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MEANING OF PALLIATIVE CARE BY THE MULTIPROFESSIONAL TEAM OF THE INTENSIVE CARE UNIT

SIGNIFICADO DE CUIDADOS PALIATIVOS PELA EQUIPE MULTIPROFISSIONAL DA UNIDADE DE TERAPIA INTENSIVA

SIGNIFICADO DE CUIDADOS PALIATIVOS POR EL EQUIPO MULTIPROFESIONAL DE LA UNIDAD DE TERAPIA INTENSIVA

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ABSTRACT

Objective: to understand the meaning of palliative care by the multiprofessional team. **Method:** a qualitative, descriptive study performed with nine professionals from the multiprofessional team of the Intensive Care Unit / ICU, through a semi - structured individual interview. The data were analyzed by the Content Analysis technique, in the Categorical Analysis modality. **Results:** two categories emerged and a subcategory << Perception of the professionals of the multiprofessional team on palliative care >>, << Implications for the patient in palliative care from the perspective of the professionals >> and << Difficulties of the accomplishment of the palliative care, in the ICU >> . **Conclusion:** the professionals have adequate understanding of the meaning of palliative care, but, there are difficulties in their accomplishment regarding communication among the team, ethical conflicts and absence of a protocol. **Descriptors:** Palliative Care; Patient Care Team; Intensive Care Units.

RESUMO

Objetivo: compreender o significado de cuidados paliativos pela equipe multiprofissional. **Método:** estudo qualitativo, descritivo, realizado com nove profissionais da equipe multiprofissional da Unidade de Terapia Intensiva/UTI, por meio de entrevista individual semiestruturada. Os dados foram analisados pela técnica de Análise de Conteúdo, na modalidade Análise Categrorial. **Resultados:** emergiram duas categorias e uma subcategoria <<Percepção dos profissionais da equipe multiprofissional sobre cuidados paliativos>>, <<Implicações para o paciente em cuidado paliativo, na perspectiva dos profissionais>> e <<Dificuldades da concretização dos cuidados paliativos na UTI>>. **Conclusão:** os profissionais possuem compreensão adequada do significado de cuidados paliativos, porém, existem dificuldades na sua realização referentes à comunicação entre a equipe, conflitos éticos e ausência de um protocolo. **Descritores:** Cuidados Paliativos; Equipe de Assistência ao Paciente; Unidade de Terapia Intensiva.

RESUMEN

Objetivo: comprender el significado de cuidados paliativos por el equipo multiprofesional. **Método:** estudio cualitativo, descriptivo, realizado con nueve profesionales del equipo multiprofesional de la Unidad de Terapia Intensiva / UTI, por medio de una entrevista individual semiestructurada. Los datos fueron analizados por la técnica de Análisis de Contenido, en la modalidad Análisis Categrorial. **Resultados:** emergieron dos categorías y una subcategoría << Percepción de los profesionales del equipo multiprofesional sobre cuidados paliativos >>, << Implicaciones para el paciente en cuidado paliativo, en la perspectiva de los profesionales >> y << Dificultades de la concreción de los cuidados paliativos en la UTI >>. **Conclusión:** los profesionales tienen una comprensión adecuada del significado de cuidados paliativos, pero, existen dificultades en su realización referentes, a la comunicación entre el equipo, conflictos éticos y ausencia de un protocolo. **Descriptores:** Cuidados Paliativos; Grupo de Atención al Paciente; Unidad de Cuidados Intensivos.

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INTRODUCTION

Throughout human evolution, the perception of death has been transformed and taking a differentiated dimension in people's lives. The process of dying, in the antiquity of the Western world, was attended by relatives, allowing the comfort and presence of loved ones at the end of life. There was a transition of concepts and perceptions, where the death, that was consummated and verified in the residences of the patients, happens to happen in the houses of health and the family, that took care, begins to transfer them to the health professionals, being this model called death modern.¹

The opposition between health and disease is associated with life and death, but, rarely, with the binomial heals and cares. In providing care to patients, they were classified as curable or non-curable. Only recently has this classification considered patients as curable or curable, that is, those out of therapeutic possibility, regardless of the disease that affects them.²

Caring for individuals with non-curable diseases and their families is an activity or a model of health care that has been called "palliative care." The origin of this concept was in England, in 1967, with Cicely Saunders, who founded the first hospice within the Modern Hospice Movement in London, which is characterized by multiprofessional care for patients and family. This would be the beginning of a new philosophy on the approach of terminally ill patients.³

In Brazil, in 1980, Palliative Care presented a significant growth, which, in the following decades, was consolidated from existing services and the creation of new centers. Today, there are more than 40 initiatives, however, small, considering the geographic extent and needs of the country.⁴

Technological advances in the health field are almost always, accompanied, by impersonal attention to the patient at the end of life, ignoring the suffering and being unable to treat the most prevalent symptoms. Patients, with no possibility of cure, are increasingly in hospitals, invariably receiving, inadequate care. Most health professionals tend to treat the disease, forgetting to treat the patient as a whole, not caring for the suffering and their relatives.⁵

The members of the multiprofessional team of the Intensive Care Units (ICUs), unprepared for this issue underestimate the comfort of the patient without possibility of cure imposing a long and suffering agony. Postpones their death at the cost of senseless

and prolonged suffering. In order for the pain and suffering, in this dying process, to be minimized, it has become a necessity, the implantation of palliative care protocols in the ICU.⁶

In view of the above, this study, aimed to understand, the meaning of palliative care by the multiprofessional team.

METHOD

A qualitative, descriptive study developed at the Intensive Care Unit (ICU) of the Washington Antonio de Barros Doctoral Teaching Hospital, a public institution located in the city of Petrolina-PE, a reference center in the area of orthopedics and neurosurgery, in addition to being a reference for the interstate network in Pernambuco and Bahia.⁷ The target population was the multiprofessional upper level team that worked in the ICU at the time of conception of the study, composed of physiotherapists, nurses and physicians. As it is a qualitative research the sample size was not pre-established, being used the criterion of saturation.⁸

The professionals were verbally invited to participate in the study, and only after the signing of the Informed Consent Term was the interview started. Data collection was performed between August and November of 2015, through the application of a semi-structured questionnaire, containing seven questions, one of which was the identification of the participants, one about the degree of training in palliative care and five questions about the knowledge, experiences, behaviors and responsibilities of the researched professionals.

The testimonies were recorded in two ways: the first one was recorded and transcribed in full, just after the interviews were conducted, and, the second part, the professionals responded through writing. Both procedures were performed by one of the researchers.

The data were analyzed through the content analysis proposed by Laurence Bardin.⁹ The interviews were transcribed immediately after their accomplishment. After this stage, a pre-analysis was made, organization of the material and reading of the material produced, called floating reading. Subsequently, a thorough reading of the material, was carried out in order to extract classification criteria of the results obtained, thus, defining, the categories and the topics of discussion. Finally, the results treatment, inference and interpretation were performed.

To preserve anonymity, the interviews were identified by the letter P and sequentially numbered according to the order of their execution. For the clippings of the lines, the ellipses and the brackets for complementary information were used.

The Guidelines and Norms for research on Human beings were considered, according to Resolution 466/12, of the National Health Council.¹⁰ The Project was approved by the Ethics and Research Committee of the University of Pernambuco (CEP-UPE) under opinion 351.104 and obtained the Institution's consent.

RESULTS AND DISCUSSION

Nine individuals represented by three professionals from each of the categories surveyed were interviewed. The predominant

sex of the participants was the female, with five interviewees (table 1). The age range was between 23 and 42 years, with a concentration between 27 and 31 years.

Regarding the time of profession, three professionals have more than five years of experience in the area, and, in relation to time acting at the ICU, four of the interviewees had less than one year (table 1). Regarding training in the area of palliative care, only one professional says he is qualified, but six participants say they have already received some kind of education about palliative care.

Table 1. Characterization of the study sample. Petrolina (PE), Brazil

Interviewees	Professional Category	Sex	Age	Time acting in this area	Time acting in the ICU
P1	Nurse	M	23	0-1 year	0-1 year
P2	Nurse	F	29	1-2 years	0-1 year
P3	Nurse	F	31	>5 years	> 5 years
P4	Physiotherapist	F	31	3-5 years	1-2 years
P5	Physiotherapist	M	28	3-5 years	0-1 year
P6	Physiotherapist	F	30	3-5 years	0-1 year
P7	Doctor	M	30	>5 years	3-5 years
P8	Doctor	M	36	>5 years	>5 years
P9	Doctor	F	42	2-3 years	2-3 years

Two categories of analysis emerged, inside the researched content: (1) "Perception of professionals from the multiprofessional team on palliative care"; a subcategory (1.1) "Implications for the patient in palliative care, from a professional perspective" and (2) Difficulties in the implementation of palliative care in the Intensive Care Unit ".

◆ Perception of the multiprofessional team on palliative care

This issue arose from the participants' statements about their perception of palliative care. The professionals mentioned that these care are provided to the patient, out of the possibility of cure, to bring relief from suffering, pain and other physical,

psychological and emotional symptoms, as described in the following statements:

[...] is a care provided for patients whose diagnosis is incurable, progressive prognosis ... and who needs care that alleviates their suffering and pain from a multiprofessional team. (P1)

[...] is a set of interventions or non-interventions (emphasis) that one must make in order to seek the physical and emotional well-being of the patient who is in the process of becoming ill or in a termination process. (P8)

This perception corroborates with the philosophy of palliative care that, according to some authors,¹¹⁻¹² proposes to offer the comfort and relief necessary to minimize the suffering and pain of the patient, thus

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offering a quality of life, which is an essential component to maintain the dignity in human finitude.

Palliative care presupposes the action of a multiprofessional team, because its philosophy is to take care of the individual in all aspects. It is fundamental, for this patient, that the team is very familiar with his problem, so that, they can help them and promote comfort within the possibilities.¹

We can observe that professionals have adequate knowledge about the definition of palliative care, both in relation to the physical, emotional, psychological and spiritual aspects, the care that this patient needs, and the importance of the multiprofessional team.

The World Health Organization (WHO) in 1990, defined palliative care and redefined, in 2002 as an approach that improves the quality of life of patients and their families facing problems associated with untreatable illnesses through prevention and relief of suffering, through early identification, correct assessment and treatment of pain, and other physical, psychological, social, and spiritual problems, including the stage of mourning.¹²

Another aspect mentioned by the participants is that care should be taken also with the family and the autonomy of the patient must be respected from the moment of diagnosis. However, none of the interviewees reports that this care was performed with the family during the bereavement phase. These findings are evidenced in the following excerpts from the interviews:

[...] the family of the patient must also be provided. (P2)

[...] care that helps us to respect the human dignity and autonomy of these patients. (P6)

[...] should be started already to the diagnosis of any disease that is progressive and incurable. (P7)

We note that these participants cite some of the behaviors and responsibilities of practitioners who are in accordance with WHO principles (2002). These principles include: reaffirming the importance of life, considering death as a natural process; to establish a care that does not accelerate the arrival of death, nor prolong it with disproportionate measures; provide relief from pain and other unpleasant symptoms; integrating the psychological and spiritual aspects into the care strategy; offer a multiprofessional approach to the family and the patient so they can cope with the patient's illness and survive the grief period.¹²

In the reports about the professionals' perception of palliative care, the description

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of the implications that patients experience when they are in these conditions can be seen. Because of this, a subcategory emerged:

♦ Implications for the patient in palliative care from the professional perspective

As previously mentioned, professionals had an adequate understanding of the meaning of palliative care, but, when questioned about the main repercussions that affect the patient without a cure, a good part cited only emotional and psychological implications, as we can observe in the following excerpts from the interviews:

[...] has repercussions in several aspects, for not accepting the prognosis (patient) and for not knowing measures that can help to improve the quality of life. [...] may present symptoms such as: sadness, denial, [...] and may develop depression. (P1)

[...] emotional aspects: fear, anguish, helplessness, family conflicts, worries about pending, fear of the dying process. (P8)

[...] denial of closeness to the end, fear of death, anxiety about a therapy that provides hope for healing. (P9)

In view of these findings, it was emphasized that, even though these professionals are aware that palliative care encompasses multiple aspects, they believe that what affects these patients most are signs and symptoms related to psychological and emotional aspects. However, some participants also mentioned physical symptoms as implications for patients with no possibility of cure, as highlighted below:

Immobility syndrome, onset of contractures and deformities [...] (P4)

[...] pain, dyspnea, functional limitation. (P8)

[...] prolongation of total pain [...] (P7)

These patients may experience physical suffering such as severe pain, dyspnea, fatigue, loss of appetite, nausea and vomiting, constipation, insomnia, wounds, delirium, seizures and other symptoms. In addition to the psychic suffering, that includes anxiety, fear, depression, loss of dignity, loneliness, fear of causing suffering to loved ones, and fear that their feelings are not valued and abandoned.

Concerning the experiences of the professionals on palliative care, we observed their lack of experience, which we inferred to be related to the short time of action of the majority, ICU profile and non-shared teamwork, culminating in the difficulty of implementing palliative care. Thus, next category of analysis emerged.

◆ Difficulties in the implementation of palliative care in the Intensive Care Unit

In the ICUs, are many patients who do not present possibilities of cure, which makes consistent the implementation of palliative care, to promote comfort and well-being in the final phase of life of these people.¹⁴

The realization of palliative care in ICUs is difficult due to some aspects such as: lack of accurate information about the disease and prognosis; decisions taken unilaterally, without the family having the opportunity to discuss the therapeutic options to be used; hostile environment, excessive technology, overly rigorous and immutable routines, that disregard the minimal needs of these patients.¹⁵

Regarding the experiences with these patients, all the interviewees spoke about the difficulty in carrying out this care, as explained in the following statements:

[...] in the ICU, my experience is that there is a very great difficulty. (P8)

[...] I have no experience in this part of palliative care, although I work long time in ICU [...] (P3)

[...] there are still many professionals who do not know how to work with palliative care, especially in an Intensive Care Unit. (P1)

The researchers inference on this aspect is that, in addition to the difficulties inherent in the ICU environment, full of technology that helps to prolong life, professionals are unprepared due to the short time in the area, as well as the profile of the ICU, which does not have a specific protocol for palliative care, nor a time to discuss clinical cases with the whole team.

The palliative care in the ICU is intended for the critical patient from the beginning of their admission, until in the stages that there is no more possibilities of curative therapies, aiming to promote the well-being of the patient, allowing him a dignified and quiet death. Such care should involve the entire multiprofessional team, which together with the patient and family, should identify unnecessary procedures and establish the necessary palliative actions.¹⁴

Some of the interviewees mentioned the lack of communication among the members of the multiprofessional team, and between the team and, the patient/family, and even lack of knowledge as one of the factors that hamper the implementation of palliative care in ICUs, as expressed in the you speak below:

[...] the team has a flawed concept that that treatment once started can not be stopped, but we can discuss this with the

family [...] has this common sense, that intensive treatment has to do everything until the last minute [...] many heavy interventions [...] (P8)

[...] when the family is aware of the situation, agreeing to the palliation, transmitting security to the patient, the experience is beneficial; there is dignity in the inevitable act of dying. (P9)

There is a lack of knowledge on the part of the team, regarding the communication and, the management of the patient without possibilities of cure. Effective communication between the multiprofessional team, the patient, and their family members interferes with the individual's state, as it helps to guide, support, clarify, and assist in the execution of their basic human needs.

Professionals, in the palliative care team need to develop active listening skills, support in the face of the limits of illness, communication, technical knowledge of the situations they will experience with the patient and their family, and also create strategies for coping with the end of life.¹⁷⁻⁸

A harmonious and convergent care to the individual, without possibilities of cure, and to his family, depends on a multidisciplinary approach. The members of the multiprofessional team need, to aim at an appropriate treatment option for these patients. In this sense, the recovery of humanization from the process of dying becomes primordial, that is, death is seen as part of a life process.¹⁹

Another factor, that contributes to the non-accomplishment of palliative care in the ICU, is the lack of a protocol to be followed by the entire team, which contributes to poor communication among professionals, so there is no consensus among all the staff regarding the decision to make or not to carry out interventions for patients with no possibility of cure. In addition to not providing legal support for the team, as explained:

[...] in Recife, in a public hospital, we were able to establish some forms of protocols [...] we were able to do some formatting so that the patient did not suffer from dysthanasia [...] which is the prolongation of the suffering. (P7)

[...] although I have been working in the ICU for a long time, in the services I worked for, there are no protocols for palliative care [...]

Besides these aspects, they also mentioned ethical conflicts related to the accomplishment or non-accomplishment of some procedures as factors that make difficult the accomplishment of the palliative care in ICU, as observed in these stretches:

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It is very difficult to deal with the team because of these fears [...] the judicialization, and the medical [...] culture mainly (emphasis), that death represents the failure of its power of intervention (P8)

[...] patients in palliative care [...], for example, as they progressed to cardiorespiratory arrest, the doctors ended up doing resuscitation for the sake of giving satisfaction to the family. (P3)

Some professionals, mainly doctors, express their fears and fears regarding legitimacy and legal protection to limit the offer of curative therapy in patients with no possibility of cure, since, they understand that the limitation of therapeutic effort could constitute infraction to some articles of the code of medical ethics.²⁰

To avoid these and other doubts, the current code of Brazilian medical ethics (2010) made explicit, in several articles and paragraphs the need and the ethical duty of the physician to provide palliative care, such as: Chapter 1 - Section XXII "In irreversible clinical situations and terminals, the physician will avoid performing unnecessary diagnostic and therapeutic procedures and will provide patients under their care with all appropriate palliative care."²¹

It was perceived, according to the interviewees' statements, that technological advances in ICUs have made ethical conflicts increasingly increasing due to the use of unnecessary measures, leading to the prolongation of suffering and pain.

CONCLUSION

The ICU multiprofessional team members showed an adequate understanding of the meaning of palliative care, in general. They understand that they are care provided to patients without therapeutic possibilities of cure and that they must have a multidisciplinary character, in the sense of controlling and alleviating the physical, psychosocial and spiritual suffering of the individual, in order to achieve integral care, leading to a dignified death and without suffering.

However, the perception of most professionals is not so profound, and this fact can be seen, when the interviewees only mention emotional and psychological aspects as the main repercussions that affect patients in palliative care.

We observed that among the difficulties listed by the participants in the implementation of this care are: non-shared teamwork; lack of time in intensive care; ICU

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profile; ethical conflicts and absence of a specific protocol.

Based on the research data, we suggest the creation of a protocol in the ICU and creation of a moment of discussion of clinical cases, encouraging the updating of the team. Other actions, that can reach a greater number of professionals, are the implementation of palliative care in the curricular curriculum of health courses, changes in codes of ethics, and a greater discussion on the subject in health institutions, from primary, to tertiary care.

It is hoped that, with this article, the reflection of professionals on the subject can be promoted, and thus subsidize the assistance to patients in palliative care, providing relief from the suffering caused by excessive therapies and promoting optimization of the material and human resources expended.

The limitations of the research were related to the difficulty in collecting the data, because the hospital was in a transition period of management and admission of new team. Associated with this fact, the professionals had little time of operation in the ICU and in the service. Another factor is the format of the questionnaire applied, which did not have all the answers recorded, not allowing the participant to freely discourse all of the time. So, that some relevant information may have been suppressed.

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