Saúde e Pesquisa
DOI: 10.17765/2176-9206.2021v14n4e8857
e-ISSN: 2176-9206

Palliative care: perception of the multiprofessional team working in an Intensive Care Unit

Cuidados paliativos: percepção da equipe multiprofissional atuante em uma Unidade de Terapia Intensiva

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ABSTRACT

This study aims to understand the perception about palliative care of the multiprofessional team working in an Intensive Care Unit. It is an exploratory, qualitative study. Participants were 14 professionals of the multiprofessional team, working in the Intensive Care Unit at a Municipal Hospital. Data collection was carried out between July and August 2019, through an individual, semi-structured, recorded and transcribed interview. Data were processed using the software Iramuteq, and submitted to content analysis proposed by Bardin. The obtained results were presented in three categories: Palliative care: promoting comfort in the integrality of the patient; Insecurity and fragmentation of palliative care: difficulties of the multiprofessional team; The Healthcare professional and the other: integration with the patient and family. Therefore, the professionals understand palliative care as a strategy to promote comfort and alleviate suffering, respecting patients' dignity and treating them as an complete and complex being.

Keywords: Bioethics. Intensive care units. Palliative care. Patient care team.

RESUMO

Este trabalho objetiva compreender a percepção da equipe multiprofissional atuante na Unidade de Terapia Intensiva sobre os cuidados paliativos. Trata-se de estudo exploratório, qualitativo. Os participantes foram 14 profissionais da equipe multiprofissional, atuantes na Unidade de Terapia Intensiva de um Hospital Municipal. A coleta de dados foi realizada entre julho e agosto de 2019, por meio de entrevista individual, semiestruturada, gravada e transcrita. Os dados foram processados no *software Iramuteq* e submetidos à análise de conteúdo de Bardin. Os resultados obtidos foram apresentados em três categorias: Cuidado paliativo: promoção do conforto na integralidade do indivíduo cuidado; Insegurança e fragmentação do cuidado paliativo: dificuldades da equipe multiprofissional; O profissional de saúde e o outro: integração com o paciente e família. Diante disso, os profissionais compreendem o cuidado paliativo como estratégia de promover o conforto e amenizar o sofrimento, respeitando a dignidade do paciente e o tratando como um ser integral e complexo.

Palavras-chave: Bioética. Cuidados paliativos. Equipe de assistência ao paciente. Unidade de terapia intensiva.

Received in June 15, 2020
Accepted on November 04, 2020

INTRODUCTION

The term "palliative" comes from the Latin *pallium* which means protection, and intends to alleviate pain and suffering, aiming to improve the quality of life of critical patients facing the threat to life. Palliative Care (PC) must cover the patient's physical, emotional and spiritual aspects, in addition to respecting their autonomy and including the family in the care process[1-3].

Palliative care has been growing in the current hospital context due to the significant increase in chronic non-communicable diseases (NCDs) in the population.[4] The work in the Intensive Care Unit (ICU) is essential since this sector is mainly intended to offer complex care.[5-6] The onset of PC should not be delayed, and can occur from the diagnosis of a severe disease, together with active treatment, in order to offer comfort conditions for the patient, as well as the relief of suffering.[3,7,8] In this sense, care should be taken holistically and not only with a curative view. However, the World Health Organization (WHO) pointed out that only 14% of those having an indication for palliative treatment do receive it.[9]

Many factors contribute to the therapeutic obstinacy, that is, disproportionate measures to avoid the end of life, to be practiced in the ICU. Some of them are: professionals' training, the technological advancement of life support, the difficulty in understanding the finitude of life, feelings of frustration, failure and impotence.[9]

Facing such complexity, healthcare professionals working in the ICU experience situations that require reflection and decision-making based on the ethical principles that underpin their conduct on a daily basis.[3,9] The multidisciplinary team is essential and must be prepared for continuous reassessments of patients, in order to offer treatment according to each one's need, promoting communication between team members and the inclusion of patients and their families in decision making. When considering the patient's autonomy and the family's will, it contributes to minimize the fear, doubt and anguish that afflict them in this process.[3]

In this context, it is noteworthy that the lack of preparation of members of the multidisciplinary team to deal with the patient without the possibility of cure, can cause prolonged suffering. Therefore, this study aimed to understand the perception about palliative care of the multiprofessional team working in the Intensive Care Unit.

METHODOLOGY

This is a descriptive, qualitative study. Thus, the Consolidated criteria for reporting qualitative research (COREQ)[10] was used to guide the methodology of the study carried out in an Intensive Care Unit of the Municipal Hospital of a municipality in the Northwest of Paraná.

The research participants were healthcare professionals who make up the ICU multiprofessional team, namely: doctors, nurses, psychologists, physiotherapists and nutritionists. The following eligibility criteria were established: being in professional practice

in the ICU for at least six months and being a graduate. Those who were on vacation or away from work for any reason during the data collection period were excluded.

Data collection took place from July to August 2019, through an individual interview, guided by a semi-structured script prepared by the authors. The interviews started with the following guiding question: Tell me about your experiences and perceptions related to palliative care as a healthcare professional in an ICU. Subsequent questions were asked to deepen the data.

The interviews were conducted by a single researcher, who had no previous contact with the study participants. They were previously scheduled and lasted an average of 40 minutes, being performed only once with each participant (n = 14), in a private room at their own workplace, in order to minimally interfere with their duties and activities. These were recorded with audio and transcribed in full, aiming to preserve the content of lines. In order to preserve the anonymity of the participants, they were identified by their respective professions, followed by the number of their entry in this research (Example: Nurse 01).

For the organization of the data, the software IRAMuTeQ® 0.7 (Interface of the R pour les Analyzes Multidimensionnelles de Textes et de Questionnaires) was used. Initially, a textual corpus was built with excerpts from the statements of the participants who responded to the objective of the study, from the frequency of the words, the text segments originated (each text segment is equivalent to approximately 3.25 lines).

For this study, the word cloud was adopted, grouping and organizing the words graphically according to their frequency in the text. Its identification occurs from a single file, called textual corpus, which is constructed from the participants' statements. The corpus is divided into segments of text or in elementary context units (ECU) and simple lexical analysis is performed, which is graphically interesting, as it allows quick identification of keywords in an image.[11]

It should be noted that the use of the software does not exempt the researcher from analyzing and interpreting the results, since it is only a tool to process and systematize the information.[12] Therefore, the data analysis occurred according to the Content Analysis proposed by Bardin, in three stages: 1) pre-analysis, through exhaustive reading of the statements with the aim of knowing, understanding and interpreting their content; 2) exploration of the material, searching for the registration units and then the units of meaning; 3) treatment of results, stage of identification of the most relevant categories in relation to the object of study.[13]

From the convergence between the data and the thematic analysis, three categories emerged, namely: Palliative care: promoting comfort in the integrality of the patient; Insecurity and fragmentation of palliative care: difficulties of the multidisciplinary team; and The healthcare professional and the other: integration with the patient and family.

The study was carried out in accordance with Resolution No. 466/2012 of the National Health Council and Resolution No. 510/2016, with approval by the Ethics Committee on Research with Human Beings under No. 1,166,696/2015. All participants signed an informed consent form in two copies of equal content.

RESULTS

Fourteen healthcare professionals participated in the study, of which 11 were women, and three men, aged between 31 and 51 years. All of them had six to 23 years of professional activity and reported having had previous experiences with palliative care. As for training, four were doctors, four nurses, three physiotherapists, two nutritionists and a psychologist.

After the convergence of data, three thematic categories were identified: Palliative care: promoting comfort in the integrality of the patient; Insecurity and fragmentation of palliative care: difficulties of the multidisciplinary team; The health professional and the other: integration with the patient and family. In Figure 1, the word cloud shows the terms with the most occurrences and highlights the most relevant ones in larger size.

Figure 1. Word cloud regarding the healthcare professionals' perception about palliative care in the Intensive Care Unit. PR, Brazil, 20202.

PALLIATIVE CARE: PROMOTING COMFORT IN THE INTEGRALITY OF THE PATIENT

The PC is understood as a resource implemented to reduce suffering and as a measure to promote comfort for critically ill patients facing the threat to life:

> *When there is an understanding that the procedures will no longer have a therapeutic purpose, you must focus and direct your strengths on symptom relief, welcoming the family and respecting religious issues. If we cannot heal, the least we can do is minimize suffering.* (Doctor 04)

Every patient is seen as a complex individual, that is, care is not restricted only to the physical aspects of pain and suffering, but also to the psychological and emotional needs of each one.

> *Comfort, peace, emotional comfort, love, affection that is given, I think this is the essential and fundamental for everyone. (*Physiotherapist 07*)*

In addition to meeting the needs of the patient from a holistic and humanized perspective, the ethical aspects that should guide the conduct of professionals are also mentioned, the principles of beneficence stand out, which includes doing good, welcoming, promoting comfort in all aspects, and not maleficence, that is, not inflicting intentional damage.

> *Offer the basic needs of the patient according to the stage he/she is in the evolution of the disease, meet the needs, whether physical, psychic, emotional, without prolonging a state of life where there will be no quality of life, in this case a dysthanasia.* (Nurse 05)

> *Invasive mechanical ventilation, collecting blood gases, are things that I understand that are unnecessary at this moment, more stress for the patient.* (Physiotherapist 07)

It is understood that promoting comfort also means avoiding futile treatments and allowing, at the right time, death to occur in a natural and dignified way, avoiding dysthanasia.

INSECURITY AND FRAGMENTATION OF PALLIATIVE CARE: DIFFICULTIES OF THE MULTIPROFESSIONAL TEAM

In this category, the professionals demonstrated the weakness in their higher education with regard to PC, and the first contact with this type of assistance occurred only during specializations or even in the field of work.

> *In my day there was no work on that, I didn't really have any knowledge about palliative care, so that when I started working I thought I was not able to do anything else and today I have another view, for sure. I see that today the healthcare professional is not prepared to deal with this.* (Physiotherapist 09)

> *I think it needs a little more openness starting at*

> *universities, when it comes to this in the academic career it may be easier for this future professional to know how to act, but when I left higher school it was little talked about.* (Physiotherapist 07)

Regarding the weakness in higher education training and, consequently, lack of knowledge on the subject, it was identified that the newly graduate does not feel prepared to deal with critical patients in PC. In view of the highlighted problem, it is suggested to approach the PC in the undergraduate curriculum as an alternative to minimize it, as observed in the following statement:

> *A degree course alone is not enough, because we end up taking a course, reading other subjects. What is really missing is to approach this in training, we end up acquiring it after, in other ways, but not in college.* (Physician 10)

Despite the deficit in initial training, it is understood that professionals should not be limited to the syllabus that was offered to them at higher education, with the need for reading and, in some cases, more courses. Another reported difficulty was how to identify the appropriate time to start the PC, since the delay in starting this care prolongs the performance of unnecessary invasive procedures.

> *Our healthcare professionals think that it is not the time to start palliative care and sometimes they are prolonging suffering, so there has to be a compression of the whole team to start this type of support.* (Physician 13)

> *Useless treatments, sometimes occupying an ICU bed, antibiotic, high-cost therapy that we know will not have any effect.* (Nurse 05)

It was observed that there is not always a consensus in the decision to suspend treatment in patients beyond the possibility of cure. In addition, difficulties were also identified among professionals regarding the standardization of care, this divergence can trigger a lack of continuity in the team's conduct, as evidenced in the following statement:

> *Of course, some procedures will be reduced, just like we had a boss before, the patient in PC was checked for vital signs only once in the period, blood glucose levels was checked, which I think is still very confusing, in the items they maintain or not, but maybe for nursing this is it, procedure.* (Nurse 01)

THE HEALTHCARE PROFESSIONAL AND THE OTHER: INTEGRATION WITH PATIENT AND FAMILY

In the following reports, it is observed that effective communication facilitates the process of implantation of PC, since it improves the acceptance of family members and patients themselves, in addition to promoting greater confidence of family members regarding the conduct taken by professionals.

> *The family is called several times to talk about the limitation of the supports and they do not understand. Not all families, we see that most families, regardless of their level of education, they understand it well, but there are some families that end up limiting the service.* (Nurse 01)

> *There must be clear communication, informing everything that is happening to the family, clarify, make the family feel safe, welcome and give comfort to the patient.* (Physiotherapist 08)

In addition, the importance of having a dialogue relationship since the beginning of the illness is highlighted, that is, the diagnosis of a serious disease, in order to create a bond with the family and the patient and prepare them to face possible adversities.

> *First, the patient is hospitalized, it is important to pay attention to the family, work with the family since admission and they need to follow the patient's evolution. The patient might have good results and not reach the palliative care, but if there is a worsening, the family is already prepared, I see that this is missing, the family member only learns at the last moment, then it is a shock.* (Nutritionist 03)

> *This issue should be discussed with the patients more often, not only the terminal patient, but when you receive a diagnosis of a serious illness, then approach the family, approach the patient.* (Nurse 05)

In a complex care sector such as the ICU, the use of light technologies cannot be neglected, which refer to relationship technologies, such as bonding, welcoming and communication, and it is observed in the statements that professionals are concerned with establishing a bonding relationship with patients and family members since hospitalization.

DISCUSSION

The professionals interviewed demonstrated that they understood the PC as a strategy to promote comfort and alleviate suffering, and stressed the importance of establishing good communication with the family and the other members of the multidisciplinary team. Weaknesses were identified in the professionals' training, as they experienced PC for the first time in professional practice. It was also possible to evidence divergences in the team's conduct, in which professionals have difficulties in establishing the appropriate time to start PCs and which conducts should be maintained for each patient.

Comfort needs can be presented in four contexts: the physical, which refers to pain; the psycho-spiritual, which includes faith and self-esteem; sociocultural, which includes interpersonal relationships; and the environmental context, which is influenced by lighting, temperature and other aspects of the environment.[12] Considering that each patient is unique and has individual values, it is important that professionals consider their uniqueness and provide humanized and attentive assistance to understand the

needs of each one, in order to offer adequate support.[14]

A study conducted in Bahia on end-of-life comfort in intensive care corroborates the results of this research. The multiprofessional team highlighted that to promote comfort, it is necessary to meet the physical needs to relieve symptoms common to the patient in PC, such as dyspnea and nausea and to avoid painful interventions. As for the psychological aspects, comfort can be promoted through dialogue, demonstrations of affection, attention, words of courage and strength. The approach to faith as a comfort strategy was also highlighted, in which professionals encourage the relief of suffering through the search for religious and spiritual aspects.[15]

From the perspective of bioethics, the multiprofessional team must bear in mind the principles of beneficence, non-maleficence, justice and autonomy.[16] The performance of invasive procedures in patients with no possibility of recovery is characterized by dysthanasia or therapeutic obstinacy,[17-18] in which the treatment causes suffering and anguish for the patients, since it prolongs the dying process. The Code of Medical Ethics and the Code of Ethics for Nurses support the suspension of treatments for the patient in an irreversible and terminal clinical situation, respecting the wishes of the patient or legal representative.[3,9,19]

The weakness in the approach to palliative care during multidisciplinary degree courses was evidenced in several studies, as well as professional dissatisfaction with the training offered. Theoretical flaws in training generate difficulty and insecurity to perform patient care in PC.[20-22] Research conducted in the United States showed that many doctors and nurses, especially the elderly, had no contact with the PC theme in their initial training and had no recent training regarding end-of-life management.[20]

Quality service at the end of life is only possible with a qualified and confident team. Therefore, continuing education is configured as an important strategy to alleviate the formative deficiency, so the properly specialized and trained team is able to act with more security.[23] Professionals working in the care of critical patients need skills dependent on hard technology, which it is understood as equipment, but it must be complemented by light technology that corresponds to ethical, human, moral and social aspects.[24]

In this context, communication stands out as a light technology, which demands active listening, professional looking and posture. With the implementation of the National Humanization Policy (PNH), the tendency is to intensify the good interpersonal relationship between patient-team-family. Research has shown that communication and the reception of family members are extremely important in the care process, making it more human and contributing to minimize negative feelings in the hospital context.[14,25] In addition to the right to information, which protects both the patient and the family,[19] the right to autonomy is also emphasized in making choices regarding treatment, to allow or restrict procedures.[9]

The weaknesses pointed out by the professionals were related to the difficulty in standardizing care, lack of continuity in the team's conduct and difficulty in identifying the moment to start the PC. Again, the importance of communication for decision-making, planning and execution of care between the members of the multidisciplinary team and the inclusion of patients and their family is highlighted.[3,9,26]

A study carried out in the United Kingdom with healthcare professionals in an ICU showed that the different clinical judgments generated difficulties in reaching consensus among the team, characterizing a significant barrier to the PC process. However, there was a consensus among them about the need for early recognition of life limiting conditions, in order to start PC as soon as possible, instead of waiting until all therapeutic options are exhausted.[27]

In addition, protocols are extremely important, as they tend to improve care, favoring the use of scientifically supported practices. With this, the variability of the conducts performed by the multiprofessional team is reduced and greater cooperation between them is promoted, what is more, the protocols offer the best available care options.[28]

As a limitation of the study, it should be noted that the population was restricted to professionals from a single hospital, not approaching workers from other ICUs. Thus, the perspectives of these actors would enrich the understanding about the configuration of assistance in PC and would make it possible to cover their real demands, leading to improved assistance and greater effectiveness of actions. In any case, the results obtained made it possible to discuss the challenges in conducting PCs.

Therefore, it is expected that the results of this research will support the strengthening of a new paradigm of attention to palliative care, by raising the awareness of health professionals, regardless of their specialty. This will allow them to understand that PCs cannot, nor should they, be dissociated from the person's other needs, and that patients need to be treated in a dignified and comprehensive way until their finitude.

FINAL CONSIDERATIONS

The study made it possible to understand the perception about palliative care of the multiprofessional team working in the ICU. It was identified that professionals understand PC as a strategy to promote comfort and alleviate suffering, respecting the dignity of patients and treating them as an integral and complex being.

Research participants stressed the importance of establishing good communication with the family and the other members of the multiprofessional team. In addition, they also highlighted weaknesses regarding professional training and divergences in the team's conduct.

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