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Health residents' conceptions on palliative care

Concepções de residentes em saúde sobre cuidados paliativos

Concepciones de los residentes de salud sobre los cuidados paliativos

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ABSTRACT

Objective: to identify the resident health professionals' knowledge about palliative care. **Method:** a qualitative study carried out with 21 professionals from a multiprofessional residency program in Bahia. Data was collected through semi-structured interviews between March and July 2023. IRAMUTEQ® software was used for analysis, followed by content analysis. Research protocol approved by the Research Ethics Committee. **Results:** the data was categorized into five classes, showing that many residents only had contact with the subject during their residency, highlighting the need to include palliative care in the undergraduate curriculum. In addition, there were doubts about the practical application of palliative care and the need for continuous professional training. **Conclusion:** it can be inferred that resident health professionals have a gap in their training process, from undergraduate to postgraduate, in relation to palliative care.

Descriptors: Health Personnel; Patient Care Team; Professional Training; Knowledge; Integrative Palliative Care.

RESUMO

Objetivo: identificar o conhecimento dos profissionais residentes em saúde sobre cuidados paliativos. **Método:** estudo qualitativo, realizado com 21 profissionais de um programa de residência multiprofissional na Bahia. Os dados foram coletados por meio de entrevista semiestruturada nos meses de março a julho de 2023. Para análise foi utilizado o *software* IRAMUTEQ® e, posteriormente, a análise de conteúdo. Protocolo de pesquisa aprovado pelo Comitê de Ética em Pesquisa. **Resultados:** categorizou-se os dados em cinco classes, demonstrando que muitos residentes só tiveram contato com o tema durante a residência, destacando a necessidade de incluir cuidados paliativos no currículo de graduação. Além disso, evidenciaram-se dúvidas sobre a aplicação prática dos cuidados paliativos e a necessidade de capacitação contínua dos profissionais. **Conclusão:** infere-se que os profissionais residentes em saúde apresentam uma lacuna no processo de formação desde a graduação até a pós-graduação em relação aos cuidados paliativos.

Descritores: Profissional de Saúde; Equipe Multiprofissional; Formação Profissional; Conhecimento; Cuidados Paliativos.

RESUMEN

Objetivo: identificar el conocimiento de los profesionales de salud residentes sobre cuidados paliativos. **Método:** estudio cualitativo, realizado con 21 profesionales de un programa de residencia multidisciplinario en Bahía. Los datos fueron recolectados mediante entrevistas semiestructuradas de marzo a julio de 2023. Para el análisis, se utilizó el *software IRAMUTEQ®* y, con posterioridad, análisis de contenido. El protocolo de investigación fue aprobado por el Comité de Ética en Investigación. **Resultados:** los datos fueron categorizados en cinco clases. Se demostró que muchos residentes tuvieron contacto con el tema sólo durante la residencia, destacándose la necesidad de incluir los cuidados paliativos en el currículo de pregrado. Además, se evidenciaron dudas sobre la aplicación práctica de los cuidados paliativos y la necesidad de formación continua de los profesionales. **Conclusión:** se infiere que los profesionales residentes de salud tienen lagunas en el proceso de formación desde el pegrado hasta el posgrado en relación con los cuidados paliativos.

Descriptores: Personal de Salud; Grupo de Atención al Paciente; Capacitación Profesional; Conocimiento; Cuidados Paliativos Integrativos.

INTRODUCTION

The World Health Organization (WHO) defines Palliative Care (PC) as a comprehensive health care practice, promoted by a multi-professional team, for patients with chronic and/or life-threatening illnesses, which aims to provide relief from psychological, physical, spiritual and/or family suffering, through interventions and actions that provide patients with measures of comfort and pain relief[1].

It is estimated that around 40 million people need palliative care each year, 78% of whom live in low- and middle-income countries, and only 14% of the population receive appropriate care[2]. These data show that the incidence will rise globally, due to the aging of the population and the involvement of chronic non-communicable diseases and other communicable diseases, which highlights the importance of developing appropriate and more effective policies and programs related to the issue, in order to maintain its applicability.

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Currently, there is a high number of patients hospitalized in palliative care, given the increase in life expectancy, technological advances and medicine development, factors that accentuate the prevalence of comorbidities, chronic and oncological diseases, reverberating in more accurate diagnoses and early treatments, which increase the survival of these patients, through Palliative Care[3,4].

Palliative care is based on principles that should guide the care provided by the multi-professional team. These include: relieving pain, not speeding up or delaying the process of the patient's death, providing bio-psycho-spiritual care, identifying the needs of patients and their families, as well as accompanying the family through the process of illness and mourning[5].

In this way, the multi-professional team is responsible for the health care of patients eligible for this care, as it provides comprehensive care, with a broader view of the patient's conditions, with a view to improving their quality of life and that of their families. However, some studies point to the unpreparedness of professionals in relation to the subject, due to lack of knowledge, as well as the training process, which in turn is based on the emphasis on the healing process and preservation of life at any cost[3,6].

These paradigms must be changed, given that most professionals confuse the concept of Palliative Care and associate it with patients with neoplasms and at the end of their lives, which reveals the deficit in the training process. To assist patients in palliative care, it is necessary to understand the individual as a whole and avoid adopting measures that do not improve their quality of life or alter their prognosis. For this reason, the benefits and harms of conduct must be assessed, as well as their standardization, with the aim of providing the real care that patients need[4,7].

It is noteworthy that, sometimes, the synonym for palliative care for many professionals becomes “nothing more should be done for the patient”, which ends up reverberating in inadequate and neglected care for patients in this condition. To this end, it is essential to know how to assess and select palliative care patients[3,6].

Thus, this study is justified by the increasing prevalence of patients in palliative care who are classified by the multi-professional team, especially in intensive care units, urgent and emergency sectors and medical clinics. Furthermore, care is often neglected, given the misinterpretation and misclassification of what it means to care for patients in palliative care.

Therefore, the aim of this study was to identify resident health professionals' knowledge of palliative care.

METHOD

This is a descriptive and exploratory study with a qualitative approach, carried out in a municipality in the interior of the Bahia capital, based on the Consolidated Criteria for Reporting Qualitative Research (COREQ).

The municipality has a Multiprofessional Residency Program in Urgency and Emergency with an emphasis on Intensivism that is linked to *Universidade Estadual do Sudoeste da Bahia* (UESB), in partnership with the General Hospital and the Municipal Secretariat. It is a postgraduate course, based on the principles and guidelines of the Unified Health System (*Sistema Único de Saúde*, SUS), aimed at health professionals, with the goal of specializing and qualifying nurses, pharmacists and physiotherapists.

The hospital where the residents work is a reference for 27 municipalities in Bahia and has a total of 345 beds, serving a population of over 600,000 inhabitants who are referred to this unit through the Bed Regulation Center and the State Regulation Center, as well as spontaneously (without regulation) serving the entire population, guaranteeing access to medium and high complexity services.

The study population consisted of 21 professionals, residents of the Multiprofessional Residency Program in Urgency and Emergency with an Emphasis on Intensivism. The inclusion criteria were residents in the first or second year of the course and the exclusion criteria were residents who, after three attempts to contact them, could not be identified at their place of work, as well as those who were absent for any reason, such as withdrawal, medical leave, maternity leave, certificates, etc. The participants were made aware of the purpose and confidentiality of the information they provided, as well as the minimal risks such as embarrassment in answering any questions by reading the Informed Consent Form (ICF) and, after agreeing, they signed it, one copy of which was given to the participant and the other was kept by the researcher.

Data was collected using a semi-structured interview script consisting of 10 trigger questions between March 2023 and July 2023 by a professional nurse resident. The Interface de R pour les Analyses Multimensionnelles de Textes et de Questionnaires (IRAMUTEQ®)[8] software was used to analyze the data produced through the interviews, an interface that enables textual analysis in various ways, basic lexicography (word frequency calculation), multivariate analysis

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(descending hierarchical classification and similarity analysis). In this study, descending hierarchical classification (DHC) was used. Subsequently, the data was analyzed using content analysis, where the material was read and explored and, finally, the results were processed using inference, interpretation and meaning[9].

Data collection began only after approval from the Research Ethics Committee of the participating institution, in accordance with Resolution 466 of 2012 of the National Health Council and Resolution 510/2016.

RESULTS

A total of 21 resident professionals took part in the study. 66.7% were female, 73.2% were over 30 years old, 81% were non-white, 85.7% were single and 90.5% had some belief/faith. In terms of profession, 47.6% were nurses, 28.6% pharmacists and 23.8% physiotherapists. Among the individuals in the sample, 76.2% had taken part in some kind of refresher course on Palliative Care.

The text *corpus* was developed on the basis of 422 text segments (TS), of which 85.55% (361 TS) were used. A total of 14,694 occurrences (words, forms or vocabularies) were found, of which 1281 are lemmas and 1103 were presented only once. Through lexical analysis, carried out using Iramuteq software, the content was categorized into five classes: Class 1, 51 TS (14.13%); Class 2, 55 TS (15.24%), Class 3, 90 TS (24.93%), Class 4, 76 TS (21.05%) and Class 5, 89 TS (24.65%).

From the five classes generated in the DHC dendrogram (Figure 1), two major topics of debate emerged from the general *corpus*, called subcorpuses.

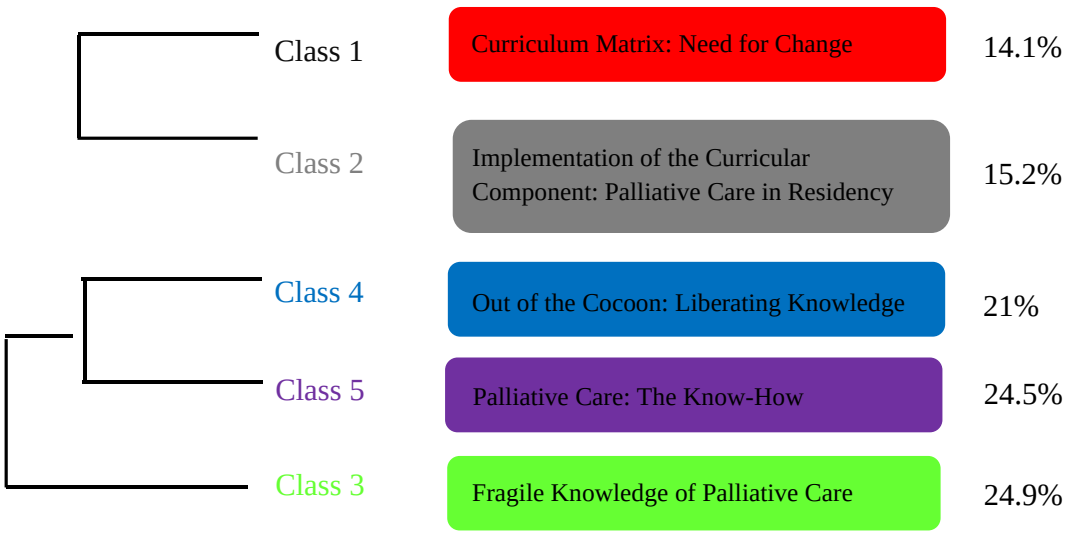

Figure 1: Dendrogram with percentage composition of classes on residents' perception of Palliative Care. Jequié, Bahia, Brazil, 2023.

Subcorpus A, Training in palliative care: the duality between undergraduate and postgraduate courses, a necessary metamorphosis, consists of Class 1: Curriculum Matrix: the need for change and for Class 2: Implementation of the Curricular Component: Palliative Care in Residency; and *subcorpus* B, entitled: Professionals' knowledge of palliative care. The analysis has two branches, the first of which has Class 4 as its corresponding class: Out of the Cocoon: Liberating Knowledge and Class 5: Palliative Care: The Know-How; and the second branch presents Class 3: Fragile Knowledge of Palliative Care.

Figure 2 shows the dendrogram related to the frequency of words that emerged in the interviews with residents, associated with their respective classes.

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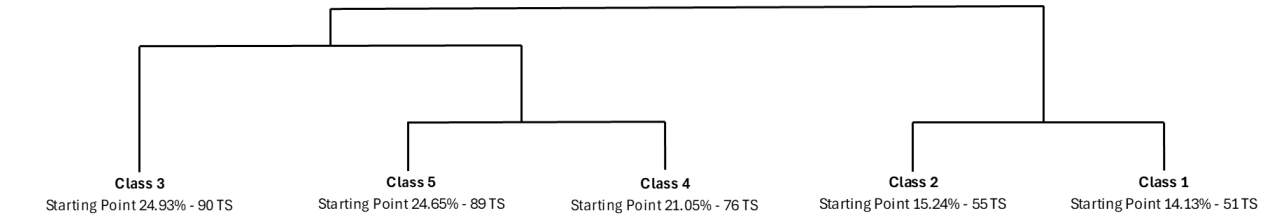

Word	F	X^2
Team	25	47.37
Professional	40	40.81
Difficulty	12	25.36
Believe	24	23.48
Lack	9	23.27
Interest	7	21.49
Perceive	13	20.27
Multiprofessional	8	20.17
PCC*	12	17.63
Facilitate	5	15.27
Same	21	14.91
View	4	12.18
Fear	4	12.18
Specialize	4	12.18
Performance	7	11.16
Unit	5	11.12
Establish	5	11.12
Diarism	5	11.12
Apply	5	11.12
Need	12	10.98

*Palliative Care Committee

Word	F	X^2
Patient	76	54.25
Life	21	41.42
Familiar	15	35.12
Comprehend	10	26.81
Family	16	22.39
Welcome	7	21.82
Moment	15	21.76
Comfort	15	19.82
Provide	10	17.15
Possible	8	14.12
Need	7	11.39
Desire	5	11.31
Table	5	11.31
Escort	3	9.25
Quality	6	8.77
Strategy	5	8.41
Offer	5	8.41
Involve	5	8.41
Dignity	5	8.41
Clinical	4	8.36
Process	8	6.93

Word	F	X^2
Leave	14	44.48
Palliation	15	44.21
Conduct	12	26.34
Take	5	19.1
Example	11	18.29
Person	13	16.96
Side	4	15.17
HGPV	4	15.17
Remove	4	15.17
Level	4	15.17
Complicated	4	15.17
Palliative	6	14.33
Pandemic	5	14.24
Case	6	11.55
Aspa	3	11.34
Wide	3	11.34
Only	13	10.72
Diet	4	10.6
Nutrition	4	10.6

Word	F	X^2
Thematic	14	53.05
Interesting	8	45.52
Find	30	42.66
Extreme	6	33.95
RMUE*	17	33.35
Importance	9	30.44
Grade	5	28.21
Inclusion	5	28.21
Discipline	9	27.13
Graduation	17	25.89
Curriculum	4	22.5
Curricular	4	22.5
Essential	5	21.91
Necessary	5	14.15
Deal	7	11.97
Achieve	4	9.71
Learn	3	7.87
Lecture	4	7.66
Look	4	7.66
Evolve	2	6.2

*Multiprofessional Residency in Urgency and Emergency

Word	F	X^2
Contact	26	107.11
Theme	25	100.86
Graduation	22	61.95
Discussion	7	26.47
Class	4	24.59
Job	5	24.09
RMUE*	14	21.39
Participate	6	21.0
Superficial	4	18.14
Work	4	13.88
Start	3	12.35
Quality of Life	5	10.91
Environment	5	10.91
Institution	4	10.89
Assistance	5	9.18
Session	3	8.79
Need	2	6.88
Promote	2	6.88
Super	2	6.88
Reading	2	6.88

*Multiprofessional Residency in Urgency and Emergency

Figure 2: Representative dendrogram with frequency composition, and chi-square (x^2) of the analysis by lemmatization, on residents' perception of Palliative Care. Jequié, Bahia, Brazil, 2023.

Subcorpus **A: Training in palliative care: the duality between undergraduate and postgraduate courses, a necessary metamorphosis**

Class 1 - Curriculum matrix: need for change

This class represented 14.3% of the total *corpus* and was made up of 51 TSs (text segments). The x^2 range that comprises this corpus is between x^2=107.11 and 6.88, and the main words that were analyzed in this class were: "Contact" (x^2=107.11); "Topic" (x^2=100.86); "Graduation" (x^2=61.95); "Discussion" (x^2=26.47); "Class" (x^2=24.59); "Work" (x^2=24.09); "RMUE" (x^2=21.39), distributed in descending order according to their frequency in the *corpus*.

It should be noted that the lack of discussions on the subject during undergraduate and postgraduate studies shows some weaknesses that reverberate in the care provided by resident professionals.

> *I had no contact with it during my degree. It was only at the residence that I had contact, you know? It was the first time I had contact with this subject and it was also when I stopped to understand and study about it [...] in residency, I believe that a subject is worthwhile, now in a more practical way, so that we have a theoretical basis, but don't stick to that lecture or something like that. (N5)*

> *During my residency I had contact with the subject, a scientific session. It's important because when some professionals graduate, they have no idea what palliative care is. (N15)*

> *I had no contact with the subject during my undergraduate studies. In residency, yes. Right at the beginning there was the session that we attended because we had contact when we entered the ICU and because we were in the ICU. (N21)*

The concept of palliative care for the majority of participants is related to the importance of proper management and assessment. However, despite having a palliative care team, there are still doubts about the classification of patients in palliative care.

> *But for me, I consider palliative care to be terminal care, when we can no longer do anything for the disease and we do it for the patient. (N2)*

> *I believe that although it's an old topic, it's not new. It seems that assistance is still a new topic. So it seems that today this discussion is beginning to emerge in healthcare. (N7)*

> *That they should be assessed by a professional who specializes in palliative care and here in the institution where the residency is held, let's say that there is still a little doubt if all the patients who are considered palliative, if they have really been assessed by a palliative care committee that has specialists in palliative care. (N 14)*

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> *He has a better quality of life and can also be a subject, right? They are there actively participating in the process of their health and illness. (N15)*

The residents also demonstrate the need for more in-depth study of the subject during undergraduate and postgraduate studies, in order to implement more specialized multi-professional care.

> *Based on my experience, the teams need to be trained in order to be able to provide better care for this patient, they need to train the team as a whole, to know what each person's role is going to be. (N13)*
>
> *I believe that more work needs to be done on this subject with training and courses, because sometimes professionals don't know much about it and don't know how to deal with it. (N17)*

Class 2 - Implementation of the palliative care curricular component in residency

After the lexicographic analysis, Class 2 represents 15.24%, 55 TS. The x^2 range that comprises this *corpus* is between 53.05 and 6.2. The main words that were analyzed were: "Thematic" (x^2=53.05); "Interesting" (x^2=45.52); "Find" (x^2=42.66); "Extreme" (x^2=33.95); "RMUE" (x^2=33.35); "Importance" (x^2=30.44).

After analyzing the text segments, it was found that it is essential to implement a specific curricular component on Palliative Care, since most professionals had no contact with the subject during their undergraduate studies, and this contact occurred during their residency.

> *I think it's valid. Because since this topic is little discussed in undergraduate courses, I believe that residency is an opportunity for us, as residents, to take a fresh look at this issue and contribute to our better training and better dealing with this type of issue. (N3)*
>
> *And since the residency is also focused on the ICU, palliative care is strictly related [...] so it would be very interesting for this topic to be included in the residency curriculum, since the profile of the patients we follow is one that fits this profile. A patient in need of palliative care. (E6).*
>
> *The inclusion of the subject in residency programs is also positive, given that in our daily lives we almost always end up dealing with patients in palliative care. (N13)*
>
> *I think it's extremely important to have this subject, this update in the curriculum, because every day we're getting more up-to-date and we're experiencing this issue of palliative care more frequently and there's still this professional deficiency. (N14)*
>
> *I think it's necessary [...] we come from a poor undergraduate background and we don't approach this subject as we should. (N19)*

The resident professionals noted the importance of broadening discussions on the subject in their field of work.

> *Maybe, if the Palliative Care Commission itself offers, we can do this, we can do that. I think it would also be interesting [...] but it's something more dynamic with case studies: we read the resolutions that govern this. It's something much more practical, which is how the residency advocates teaching. (N5)*
>
> *It's interesting to prepare professionals for a subject that is still a little discussed in undergraduate courses and to prepare them even more for the workplace. That it's something routine in our daily lives. (E11)*
>
> *They don't speak the same language and this has negative repercussions for the patient. In this current context of residency, I think it leaves a lot to be desired, I think we still have a lot to learn. (N19)*

***Subcorpus* B: Professionals' knowledge of palliative care**

Class 3 - Fragile knowledge of palliative care

Class 3 represents 24.93% of the total *corpus* analyzed and is made up of 90 TS, with a range of x^2=47.37 and 10.98. The main words generated from the analysis of this class were: "Team" (x^2=47.37); "Professional" (x^2=40.81); "Difficulty" (x^2=25.36); "Believe" (x^2=23.48); "Lack" (x^2=23.27); "Interest" (x^2=21.49); "Perceive" (x^2=20.27); "Multiprofessional" (x^2=20.17); "Palliative Care" (x^2=17.63).

This class discusses the perspective of the resident professionals interviewed on the fragility and difficulties that the multi-professional team has in terms of knowledge about palliative care, which in turn influences care and has repercussions for patients.

> *I see the same thing as being very deficient, because there is a lack of knowledge, foundation, discussion and, often, a lack of interest in applying palliative care, because there is fear, there is stigma and then little is said about palliative care. (N1)*

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> *I think it's a question of knowledge on the part of some professionals. The way in which this evaluation is conducted and the question of how the Palliative Care Commission should be more active. (N3)*
>
> *I realize that the concept, the definition of palliative care is still not very well understood by some of the professionals on the team, often due to a lack of professional experience, a lack of study during graduation and interest [...]. They can't reach everyone and they won't always be there. So the team needs to be better qualified, the vision of the professional needs to be improved, which will only happen with training, with study. (N7)*
>
> *So, I think a lot of issues get lost, a lot of professionals, they don't follow the same path, they sometimes end up diverging on the issue of care (E10).*
>
> *I think the biggest difficulty is the lack of knowledge, even on the part of professionals who view palliative care in the wrong way and the facility we have is the favorable environment for this, but we have terminally ill patients who need this care that doesn't happen effectively. (N20)*
>
> *But in general, I think it would be important if the professionals were better prepared, because we realize that there is a lot of information shock and a lot of talk about there being nothing else to do. (N21)*

Another point that was observed was the stigma in accompanying and assisting patients in palliative care and the erroneous understanding of its application, as well as the lack of consensus on multi-professional approaches, which means that the patient is not adequately attended to in terms of the needs presented at a time of such fragility.

> *The team has a very stigmatized view of palliative care. They are often too afraid to apply palliative care, believing that palliative care is when there is no longer any therapeutic prospect of treating the patient's illness [...]. But you can understand the patient with an incurable disease in different ways and apply palliative care in different ways. So, you don't need to anchor yourself in a profession, in a professional to institute palliative care. (N1)*
>
> *I believe there are still many gaps in what palliative care really is. So, often the professionals themselves get lost. And they don't know how to really address each patient's needs. (N10)*
>
> *So the difficulty I see is in relation to professional resistance, a mistaken view of the subject, that people once again think that there's nothing to be done for that patient. (N11)*
>
> *One professional today says let's put it in and the other professional tomorrow disagrees and says no. So, I believe that there needs to be progress on this issue of multi-professional discussion and everyone coming to a consensus. (N16)*

Class 4 - Breaking out of the cocoon: liberating knowledge

This class represents 21.05% and is made up of 76 TS, with an x^2 interval of 44.48 and 10.6. The main words that were analyzed were: “Leave” (x^2= 44.48); “Palliation” (x^2=44.21); “Conduct” (x^2=26.34); “Remove” (x^2=19.01); “Example” (x^2=18.29); “Person” (x^2=16.96).

In relation to knowledge about palliative care, it was found that once understood, behavior changes, with better assertiveness and implementation of this care in an integral way, enabling resident professionals to develop a more critical eye.

> *There is nowhere else to run and she has entered palliative care. Today, for example, the patient started to become hypotensive and she was deciding, since it was palliation, that she wasn't going to raise her daughter-in-law anymore, and then her colleague decided to raise her daughter-in-law. (N2)*
>
> *The perception I have is that the hospital-centric, medicalizing and even religious curative model creates a taboo that makes it difficult to understand that palliative care doesn't mean “letting die” and with this I believe that it often happens late and inadequately. (N8)*
>
> *And this is a broad aspect that requires preparation for appropriate therapies, psychological preparation to act appropriately with the whole situation, not only with the patient, but also with the patient's family. (N9)*
>
> *When you prepare a team so that they understand what palliation is, it means that some behaviors that are done today are abolished, such as the practice of withdrawing a diet. If a person is alive, there's no reason why you shouldn't offer them nutrients. (N15)*
>
> *A discussion between each professional in each area could go deeper into the patient's case and not just be another patient in the diarist's office, who will have a different approach the next day. (N18)*

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Class 5 - Palliative care: the know-how

It represents 24.65% of the total *corpus* analyzed and is made up of 89 TS, with a word dendrogram showing an x^2 range between 54.25 and 6.93. The main words generated from the analysis of this class were: "Patient" (x^2=54.25); "Life" (x^2=41.42); "Familiar" (x^2= 35.12); "Comprehend" (x^2=26.81); "Family" (x^2=22.39); "Welcome" (x^2=21.82); "Moment" (x^2=21.76); "Comfort" (x^2=19.82).

In the analysis of this class, pertinent questions emerged as to the way in which professionals outline their conduct with a view not only to the patient, but also to the family and all those who are part of their coexistence, offering a comprehensive practice.

> *It's putting the patient in touch with their family, fulfilling their wishes, it goes much further than that. It's about assisting the patient in a holistic way and understanding them as a whole. So, creating protocols and training the teams very well to assist these patients. (N6)*
>
> *I would add that palliative care should be discussed constantly, so that we always understand its real importance. I also believe that a good professional should always be open to any information that improves the patient's quality of life, especially in a palliative care situation. (N8)*
>
> *So, how can we articulate strategies among ourselves to improve the patient's comfort and communication with family members, to see and identify possible other needs of the patient to help them make this whole process more comfortable and less stressful than it already is? (N11)*
>
> *Knowing about palliative care means offering comfort to both the patient and the family, right? Knowing how to talk to family members, how to welcome them at this time. The work of the multi-professional team is of the utmost importance, right? (N16)*
>
> *Sometimes there are family members who don't understand, who think that because the patient is in hospital, they still have hope. To recover, to have an active life as before. (N21)*

In relation to the concept of Palliative Care, it can be seen that the perception of resident professionals has become better known and applied over time.

> *Well, I understand that palliative care is care that is given to the patient. Who has a disease that can't be cured or a life-threatening disease, and this is care that isn't just given to the patient [...] either through the creation of protocols or consultations. The scientific basis. And also bear in mind that caring for a patient in palliative care is not just about providing analgesia, but also about providing dignity and comfort. (E6)*
>
> *I understand that palliative care is a way of offering care to patients who no longer have any other therapies to continue living. In other words, it's a patient who has tried all the other therapeutic options. (N7)*
>
> *I understand that palliative care aims to provide a holistic quality of life for patients when their pathology does not have a favorable prognosis, and that we must also guide and approach the patient's companions in the right way. (N8)*
>
> *I understand palliative care as a way of providing comfort to the patient at a stage when a state of health in which pharmacological measures and medical procedures are no longer able to reverse that situation. (N19)*
>
> *But I think there could be a protocol, a minimum of care to be given to this patient, from bathing to medications to what procedures could be carried out. (N21)*

DISCUSSION

This study showed that most residents did not have any contact with the subject of palliative care during their undergraduate training, only superficially during postgraduate studies, a reality experienced in other higher education institutions.

A documentary study that analyzed the curricular matrix of federal higher education institutions identified that, in relation to nursing courses at a national level, only 11 higher education institutions have a specific subject on palliative care, and only one of these has a compulsory curricular component; the others offer the content as an optional subject. This finding demonstrates the fragility of professional training since graduation and is an important gap in training that can lead to inadequate care for patients in palliative care[10].

Another documentary study, which evaluated the curricular matrix of health courses at a federal institution, showed that there is a gap between theoretical and practical teaching during the undergraduate course, demonstrating the absence of a discipline that covers the subject in a more specific way, as well as showing that the curricular matrices present only specific content such as spirituality, ethics and bioethics, among others, which are dispersed in the various disciplines.

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It should also be emphasized that a more technicist education, based on the biomedical model, is a step backwards nowadays and is a barrier to change in the behavior of professionals[11].

The training process requires educational and political investment. For this barrier to be broken down, palliative care needs to be strengthened, and interdisciplinary work needs to take place. To this end, it is necessary to implement a multidisciplinary subject that is compulsory for all health courses. In this sense, the Medicine course, through Resolution No. 3/2014, which was amended in 2022, provides curricular guidelines and includes Palliative Care as a compulsory curricular component[12].

One study developed a proposal with themes for the modules of the Palliative Care curriculum component for medical students, based on basic principles, symptom management, early assessment and ethical and legal issues. In addition, they reverberate the importance of interprofessional education, as each area can make contributions and, consequently, through discussions, all professionals can improve their knowledge and enhance their skills[13].

There is a gap during the academic training of health professionals, since the development of curative techniques and skills is prioritized, aimed only at relieving and comforting pain, making them technicists, without having a broader view of patients, developing fragmented care centered on biological needs. This scenario highlights the importance of training in Palliative Care and maintaining the triad of specialized, comprehensive and individual care, for quality and equitable assistance that promotes health, quality of life and human dignity[14,15].

The resident professionals also identified that, even at postgraduate level and despite living with palliative care patients on a continual basis, their contact with the subject was only during some continuing education activities and on an occasional and infrequent basis, which encourages the need to broaden discussions in order to improve and reformulate curricula in both undergraduate and postgraduate courses.

Thus, these limitations begin at undergraduate level and extend to postgraduate studies, demonstrating how necessary it is that the training of future professionals and professionals in uniprofessional or multiprofessional residencies be focused on humanization, so that they can be sensitized and apply Palliative Care, respecting human dignity and providing comfort and well-being to patients and their families[16].

In view of the scarcity of content during the training of resident professionals, they stated that it is essential to include new knowledge on palliative care in the curriculum, with a view to training new professionals who have an expanded view of comprehensive care and incorporating palliative care earlier and earlier, with a view to promoting quality care that includes the family and caregivers in the planning of this care inherent to the patient, eligible for palliative care, with the aim of providing quality of life for all involved[17].

The resident professionals emphasized how important it is to know about the subject, especially nowadays. Because, through understanding, the form of multiprofessional action can be offered in the best way, according to the resources available. The lack of knowledge about palliative care compromises the provision of individualized care, according to the demands of each patient[18].

Sometimes, the multi-professional team working mainly in Intensive Care Units (ICU), where many patients are eligible for Palliative Care, are unprepared to assist these individuals. Professionals face some difficulties in accepting death as something inherent to the human being and seek to offer various therapeutic approaches to prolong life at any cost, since this is the way, they learned during their undergraduate studies[19].

This situation makes it necessary to reflect on training, which may be inadequate, given the lack of knowledge about how to deal with palliative care patients, which in turn directly interferes with the care plan[3,4.] Despite this fragility, the professionals recognize that these patients need the promotion of comfort, pain relief, in order to reduce suffering and provide dignity and autonomy, which can be operationalized by the multi-professional team through an effective tool: communication[10].

Care should be based on relieving pain, controlling other physical, social and psychological symptoms and, consequently, maintaining quality of life, as well as minimizing unnecessary and highly invasive treatments, carrying out assessment and reassessment to determine whether there will be any changes and/or continuity of the therapeutic plan in a multi-professional manner. Furthermore, it is essential to understand the inclusion of family members in the context of care and to maintain effective and enlightening communication, as well as qualified listening[20].

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It also highlights the need for support for the multi-professional team, who need psychological support due to mental exhaustion in the face of their daily demands with patients in palliative care. The professionals on the team feel fragile and resort to spirituality in order to maintain satisfaction in the performance of their activities, to promote humanization and make it possible to build a balanced relationship between patient, team and family and strengthen the bond[6].

In addition, the speeches show that there is a difference between care provided by a professional who has some training in palliative care and one who does not. Corroborating these findings, an action research study showed that after the intervention of a continuing education activity, professionals rethought and changed the way they understood the subject, enabling critical self-reflection and awareness of the need to change their clinical and/or care practices. This shows that continuing education activities need to be strengthened as a tool for transforming professionals, in order to continue the quest to improve the care provided[21].

In view of this, it is believed that health professionals who have professional training that includes palliative care in their curriculum will be better able to act and meet the demands of such specific care, through a holistic approach that includes the patient and their family.

In this way, knowledge related to the subject becomes liberating as understanding and incorporation of changes in the routine habits of health professionals' practices occur, which in turn can be inadequate in the face of patients in palliative care.

Furthermore, it is essential to combine technical knowledge with humanitarian competence, as professionals must propose therapeutic measures aimed at relieving suffering, seeing death as an inherent stage in the natural process of life. Therefore, taboos and stigmas related to Palliative Care need to be extinguished and, in order to do so, professionals need to broaden their field of vision and develop a more attentive look that combines science and humanism, as this way they will be able to perceive the real demands of patients. These professionals have been trained according to a curative model, but palliative care is not limited to essentially therapeutic possibilities. The patient must be given the comfort to live to the full for as long as he or she can, even at the moment of finitude. Care that encompasses psychosocial and spiritual aspects, and that their families and loved ones are also cared for, and it is essential that the multi-professional team acts with this objective in mind[22-25].

In addition, it is important to emphasize that Palliative Care is a public health issue, and it is important that there are more discussions and that public policies are developed to strengthen and implement Palliative Care for the entire population.

Study limitations

It should be noted that the results of this study are specific to the team of residents studied. Thus, it is necessary to carry out studies that address knowledge about Palliative Care from undergraduate to postgraduate level, since students assist and/or will assist the family/patient binomial in palliative care.

It is hoped that this will help to improve the approach to palliative care, so that every professional understands the importance of providing care that improves quality of life and relieves suffering. On the other hand, work environments need to be rethought, making them specialized, efficient and effective, with the aim of reducing dissatisfaction and increasing the gains from providing assistance to family members and palliative care patients, and for institutions to offer continuous monitoring.

CONCLUSION

Based on the findings of the study, it can be inferred that resident health professionals have a gap in their training process, from undergraduate to postgraduate, in relation to palliative care. There should be greater dissemination of knowledge and continuing education about palliative care among health professionals. To this end, it is important for higher education institutions to reformulate their curricula and guidelines, adding the subject as a specific curricular component.

In addition, it is important that health establishments offer continuing education activities, such as courses and/or training on Palliative Care, so that professionals can make a careful assessment of their work process and adopt palliative measures for patients.

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Author's contributions

Conceptualization, R.G.S.C. and J.S.O.; methodology, R.G.S.C. and J.S.O.; software, R.G.S.C., J.S.O e W.S.S.; validation, R.G.S.C., J.S.O e W.S.S.; formal analysis, R.G.S.C., J.S.O. and W.S.S.; investigation, R.G.S.C. and J.S.O.; resources, R.G.S.C.; data curation, R.G.S.C. and J.S.O.; manuscript writing, R.G.S.C. and J.S.O.; writing – review and editing, R.G.S.C., J.S.O, W.S.S, M.P.L, J.C.M. and D.B.R.; visualization, R.G.S.C., J.S.O, W.S.S, M.P.L, J.C.M. and D.B.R.; supervision, R.G.S.C. and J.S.O.; project administration, R.G.S.C. and J.S.O. All authors read and agreed with the published version of the manuscript.