

Perception of the Nursing Team in Relation to Oncologic Patient Assistance in Palliative Care in the Intensive Care Unit

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Abstract— *Introduction: The palliative care in general should retake the possibility of perceiving death as a natural and expected process, facing a life threatening disease. Even if there are efforts aiming toward Palliative Care in the ICU, there are still difficulties that hinder such practice, by the fact that it demands individual activities toward the patient. Objectives: describe the perception of the nursing team in relation to oncologic patient assistance in palliative care admitted to the ICU. Methodology: Descriptive, transversal, quali-quantitative study, with field data collection, in which 29 nursing professionals were interviewed through an individual questionnaire, made by the researcher herself in a hospital from Rondônia countryside in 2020. Results: it was possible to prove that the Palliative Care theme is still not widespread and lot of professionals don't know its principles, such reality hinders the care in relation to these oncologic patients admitted to the ICU. Conclusions: It stands out, then, that there is a need for the nursing team to be ready to attend oncologic patients, just as it becomes evident the team's interest over the presented theme. To offer continuing education about intensive care is essential, just as providing an emotional support to these professionals who deal everyday with pain, suffering and death.*

Keywords— *Oncologic Care. Nursing. Intensive Care Unit.*

I. INTRODUCTION

The concept of Palliative Care (PC) was initially developed in the 50's by the English doctor Cicely Saunders, pioneer of the modern PC movement, on of her lines that circulates to the present day is: “Suffering is only intolerable when nobody cares.” (Health, 2014).

In the 90's the World Health Organization (WHO) first defined the Palliative Care as total and active care towards terminally ill patients, where their social, spiritual, psychic and pain relief issues are put first(Forte *et al.*, 2018).

Palliative Care are based in principles, according to the World Health Organization they are; to provide relief from the pain and other unpleasant symptoms, to assure life and consider death as a normal process of life, do not accelerate or postpone death, integrate psychological and spiritual aspects in the patient care, offer a supporting system that enables the patient to live as actively as possible until the moment of death, assist family members through the patient's disease and also through mourning, grant a multi-professional approach to focus the needs of the patients and their relatives, including support through

mourning, improve the quality of life and positively influence the course of the disease, starting as soon as possible, along other therapeutic measures (WHO, 2017).

In the 21st century the palliative care became attributions of health professionals, under the responsibility to offer the necessary support to the patient and his relatives. There are randomized studies showing that patients who receive cares such as: pain and fatigue management, nausea and shortness of breath control, had their life span prolonged. These care require not only the treatment of physical symptoms but also the emotional symptoms, such as fear, anxiety and depression, symptoms that are common on relatives and severely ill patients (Forte *et al.*, 2018).

In general they should retake the possibility to perceive death as a natural and expected process, facing a life threatening disease. Some more severe patients end up needing specialized care such as the intensive care at some point of their illness process (SAÚDE, 2018).

The focus on palliative care has been more and more debated, also receiving more evidence and even worldwide prominence, a conference about ethics gathered 21 care doctors in the World Congress of WFSICCM in Durban in South Africa, where the main debated subject was the care at the end of life in Intensive Care Unit (ICU), in the multidisciplinary team everyone must be engaged so the use of the technology that we have nowadays do not end up inadequately prolonging the lives of those patients in the ICU (Myburgh *et al.*, 2016).

The WHO through the World Palliative Care Alliance published the Global Atlas of Palliative Care at the End of Life, in order to emphasize the subject and bring more enlightenment on the theme (Myburgh *et al.*, 2016).

However the multidimensional discussions toward the improvement of the nursing work and the health team aims toward quality in assistance. Some international epidemiological data about cancer still define it as a public health problem justifying the constant investment in research to subsidize diagnostic and therapeutic technologies that become more and more efficient, for diagnosis, treatment and also to raise the survival rate of the patients stroke by this illness (Mendonça *et al.*, 2012).

In order to improve treatment during dying in the ICUs of Brazil, the I Forum of the End of Life Study Group of the Southern Cone happened in the year 2009 at Porto Alegre city. With the presence of members from the Brazilian (AMIB), Uruguayan, (SUMI) and Argentine (SATI) Society of Intensive Medicine, with the objective of elaborate appropriate recommendations to diagnostic and treatment of terminally ill patients under PC. In 2010

the II^o Forum of the End of Life Study Group of the Southern Cone happened. In the XV Brazilian Congress of Intensive Medicine, at Brasilia city. Aiming to elaborate actions to be offered to palliative patients in critical condition. In this forum the flow chart for providing palliative care in the ICU was elaborated, containing recommendations toward the palliative care to be offered to critically ill patients. In this delicate moment the patient's family should be privileged with communication, for them to accompany the patient and prepare for his death (Moritz *et al.*, 2011).

Furthermore the lack of specialized professionals is also evident. There are few training centers for Palliative Care in Brazil, most of them are located in state of São Paulo. Another great obstacle is society's reluctance about discussing death and terminality (Health, 2014).

In the ICUs is where we find the largest number of critical patients, some of them in end of life situation, surrounded by technological and specialized devices, even with so much availability of technologies present in ICUs, there are still evidences related to the unpreparedness of professionals in order to develop care actions to patients that are dying. "The academic background of the health professionals does not contemplate deeper theoretical approaches directed to death and dying, and there are few discussions on the subject among the undergraduates" (N. C. B. Barros *et al.*, 2013).

Now with the exposed data, the improvement of communication among the members of the multi-professional team and an in-depth knowledge about palliative care in the ICUs can avoid conflicts and grant the improvement in diagnostic, treatment and raise the survival rate of those patients (Tiengo, 2017). Thus this study aims to identify the knowledge of the nursing team about intensive care in relation to the specialized assistance to the oncologic patient under palliative care, as well as its comprehension and the main feelings experienced by the team when providing such care.

Considering that in Brazil the PC is still little diffused even with the presence of relevant forums addressing the topic, one of the main obstacles is the lack of discipline in the professional resumes, they are trained for life maintenance at all cost (Health, 2014).

Therefore this research aims at verifying the knowledge that those nursing professionals who act inside the ICU, have about palliative oncologic patients, checking out their possible qualification for that. Pointing the frailties of the provided assistance and describing the feelings experienced by the team.

In this manner this study has full relevance for a better understanding about what is palliative care and in which way the nursing team can properly provide such care to terminally ill patients admitted in an Intensive Care Unit (ICU). So they can experience a dignified death with less suffering as possible.

II. METHODS

It is a descriptive study of transversal character and qualitative nature, carried out in two Intensive Care Units with a total of 18 beds in a Regional Hospital in Rondônia. The sample is probabilistic for convenience, composed by 29 professionals, counting with 50% plus one from each category, in which 05 nurses, 03 nursing residents and 21 nursing technicians are defined. For selecting the participants; being both technical and academically graduated in nursing and be an effective member of the team was utilized as criteria for inclusion, and also to accept participating in the research and the criteria for exclusion was applied to the workers who had less than 3 months acting in ICU, for such time be defined as minimum period of adaptation and engagement.

The data was collected in January 2020 through a semi-structured mixed questionnaire, applied individually according to the professional's availability, in the ICU itself, with an average duration of 15 minutes each.

For the data analysis, the objective and essay answers were submitted to analysis of content and thematic modality. In a set of techniques which allows interference from the obtained content composed by three phases: 1) pre-analysis, 2) data exploration; 3) treatment of the results, interference and interpretation. Then the categories were identified and named as: "The perception of the nursing team about what is palliative care" and "The knowledge about what are the principles of palliative care".

The development of the studies met the requirements and ethical precepts in effect in the country and the project was approved by the Ethical Committee in Researches on Human Beings from the Cacoal College of Biomedical Sciences under the number 3.778.295. All the participants signed a two-way Informed Consent Form. For differentiation and preservation of their identities the professionals were identified with page numbering, only indicating the options: "N: nurse, NT: nursing technician and R: nursing resident.

III. RESULTS

The total number of professionals was 29, 24 female (82,8%) and 5 male (17,2%), aged between 23 and 53 years old, with an average of 34 years old. The female predominance is explained by Donoso (2000), evidencing that the English word nurse has its origin in Latin, from the name *nutrix*, which means "mother who creates". The time of performance in nursing among the researched subjects ranged from 03 months up to 18 years, with the average of 07 complete years, now the performance time in hospital was between 03 months up to 10 years, with the average of 03 full years, and the performance time in the ICU sector varying between 03 months up to 09 years, with the average of 03 full years, knowing that this percentage was calculated from the answers of 27 questionnaires, 02 interviewees did not answered about their respective performance time. About the degree of training, 21 of technical training (72,4%), 5 graduated (17,3%) and 3 with *latusensu* specialization (10,3%).

A category came after a careful analysis of the collected data, one that deals on the nursing team's perception about what is palliative care, the most mentioned data in this category was "to promote relief from pain and suffering, in order to promote comfort and a more humane care" this can be detailed by the following quotes:

"...care offered to the patient without physical healing ends, only to promote comfort and well-being within the conditions of the patient and the pathology (R 01)".

"...palliative care on my point of view is about the multidisciplinary care which provides comfort and well-being to the patient, the being treated as a whole, the reduction of pain, the mental and spiritual peace; all of those care not restricted only to the patient, but may extend to his relatives (N 04)".

"... it's humanized care, making it possible to the patient an end of life quality, offering a humane and compassionate assistance facing an incurable disease, always having in mind that palliative care deals with the person and not the disease, easing symptoms without physical healing purposes, just dignified and high on quality (NT 06)".

"... to offer a dignified assistance to the patient in process of terminal and/or incurable disease in cases where there are no possible means to reverse the clinical

picture, with treatments or means that don't extend his suffering (R 02)".

Still on this category of the perception of the nursing team about what is palliative care, it is evident that palliative care aims to promote relief from pain, suffering and a more humane care to those terminally ill patients, as stated below:

"... promote more comfort to the patient in the end of his life, not only physical comfort, but also psychological, offering a treatment that nullify or at least reduce the pain as much as possible and give him peace and safety in a more humane treatment as much as it is possible (NT 07)".

This thought that palliative care are to promote comfort measures to the patient at the end of his life can also be observed in the lines described below:

"... palliative care are comfort measures to the patients diagnosed with terminal illness. It's when the professional provides care so that the patient fell less pain and discomfort as possible, measures which won't make the patient to get better so he can be discharged, but instead to provide him with a "less painful" death (N 05).

"... they are the basic and humane care with the patient in order to promote comfort to his body and mind. In order to minimize the suffering from the patient and his relatives (NT 08)".

"... it's a multi-professional approach towards the patient who needs such care, with the objective to improve the quality of life, comfort easing the suffering and pain, all accomplished in a humanized way (NT 09)".

About the category related to "The knowledge about what are the principles of palliative care". A quantitative of 11 (37,9%) from the interviewed professionals who did not know the principles of palliative care was obtained, and 18 (62,1%) of the professionals who said they knew

which principles are those, have their speeches illustrated below:

"... to ease the patient's symptoms not in search of cure, if that's the diagnostics. Accept that death is a natural process and part of daily life, neither postponing life nor delaying death, natural cycle. Respecting the psycho-social and spiritual aspects of the patient, and provide an ending of life as natural as possible, keeping the patient and his relatives aware of that (NT 06)".

We can also observe on the next speeches other opinions about what are the principles of palliative care

"... comfort, pain reduction and understand death as a natural process (N 04)".

"...pain relief, helping on acknowledging death as a natural process, offering support and guidance to the relatives so they participate in the best way possible in taking care of the patient (N 13)".

"...the main care are related to the pain so there is no suffering and also to the psychological conditions with professional guidance depending on the case (NT 11)".

"... they are actions aiming toward improving the life quality of the patients and their relatives who face problems associated to life threatening illness, which are: prevention of pain and suffering relief with pain control and relief of other symptoms such as psycho-spiritual and social ones (NT 12)".

The theme, training and specific information in the palliative care field presented two requirements mentioned by the team, in the first requirement when questioned if they had already received training on palliative care 10,3% of them answered yes. While 89,7% have never received this kind of information or training. Now about if they would like to receive training on palliative care; 100% of the interviewed has shown interest about continuing education in the palliative care field.

Chart 1 – Found results about factors on the matter of frailties from the team and the main feelings experienced by those professionals into adult ICU from Cacoal Regional Hospital, 2020.

FRAILTIES	%
Lack of Understanding of the Disease by the Professionals	37,93
Insecurity of professionals	34,48
Lack of Communications among Health Professionals	55,17
Emotional Wear of the Team	68,96
Inadequate Physical Structure	58,62
Not Knowing how to Deal with the Patient's Demands and Expectations	31,03
FEELINGS	%
Compassion	58,62
Valuation of Life	68,96
Humanity	79,31
Anguish	37,93
Pain; Frustration; Anxiety	24,13
Solidarity	65,5
Mourning	13,79
Sadness	34,48
Palpitation; Throat Lump	17,24
Sense of Duty Fulfilled	44,82
Happy about Helping	51,72

Font: Jesus, Pinheiro and Lima, 2020

IV.

V. DISCUSSION

According to Gomes and Othero (2016), palliative care are complex and reality challenging, presenting itself as an innovative way of assistance in the health field and it is gaining space in Brazil, it is different from healing medicine, it is focused on comprehensive care, through its principles which are related to prevention and control of the symptoms, aiming toward the well-being of all patients who face a terminal and life threatening illness.

The term "palliate", originates from the Latin *palliare*, meaning, to make it more bearable, mitigate, remedy on a provisional basis. Palliative Care basically

consists in a philosophy that can be used in many different contexts, highlighting the relief of symptoms, pain and the suffering from those who are facing chronic-degenerative diseases or terminal stage, they treat the patient as a whole, aiming for improving his quality of life (Pessini & Bertachini, 2006).

In view that disease and suffering always come together, when the disease is grave and the suffering is intense, the palliative care offer intensive treatment which then demands for Intensive Care Unit. It is therefore objected that while there is progression of the illness, the treatment of the patient changes from healing to palliative,

thus generating comfort and relief of his symptoms (Oliveira et al., 2008). In view that in the ICU, the integration between the palliative and curative care since the moment of admission has been more and more highlighted to a greater relevance, searching for quality attendance (N. Barros et al., 2013).

When the interviewed were asked about what would be palliative care, many of them answered that it aims to provide relief from suffering and to offer comfort to terminally ill patients. In palliative care the interrelationship among all the involved ones is essential, which are, the patient, his relatives and the multi-disciplinary team. A wide approach allows the inclusion of this practice in both the health system and into society (Moritz et al., 2012).

Moritz (2012) also portrays that PC can and should be offered along the palliative care, since they are necessary for prevention and treatment of patients and their relatives. Thus he also brings some of the fundamental principles of PC into ICU which are: accept death as a natural process, always prioritize the best interest and wishes of the patient, reject diagnostic and therapeutic futility, neither shorten life, nor prolong the process of death, grant quality of life and death, relief pain and other associated symptoms, take care of the clinical, psychological, social and spiritual aspects of both the patients and their relatives, respect the autonomy of the patient and their legal representatives.

In relation to the principles of Palliative Care, it was clear that the participants have somewhat limited knowledge, although they exhibit values compatible with some principles of those care. The participants related it to death and to comfort measures, although, none of the participants conceptualized it as the treatment proposed by WHO. This finding is also pointed by other study stating that in Brazil the PC are still not very widespread by most of the population and also by health professionals (Freitas & Pereira, 2013).

In terms of training in palliative care, in Brazil, there are many different challenges to overcome and, among them, lies the difficulty in the education of health professionals about the terminality and quality of death matters (Dias et al., 2007).

To offer PC with quality means to implement innovative actions and among them; changes in attitude and education of all professionals involved with chronic ill patients or with an expectation of near death. Therefore, in order to act into the perspective of palliative care, it is relevant to invest in training the professionals. Educating

not only the nurses, but all the nursing team (Vicenzi et al., 2016).

When asked about training in specific information in the PC field, it was almost unanimous the number of interviewees who have never received training or any other kind of course about this matter. It also became evident that everybody would like to receive more information about this content, The National Policy for Permanent Education (PNEP) was instituted in February 2004 to make it easier to access those information and training, it has the objective to change the institutional practices, to improve the quality of attention and health assistance, to compromise the team with its work process and improve the relation among the work teams (Ministry of Health BRAZIL, 2004). Considering that PC implies a trans-disciplinary approach with psychology, religion, effective communication, philosophy, ethics and atransversality toward the patients' answers, their suffering, anxiety and fears, in the midst of therapeutic strategies (Silva & Guimarães, 2012).

Studies by Silva *et al.* (2015) show that the deficiency in the field of training make it harder for the development of the PC and also they highlight the difficulty of the professionals about dealing with the death subject, with the necessities from the end of life and that it can even take to dehumanized care. Such characteristics can compromise the quality of care given, in a way that can provide negative experiences. Thus one of the methods to change this practice, they suggest changes in training and more developments from the permanent education.

Studies shows that palliate is a dimension of care in health and all of the professionals should know when the palliative care will be necessary, considering that the challenges to the multi-professional team in palliative care were described as frailties when addressing the terminality process. Throguh the reports, the participants mentioned the lack of comprehension of the illness, insecurity, emotional distress, inadequate physical structure and lack of communication in relation to the palliative care, being this fact a trigger of conflicts. It is known that the communication skill is essential to the multi-professional work, this thinking was also observed in another study, in which the excellent and the respect among the team contribute towards an high quality assistance. This study shows that; assisting people in terminality mobilize emotions in the health team members, because death becomes part of their daily life, creating conflicts and need for consideration, making necessary for a support (Cardoso et al., 2013).

When related to feelings and perceptions, the results show both the diversity and the extremes of the emotions. Thus it is considered essential that the findings be regarded into permanent education since the professional, besides knowledge, needs emotional support, since the ICU environment itself generates a great amount of emotional distress and other factors that make the professional feel undermined, as the same finds himself daily in contact with death. Knowledge enables a positive attitude, not only to help others, but also for self-care. However, some professional in certain situations will need psychological support, that can be offered by the work team itself. Studies show that when it occurs in an organized and planned way, the results are more evident, benefiting the professionals, teams, patients and relatives, in a complex cycle of relation and also technical, scientific and humane improvement (Honório, 2016).

The author brings some strategies for the technical-scientific improvement and also for psycho-emotional support, highlighting; professional education towards learning, acceptance and management of emotions and existential confrontation, rebuild and update the beliefs related to life and death, development of the studies about PC sharing results among the various work teams, education to self-care, offer training such as forums and workshops to improve the communications of professionals, offer professional counseling to take care of the patients in palliative situation, use of standardized protocols in the care practices in order to avoid unnecessary and conflict trigger interventions (Honório, 2016).

In end-of-life situations due to numerous terminal illness where the patient is considered out of healing possibilities, the role of the multidisciplinary team in the ICU is to commit to change this utterly technical scenery by implementing less aggressive care, searching for quality of life or quality of death, if it occurs, offering more humane care to those patients. Thus, to know the conceptions related to implementation of palliative care, and also the end-of-life process would allow this health team a better understanding of its values and beliefs when facing such process, feeling ready at the moment of acting on patients and relatives on such situations. In this manner the professionals categorized the nursing assistance and innervation to be given to the oncologic patients as highly important, this fact is also verified in many different studies (Silveira et al., 2016).

VI. CONCLUSION

It was verified in this study that the aging of the population and the occurrence of chronic and degenerative diseases has been occurring more frequently, a lot of those disease cause the patient to need an Intensive Care Unit - ICU admission, thus requiring the nursing team to be prepared both in practice/evidence based knowledge, and psychologically/emotionally.

The Palliative Care presents itself as a new way of assistance, with an approach toward the human being in his integrity and the need for intervention in consequence of symptoms of physical, social, emotional and spiritual nature granting the terminality process to be as good as possible.

It is possible to observe that the nursing team shows interest in the proposed theme, and that one of the greater obstacles to overcome be the communication among the teams and the understanding of the patient's pathology, thus causing hasty and generally unnecessary conducts, at the end causing even more suffering to the patient.

It was also evidenced in the study the fact that it is necessary to offer continuous education, just as training and access to information to the referred them thus preparing those professionals for the direct attention to the patients in palliative care.

It is important that there is some kind of psychological support to the professional who deal directly with terminal ill patients, because they are dealing directly with death everyday and also with the intense suffering of such patients, thus generating a lot of emotional distress on the professionals and the lack of such support can directly affect this kind of support.

“Death, you are brave, Your power is great, When I arrived in this world, You were already killing people. I kept inside my mind, This great accuracy of yours, However I ask you a favor, To go to the holy field, Don't make me suffer too much, Death, kill me painless!”

(*Patativa do Assaré*)

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