Health professionals facing the patient out of therapeutic possibility of cure

Profissionais de saúde frente ao paciente fora de possibilidade terapêutica de cura

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RESUMO

Objetivo: conhecer os sentimentos, a formação e a conduta dos profissionais de saúde de nível superior diante do paciente fora de possibilidade terapêutica de cura em uma unidade hospitalar. **Método:** Trata-se de uma pesquisa qualitativa, descritiva e exploratória. Os sujeitos do estudo foram quinze profissionais de saúde: três médicos, um fisioterapeuta, um nutricionista e dez enfermeiros que faziam parte do grupo de servidores efetivos desse hospital. Os dados foram coletados por meio de entrevista semiestruturada e gravada, contendo questões abertas. **Resultados:** Após análise dos dados surgiram quatro unidades temáticas: sobre a morte e o morrer, diante do paciente fora de possibilidade terapêutica de cura, cuidados paliativos e a família, formação profissional para cuidados no fim de vida. **Conclusão:** com a pesquisa, considerou-se que a aceitação da morte está presente, entendendo como processo natural, que há falta de formação voltada para cuidados paliativos e reflexões sobre a temática da morte e que os cuidados paliativos se estendem as famílias. Destacamos a necessidade de formação concreta voltada para atender o paciente no fim da vida e discussões sobre a morte e o morrer.

Descritores: Morte; Morrer; Cuidados paliativos.

ABSTRACT

Objective:: to know the feelings, training and conduct of higher level health professionals in front of patients without therapeutic possibility of cure in a hospital unit. **Method**: It is a qualitative, descriptive and exploratory research. The study subjects were fifteen health professionals: three doctors, one physiotherapist, one nutritionist and ten nurses who were part of the group of effective employees of this hospital. Data were collected through semi-structured and recorded interviews containing open questions. **Results:** After analyzing the data, four thematic units emerged: on death and dying, in front of the patient with no therapeutic possibility of cure, palliative care and the family, professional training for end-of-life care. **Conclusion:** with the research, it was considered that the acceptance of death is present, understanding as a natural process, that there is a lack of training focused on palliative care and reflections on the theme of death and that palliative care extends to families. We emphasize the need for concrete training aimed at attending the patient at the end of life and discussions about death and dying.

Descriptors: Death; Die; Palliative care.

Introduction

Since the dawn of mankind, when man became sapiens, death has recorded an event that most assured life, which has no understanding, control and predictability. The process of perception of death and death is changed over time, programmed for a serene and natural acceptance for a society taboo situation.[1]

Life and death become inseparable partners, and although man shares with animals the rising, growing, aging, and dying, only he among all living beings is the only one aware of his finitude. This consciousness is not separate from the world around it, but a consciousness that tends toward the world.[2]

In this way, man's gaze on the world is generated by his experiences through perceptions of everything that has ever been lived, so that man always knows the death of the other, even inseparable life and death, as long as there is life, death will not exist, when death comes, life will have to give it its place.

Observing the behavior of men before death in other times, from the Middle Ages to the Modern Age, had a certain shift of focus towards death. Throughout the Middle Ages, death was seen and understood as a surprise, fatal and natural phenomenon that could not be interfered with, could only be accepted and understood. Already in the Modern Age or the focus is on causes and motives that lead to the death of an individual and this causes concern for science to act with methods and formulas to be able to stop and modify the course of death.[3]

The advent of technology is increasingly providing health improvements, dying has been distancing itself and death has been increasingly hidden away from the eyes of society and then transferred to hospitals.[1]

The repulsion for death and the knowledge acquired for its indefinite postponement by medicine, legitimized the passage of the dying man's room from his home to the hospital. This became the temple of solitary death. Only the next of kin follow, at a safe distance, the often long and silent end of the loved one. The solemn and detailed death in the family comes to an end: one dies in the hospital, a symbol of the extraterritoriality of death. Since death is considered obscene and embarrassing, nothing can be left behind.[4-5]

Thus, to overcome the difficulties encountered in the terminality process, palliative care has emerged as a therapeutic modality that aims to improve the quality of life of patients and families in coping with life-threatening diseases through prevention and relief. physical, psychosocial and spiritual suffering, prioritizing a multiprofessional approach.[6]

The advent of palliative care emerged as a new idea of "contemporary death", which is the conclusion of a work, preferably beautiful, harmonious and productive, endless pursuit of self, totality, individual identity and should result in a dignified end of life. it's beautiful. The product of this construction leads to the idea of an aestheticization of death, in which the patient remains calm, once welcomed by a team that treats him individually. In its uniqueness, it can remain with its physical characteristics, with its clothes, props, in a personalized environment: at home or in the hospice room [as the establishments of this genre are called], decorated according to your choice. Often, the image of "beautiful death" is associated with the idea of "peaceful death", coupled with the maintenance of personal identity, where beauty is closely linked to the ideas of peace and harmony. The "good death" is produced by the dying and the product must be beautiful.[7]

The principles governing palliative care are: reaffirming the importance of life, considering dying as a natural process; establish care that does not accelerate the arrival of death or prolong it with disproportionate measures (therapeutic obstinacy); provide relief from pain and other painful symptoms; integrate psychological and spiritual aspects into care strategy; offer a support system to help the patient lead as active a life as possible before death comes; provide a support system for the family so that they can cope with the patient's illness and survive the grieving period.[8-9]

Today, palliative care training bridges the gap between death seen as treatment failure and death from the perspective of providing quality, humanized care. Thus, there is a harmonization between the technical competence of medicine with healing and the culture of respect for the autonomy of the patient with regard to their health and life decisions.[10]

It is noticeable that palliative care has multiple interfaces with other disciplines and issues related to family, quality of life, death, spirituality, pain, and changing attitudes and expand its scope for care practices beyond the patient's health. They have as one of their striking features a chain of actions, concerns and care, which brings ahead the other who needs help. This reinforces its ethical dimension for professionals, as it points to the relational dimension of the human. This care also involves a complex network of interactions, encompassing different forms of knowledge, values, beliefs, meanings and resilience, shaping health practices in a sociocultural context.[11]

In this context, the research is justified by the importance of knowing the perception of health professionals about end-of-life care, as regards professional training to face the challenges of patient care outside the therapeutic possibility of cure. , as well as their feelings, weaknesses and behaviors adopted, so as to enable further discussions about improvements in the provision of such care.

In this sense, the objective of this study was to know the perception and how the health professionals of a hospital unit deal with patients who cannot cure themselves, death and palliative care.

Method

This is a descriptive exploratory study with a qualitative approach. The fact that it is qualitative allows to describe and interpret more broadly what is transmitted to it, not worrying about generalizations, principles and laws, focusing its attention on the specific, peculiar and individual, aiming for the understanding and not the explanation of the assessed phenomena.[12]

Data collection was performed at the Seridó Regional Hospital - HRS, known as the former SESP Hospital. The interviews were conducted in October and November 2016, through a recorded interview, with open questions addressing the following themes: death and dying, knowledge about palliative care, training on end-of-life care and the possibility of performing palliative care in the referred hospital within the training area of each interviewee.

The interview was conducted after direct approach to the professional in times of low demand for services and from the acceptance was presented the Informed Consent Form - ICF, after agreement, it was signed and the recording of the interview began. , later transcribed to an electronic Word file and submitted for data evaluation and analysis.

We used a interview technique in which the researcher seeks the information contained in the speeches of the subjects involved in the research.[13] The interview was guided by guiding questions (Chart 1). The target audience for the survey was all top-level professionals hired at HRS who agreed to participate upon invitation. The potential target audience would be all professionals in the unit, a total of 32 professionals with diverse backgrounds in the health area such as doctors, psychologists, social workers, physiotherapists, nutritionists and nurses.

Chart 1- Interview - Research Questions

Interview - Research Questions
1. What do you understand about death and dying?
2. What do you mean by palliative care?
3. Did you have any end-of-life discipline, course or training in your training??
4. How did this training take place?
5. How do you feel about the patient out of therapeutic possibility of cure?
6. How do you feel about the dying patient who is ordered not to revive?
7. Is it possible to perform palliative care in your professional field? Yes or no and why.
8. Is there anything you would like to say that I didn't ask?

Among the professionals who made up the target audience, 22 professionals from different backgrounds were approached, with seven refusing to participate in the research, four of them by social workers, a psychologist and two doctors.

Fifteen higher education professionals participated in this study, being three physicians, a physiotherapist, a nutritionist and ten nurses with varied professional times. These participants agreed to answer the questions after direct approach.

The analysis of the results was made from the perspective that stipulates the different phases of content analysis, such as sociological inquiry or experimentation, are organized around three chronological poles: 1) pre-analysis; 2) exploration of the material; 3) treatment of results, inference and interpretation.[13]

After analyzing the content of the interviews and faced with the most diverse contents described by the interviewees, they started to categorize the speeches, gathering them according to the presented contexts, dispensing with the location of the interview seeking a common category for the most important speeches, thus starting the process of categorization (Chart 2). From the categorization, an analysis of the discourses is performed in a more grouped, more objective and concrete way, extracting from the subjectivity of the transcribed answers the true feelings and anxieties of these professionals.

Chart 2- Categories and Analysis Elements.

Category	Elements of Analysis
About death and dying	Natural process
	End of life cycle
Facing the patient out of therapeutic possibility cure	Provision of palliative care
	Do not prolong suffering
	Anguish
	Impotence
Palliative care and family	Staff Need
	Multiprofessional Support
Vocational training for end-of-life care	Insufficient training
	Training Need

Results

The Acceptance of Death

Death can be defined as the ultimate cessation of life. Dying, as the interval between the moment the disease becomes irreversible and the one when the individual ceases to respond to any therapeutic measure, inexorably progressing to death.[15]

There were reports of acceptance of death as a natural form and seen as the end of a life cycle, emphasized by the discourse supporting the non-prolongation of suffering through unnecessary procedures in view of the imminence of death.

> *[...]*
>
> *over time I learned to accept it, also that dying, it's as natural as eating, as natural as you do in life, luckily we die, but it's natural, everything alive dies, nothing that was alive to this day had eternal life. (E 06)*

The feeling of acceptance arises from the realization that death is inevitable. It is assumed that despite everything that can be written or said, only man is aware of his death, since all living beings have a life cycle, yesterday we are born, today we grow old, tomorrow we die in a consumed act.[16]

> *[...] because the resuscitation at that moment was only going to prolong, so it went against palliative care instead of offering that patient comfort, pain relief, on the contrary, it would stress him further, stress his death process, provoke him. an unnecessary pain and, most important of all, was not going to have any effect. (E01)*

It is an unquestionable fact that any professional action should be based on attention and respect for the bioethical principles of beneficence, nonmaleficence, patient autonomy and justice; It is also consistent in the use of resources to define health care. Doubts about the extent to which investing in the patient persist.[17]

> *[...] won't prolong the patient's suffering, from the moment you resuscitate a patient who has no indication of resuscitation you are prolonging his suffering, so that's why I'm often in favor (E06).*

The principles of beneficence, nonmaleficence, patient autonomy, and justice, along with a great deal of common sense, underlie the decisions of these professionals as in this excerpt from one of the interviews:

> *"[...] the attempt to revive, you are increasing the suffering of that patient who goes up to palliative care, that goal of us to give the patient a comfort especially at the end of life." (E11).*

Professionals involved in this type of care have the difficult task of deciding to maintain the lives of patients who have already been beaten by the disease, where clinical treatment is no longer effective and the whole organism goes bankrupt, so they are not left with it. nothing but respect for the normal course of nature, accepting death as inevitable and irreversible, promoting the comfort of a dignified death.

Facing the patient out of cure therapeutic possibility

In the face of the patient without therapeutic possibility of clinical cure, the feelings of helplessness, anguish and sadness were found. This feeling created by the curative model taught in health courses, where the success of medicine is the complete cure of the patient, when this is not possible, is the feeling of failure of science, forgetting what nature in its steady course at. sometimes does not accept interference.

> *"I think like everyone else, we feel helpless because it is a moment that you, all your knowledge, all that you have learned, you cannot use to save a life." (E 15).*

Health professionals in assisting the dying of terminal patients were led to reflection on the finitude of human life. Although they have several scientific and technological resources that allow the prolongation of life, the moment death arrives it is clear that there is nothing to do.[18]

The terminally ill patient and palliative care

The death of the terminally ill patient from the perspective of palliative care is not seen as a therapeutic failure, but as a huge possibility for reflection and learning for the team, it is a moment of reflection on their own finitude, it is time to think about what is, in fact, making itself of existence itself.

> *[...] such a patient is in palliative care so I said, oh it's just palliative care after I promptly corrected myself, just no, everything. Palliative care, the fact that you provide the least,*

> *the least comfort to the end-of-life is of the utmost importance, you are freeing him from pain, from suffering. (E01)*

Palliative care is not aimed at healing, but the promotion of quality of life and comfort in the final moments, so those who provide palliative care are not faced with the imminence of failure to assist the patient in their terminality, but with the infinite possibility of making it worth the last days of life, with real life on those days, not only with the presence of vital signs within the standards considered normal.

Patients will be out of therapeutic healing, but they will be under palliative care therapy, getting assistance from other areas of life, being able to meet the true being that person has been all their lives and now preparing to stop to exist in order to separate oneself from those he likes, those who have been present throughout his life, and even those who have only been together in the course of illness and the process of dying.

Professional training to deal with the patient at the end of life

The training of health professionals regarding the theme of death and dying by universities and training courses was considered insufficient in the research findings. In the interviewees' statements, when asked about the training in end-of-life care, most of them brought the statement of the lack of such training, and when there were any, they were restricted to a single discipline throughout the undergraduate course, usually linked to the discipline. of ethics and bioethics, but a discussion on the subject.

The evidence in the gap of vocational training on the theme of death and dying. The content taught in the undergraduate, does not significantly fill the need for professional knowledge to take care of the dying. Death is a very complex phenomenon with profound human implications and this phenomenon must be understood in an interdisciplinary manner, which is not commonly seen in most courses.[1]

> *[...] It is a very big deficiency of ours, not only the nurse, the doctor, the psychologist, the social worker, the physiotherapist, the technician, anyone who is "in", in the care team at that moment and if this is taken into account by the gym, I think we would be much better today. (E07)*

A literature review consistently showed that the subject of death and dying has been neglected in training institutions, which has repercussions on tensions that affect professional practice. As a result of the lack of preparation, difficulties and sufferings experienced by nursing professionals and students arise that often end up resorting to solitary solutions in facing the mobilizing questions of concern. The little attention given to the theme has repercussions on the behavior adopted towards the patient, which sometimes becomes cold, distant, impersonal and technical.[19] Continuous and constant exposure to stress generated by daily contact with patients' death and dying, without institutionalized protective devices for its relief and elaboration, can affect the mental health of professionals.

Palliative care and the patient's family

The family was cited as an important part to be assisted by palliative care, being the main cell of the patient's life that often has a view of death different from the patient's view and do not understand when the therapeutic possibilities for cure are exhausted. At this point, the multidisciplinary team makes a huge difference in providing support and providing information about the patient's condition.

With regard to the family, the most difficult task is to make it understood that healing is no longer possible and that the desire to have your loved one alive for a while will only be possible through therapeutic measures that take away the comfort and meet the good death principles and often these explanations are not given clearly by the doctors conducting the treatment, sounding like a patient abandonment in the lay understanding of family members.

> *"[...] There is still the family issue right, the welcoming of the family and, as a professional you make understand that process right, so that is, it is minimized excessive and unnecessary suffering for the patient and family" (E 07)*
>
> *"*
>
> *I think that this issue of palliative care should be something very well talked with the family, especially right, because you come to a person who is sick and say that she, her, her patient has no cure anymore it's very hard."(E 10)*

This is a time of crisis for the family that can result in suffering, doubt and conflict. It is closely related to its preparation to face the death process, the social structure in which it is inserted, the intensity and the way everything happened.[17] Providing palliative care and assisting patients in their terminality goes far beyond the mere presence with technical means and curative measures, it is necessary a closer involvement of the soul, the awareness that we are not eternal but beings to death. Understand that only those who lived die, only those who knew how to enjoy the gift that death gives us, this gift is life.

Discussion

Feeling unveiled involves the theme of death and dying, enriches and consolidates the academic knowledge about such a process, allowing the reorganization of concepts and creating spaces for the dialogue between living and dying.[1] In this process of academic formation, it is necessary to train these future professionals, encouraging them to lose their fear of death and learn to take care of their being on the verge of death. And with that care, gather the lessons that the moment provides to better face life.

Nursing professionals are prepared to assist in treating and curing patients through care, losing sight of the fact that death is part of the human condition. Care and care are essential both throughout life and at the moment of death.[20]

It is challenging care, a daily challenge in dealing with the patient's worsening state, acceptance, fear, anxiety and confidence, taking care of the patient out of healing but not out of care.[20]

We need to reflect on the theme of dying, because this way we will have professionals more sensitive to the needs of those they care for and may provide more humanized assistance. This reflection should be reinforced in the academy since, this space, the student experiences a learning process in order to develop new values and concepts about human life from a bioethical perspective.[1]

End-of-life hospitalization is necessary when it is impossible for family members to keep a patient at home indefinitely while working, especially when the patient's autonomy and independence are severely compromised, when they are unable to endure or assist a person's suffering. dear or when specialized life-sustaining resources are needed.[21] Palliative therapy begins when curative therapy is no longer the goal, being associated with an interdisciplinary intervention that does not aim to anticipate death or prolong life, being focused on the control of symptoms such as pain, fatigue, dyspnea and preservation of the patient's and family's quality of life, so that they live as actively as possible this stage of life.

Caring for the terminally ill patient represents a major challenge for practitioners who must recognize that when healing goals cease to exist, care goals should be reinforced. Thus, when knowledge can do nothing else to save a person from the inevitable, therapeutic communication (where touch, gaze, and body expression become messengers) enables one to help the person die with dignity.[22]

The studies are unanimous in pointing out the lack of academic formation for the professional classes that are inserted in the outpatient and hospital environment, constituting an important failure in the education of people who faced the conditions of finitude and terminality in their entire work process.

Final Considerations

Therefore with this research it is possible to notice a great deficiency in the teaching and preparation of health professionals to deal with terminally ill patients and death. This theme has been neglected to the detriment of teaching techniques and procedures to maintain life, a characteristic of the curative model, which aims at healing above all, leaving aside the quality of life in the last days before death, depriving this event of all dignity and emotion it deserves, accepting that nature has its own time.

Palliative care is no longer a dream or just a new modality of care to become a necessity. For this to be effective in health services, quality training from undergraduate level is needed to promote end-of-life dignity. A patient out of therapeutic healing needs dignity, respect, and support in all its dimensions, and this is only possible if this assistance is provided by those who are truly prepared to understand the patient's limits, understand their fears, support those who stay.

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