposed question, this study aimed to investigate the understanding of medical residents about palliative care.

METHODS

This was an exploratory research with a qualitative approach conducted at the teaching hospital of a federal agency located in João Pessoa, Paraíba. That institution is the practice field in the professionalization of graduates and residents in health programs, thus contributing to the improvement of future professionals.

The study population involved medical residents in the area of anesthesia and surgery, who were providing care to patients hospitalized in the institution. The inclusion criteria for sample selection were: being active during the data collection period; having worked for at least six months in the elected institution for the study, and have an interest and willingness to participate in the study. Considering the nature of the study, the sampling process was accessibility. Thus, we worked with a sample of 19 medical residents in the area of anesthesia and surgery.

The collection of empirical material occurred in August of 2013 through the use of an instrument containing subjective questions, pertinent to the purpose of the study. This material was analyzed qualitatively, through the technique of collective subject speech (DSC), which consists of a set of tabulation procedures of qualitative data. These procedures involve the following operational steps:

- selection of key expressions of each particular speech;
- identification of the main idea in each of these key phrases forming the summary of the content of these expressions;
- grouping of similar or complementary core ideas;
- elaboration of the collective subject speech from the grouping of similar central ideas and key expressions.¹¹

It should be noted that the ethical aspects related to research involving human subjects were observed as recommended by Resolution No. 466/2012 of the National Health Council, particularly with regard to respecting the participants' autonomy and confidentiality.¹² The research was submitted to the Research Ethics Committee of the Lauro Wanderley University Hospital of the Federal University of Paraíba and approved under no. 184/10.

RESULTS

The sample consisted of 19 residents, including 58% from the anesthesia area and 42% from surgery area, aged between 24 and 30 years, 58% males.

In response to the question "what is your understanding of palliative care?," it was possible to consider three central ideas: it aims to improve the quality of life of patients with incurable diseases and at terminal stages; it seeks to provide comfort and dignity to

the patient without a therapeutic possibility of cure; and provides relief from symptoms, pain, and suffering in terminally ill patients (Figures 1, 2, and 3).

CENTRAL IDEA 1

Aimed at improving the quality of life of patients with incurable disease or terminally ill.

Collective subject speech

Palliative care aimed at providing quality of life for terminally ill patients; Palliative care is [...] important for debilitated patients who have suffered [...], since there is no solution to their disease, but improve their quality of life without pain, for example; They are approaches that provide better quality of life for patients who are at the end stage of an illness; Palliative care are those measures designed to improve the quality of life of terminally ill patients [...]; It is a way to assist the terminally ill patient in order to offer a better quality of life [...]; Care for the patient to live as best as he can, given that he has an incurable disease; It is the care provided to terminally ill patients without prognosis in order to ensure the best quality of life to the patient.

Figure 1 - Central idea 1 from doctors participating in the study when answering the question: what is your understanding about palliative care?

CENTRAL IDEA 2

It searches to provide comfort and dignity to the patient without therapeutic possibility of cure.

Collective subject speech

Palliative care is measures adopted to provide comfort and dignity to patients without therapeutic possibility of cure; It represents extremely needed care for patients to have a dignified life with full respect [...] before their conditions. It is care for terminally ill patients in order to give comfort and dignity to the patient; These are measures aimed at providing greater comfort to patients with no chance of curative treatment.

Figure 2 - Central idea 2 from doctors participating in the study when answering the question: what is your understanding about palliative care?

According to the central idea 1 expressed by medical residents in the study, palliative care is understood as care provided to improve the quality of life of patients who are outside the therapeutic possibilities of cure due to a terminal or incurable disease.

In many cases, medical professionals consider the outcome as a personal defeat in situations in which they are faced with the lack of resources to cure the patient because the treatment and the patient's full recovery is evidenced during training

and little is discussed about care arrangements for patients outside of possibilities of healing. However, it was noted that physicians stress that providing the well-being of the patient with an incurable disease, is weakened, and needs special care that promote the improvement of his quality of life is of utmost importance.

The speech of the medical residents involved in the study and evidenced in the central idea 2 highlights that palliative care provides comfort and dignity to the patient outside the therapeutic possibilities of cure and focus on the “patient’s autonomy” and “good death” aspects related to the field of bioethics.

It is difficult for health professionals, especially to the doctor, to accept that there are no more treatment options and that the main attitude is to approach the patient in the best way possible and respect his wishes. Nevertheless, it is observed that the medical residents understand that death is a natural process and that life goes beyond the biological body in which the cure is the primary medical purpose. For them, one must consider the individual in the face of a terminal illness in its wholeness considering other aspects such as respect for his dignity and autonomy.

CENTRAL IDEA 3

Propiciam alívio de sintomas, dor e sofrimento do paciente terminal.

Collective subject speech

It is care provided to terminal patients or with diseases in advanced stages, aiming [...] to decrease the pain and suffering; Palliative care aim to offer to the terminal patient dignified conditions, such as the relief of symptoms and pain [...]; They are offered to terminally ill patients to relieve their pain and symptoms [...]; palliative care seek to mitigate the suffering of terminally ill patients.

Figure 3 - Central idea 3 from doctors participating in the study when answering the question: what is your understanding about palliative care?

The speech included in the central idea 3 reveals that palliative care promotes pain, symptoms, and suffering relief in patients suffering from life-threatening diseases. Thus, when assisting the patient in palliative care, doctors should be attentive to their needs, which in addition to the physical ones, have those of indispensable psychological and spiritual character because most of the time the feelings of pain and loneliness are intense.

DISCUSSION

According to the World Health Organization (WHO), palliative care is presented as an approach that improves the quality of life of patients and families, especially when the disease is at an advanced stage and cure is unlikely, or even when the disease is in the terminal phase.¹³

When there is no more therapeutic possibility of cure, the focus of care turns to the attention that promotes a good quality of life, comfort, relief of symptoms, psychosocial and spiritual support, and support in the grieving process.³

Note that the quality of life can be understood as an intimate feeling of comfort, well-being or happiness, in the performance of functions related to family life, society, and work, and involves the physical, intellectual, psychological, and social aspects.¹⁴

Palliative care, expressed in various approaches observed in the literature, relates essentially to the quality of life.³ The relationship between the meaning of terminal life and palliative care for medical oncologists reveals that the quality of life frequently appears in their concerns, which demonstrates the importance of considering the quality of life as an important factor in the care provided to patients with terminal or incurable illnesses.¹⁴

The concept of quality of life is of paramount importance for the patient and his family. For this reason, palliative care is recognized as an approach that reaches the ideal, through measures and procedures that respect the individual and include him as a social being, filled with values, beliefs, and needs.³ It is important to remember that increasing the quality of life is relevant not only for the patient but also for his family that suffers before his health condition and needs for medical staff and other health care professionals, meeting the first central idea originated in the speeches of doctors participating in this study.

In situations where the chances of treatment are no longer present, the primary goal of care is not to postpone death, but to make life more comfortable and dignified.¹⁵ Therefore, the recognition of the limits of therapeutic technologies in front of a terminal or incurable disease process is exceedingly important not to harm the dignity of these individuals and boost the movement towards the practice of palliative care.¹⁶

Similarly to the findings of this research, a study on the perception of nurses in relation to the patient in palliative care showed that these professionals rec-

ognize the right to dignity outside of the healing possibilities. According to the interviewed nurses, dying with dignity requires respect for the patient's condition, his views, constraints, fears, and anguish.¹⁷

Note that dignity is an attribute that is inherent in all human beings. It is the most representative expression of the right of a civilizational character and reveals a growing process of apprehension of man about himself and the principles that must lead life in society.¹⁸

The act of caring for others is among the assumptions of human dignity.⁶ Thus, dignity requires the realization of care that meets the individual needs considering him as a holistic being. Therefore, the therapeutic resources should be directed to the maintenance of the individual's dignity.¹⁹ Hence, according to the understanding of the speech on the collective subject 2, palliative care is understood as the type of care provided for the comfort and dignity of individuals during the process of finiteness.

The ideology of palliative care is to meet fully the person's needs promoting the overall well-being and dignity of chronic and terminal patients, and the possibility of not being expropriated in the final moment of life.² Thus, to admit that the remedies available to the rescue of healing have been exhausted and the patient is headed for death does not mean that there is no longer anything to do. Thereafter, according to the speech on the collective subject 3, aid based on palliative care can be offered to the patient aimed at pain relief and reduced discomfort.²⁰

This care modality intervenes to decrease unpleasant symptoms such as pain, dyspnea, and constipation caused by the disease advance or treatment used. However, they require a doctor's knowledge beyond the control of signs and symptoms and require communication skills, teamwork, competence in conducting the care, and supporting techniques in situations of confrontation with death and fight for patients and families.²¹

With regard to drug treatment, it is essential to adopt the standard of daily assessment of the patient's pain and, if possible, find out its triggering cause because the painful experience is an individual phenomenon. Thus, one can define the most appropriate drug therapy to the patient, ensuring the rational use of medications.²²

In addition to the conventional therapies, complementary methods are being increasingly used in pain management for patients in palliative care, with emphasis on measures that include physical methods:

transcutaneous electrical nerve stimulation, heat and cold manipulation, acupuncture; mechanical, massage and physical activities; cognitive: relaxation and directed distraction, guided imagery, deep breathing, biofeedback, and educational groups, among others.²³

The pain control and relief and psychological and social symptoms are the individual's right and the professionals' duty, who must adopt strategies that promote the reduction of suffering brought about by diseases.³

Hence, according to the understanding of the participants in this study, to prevent or quell symptoms does not mean just dealing with physical suffering but all dimensions including the emotional, social, and spiritual suffering.

CONCLUSIONS

The collective subject speech of doctors participating in this study evidence the meaning of palliative care as a form of care that provides improved quality of life, comfort, dignity, and relief of symptoms and pain to patients without therapeutic possibilities of cure.

The doctors involved in the study recognize the value of the practice of palliative care to provide adequate and comprehensive treatment to patients without therapeutic possibilities of cure, with the central focus on improving their quality of life in the disease process and its terminality.

It is hoped that this study will enable new thoughts with respect to palliative care as a humanistic practice to patients with incurable diseases and in terminal phases, and stimulate the production of new studies in Medicine or other areas of health, including new possibilities for its approach in the assistance, teaching, research, and extension realms.

REFERENCES

1. Floriani CA, Schramm FR. Palliative care: interfaces, conflicts and necessities. *Ciênc Saúde Coletiva*. 2008 Dec;13(2):S2123-32.
2. Chaves JHB, Mendonça VLG, Pessini L, Rego G, Nunes R. Cuidados paliativos na prática médica: contexto bioético. *Rev Dor*. 2011 July/Sept;12(3):250-5.
3. Silva EP, Sudigursky D. Concepções sobre cuidados paliativos: revisão bibliográfica. *Acta Paul Enferm*. 2008;21(3):504-8.
4. Bifulco VA, Iochida LC. A formação na graduação dos profissionais de saúde e a educação para o cuidado de pacientes fora de recursos terapêuticos de cura. *Rev Bras Educ Med*. 2009 jan/mar;33(1):92-100.

5. Santos FS. Cuidados paliativos: diretrizes, humanização e alívio dos sintomas. São Paulo: Atheneu; 2011.
6. Oliveira JR, Ferreira AC, Rezende NA. Ensino de Bioética e Cuidados Paliativos nas Escolas Médicas do Brasil. *Rev Bras Educ Med.* 2013 abr/jun; 37(2):285-90.
7. Figueiredo MGMCA, Stano RCMT. O Estudo da Morte e dos Cuidados Paliativos: uma Experiência Didática no Currículo de Medicina. *Rev Bras Educ Med.* 2013 abr/jun; 37(2):298-307.
8. Chung EK, Rhee JA, Baik YH, Oh-Sun A. The effect of team-based learning in medical ethics education. *Med Teach.* 2009;31(11):1013-7.
9. Pessini L, Hossne WS. Terminalidade da vida e o novo código de ética médica. *Rev Bioethikos.* 2010; 4(2):127-9.
10. Conselho Federal de Medicina. Resolução nº 1931 de 24 de setembro de 2009. Aprova o Código de Ética Médica. Brasília: Diário Oficial da União; 2009.
11. Lefevre F, Lefevre AMC, Marques MCC. Discurso do Sujeito Coletivo, complexidade e auto-organização. *Ciênc Saúde Coletiva.* 2009 jul/ago; 14(4):1193-204.
12. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução nº 466, 12 de dezembro de 2012. Brasília: Ministério da Saúde; 2013.
13. World Health Organization. National cancer control programmes: policies and managerial guidelines. 2th ed. Geneva: WHO; 2002.
14. Fraga F, Boas RFOV, Mendonça ARA. Significado, para os médicos, da terminalidade da vida e dos cuidados paliativos. *Rev Bioet.* 2012; 20(3):514-9.
15. Vasconcelos EV, Santana ME, Silva SED. Desafios da enfermagem nos cuidados paliativos: revisão integrativa. *Enferm Foco.* 2012; 3(3):127-30.
16. Pessini L. Lidando com pedidos de eutanásia: a inserção do filtro paliativo. *Rev Bioet.* 2010; 18(3):549-60.
17. Fernandes MA, Evangelista CB, Platel ICS, Agra G, Lopes MS, Rodrigues FA. Percepção dos enfermeiros sobre o significado dos cuidados paliativos em pacientes com câncer terminal. *Ciênc Saúde Coletiva.* 2013 set; 18(9):2589-96.
18. Silva HB. O princípio da dignidade humana na constituição brasileira. *Rev Bioét.* 2010; 18(3):573-87.
19. Medeiros MB, Pereira ER, Silva RMCRA, Silva MA. Dilemas éticos em UTI: contribuições da Teoria dos Valores de Max Scheler. *Rev Bras Enferm.* 2012 mar/apr; 65(2):276-84.
20. Ribeiro EE. Tanatologia: vida e finitude. Informações gerais para os módulos: velhice e morte, Medicina e morte, cuidados paliativos e bioética. Rio de Janeiro: UERJ/UnATI; 2008.
21. Fonseca A, Geovanini F. Cuidados paliativos na formação do profissional da Área de Saúde. *Rev Bras Educ Med.* 2013 jan/mar; 37(1):120-5.
22. Rabelo ML, Borella MLL. Papel do farmacêutico no seguimento farmacoterapêutico para o controle da dor de origem oncológica. *Rev Dor.* 2013 mar; 14(1):58-60.
23. Graner KM, Costa Junior AL, Gustavo SR. Dor em oncologia: intervenções complementares e alternativas ao tratamento medicamentoso. *Temas Psicol.* 2010; 18(2):345-55.