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Continuous Education in Palliative Care: an Action Research Proposal

Educação Permanente em Cuidados Paliativos: uma Proposta de Pesquisa-Ação

Ducación Permanente en la Atención de Hospicio: una Propuesta de Investigación-Acción

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ABSTRACT

Objective: The study's purpose has been to further understand how a continuous education proposal could contribute to the improvement of professional health knowledge with regards to the palliative care. **Methods:** It is an action research type with a qualitative approach, which was carried out at a referral hospital in oncology that is located in the Southern region of Brazil during the period from April to May 2015. The study was performed through the application of a questionnaire with open questions before and after the education activity, then being analyzed from content analysis of the thematic type. **Results:** 213 professionals participated. Five thematic categories were constructed, as follows: Professional knowledge before the action: care towards the terminal patient; Professional knowledge before the action: care to the patient without both cure and treatment possibility; Sensitization to the principles of palliative care: the starting point; Safety care: understanding the proposal and its indications; and, Feeling the need to self-learning. **Conclusion:** It was identified the reduction of professionals insecurity and the improvement of the knowledge. It is important to highlight the larger propagation about this philosophy of care.

Descriptors: Palliative Care, Continuous Education, Healthcare Professionals, Knowledge.

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RESUMO

Objetivo: Compreender como uma proposta de educação permanente pode contribuir para a melhora do conhecimento profissional de saúde sobre cuidados paliativos. **Métodos:** estudo qualitativo do tipo pesquisa-ação desenvolvido em um hospital de referência em oncologia no sul do Brasil. Os dados foram coletados por meio da aplicação de um questionário com questões abertas antes e após a atividade de educação e analisados a partir da análise de conteúdo, do tipo temática. **Resultados:** Participaram 213 profissionais. Categorias temáticas construídas: Conhecimento profissional antes da ação: cuidado ao paciente terminal; Conhecimento profissional antes da ação: cuidado ao paciente fora de possibilidades de cura e tratamento; Sensibilização para os princípios dos cuidados paliativos: o ponto de partida; Segurança para cuidar: entendendo a proposta e suas indicações; e Sentindo a necessidade de educar-se. **Conclusão:** identificou-se a diminuição da insegurança dos profissionais e a melhora do conhecimento. Destaca-se a maior divulgação sobre esta filosofia de cuidado.

Descritores: Cuidados Paliativos, Educação Permanente, Profissionais de Saúde, Conhecimento.

RESUMEN

Objetivo: Comprender cómo una propuesta de educación permanente puede contribuir a la mejora del conocimiento profesional de salud sobre cuidados paliativos. **Métodos:** estudio cualitativo del tipo investigación-acción desarrollado en un hospital de referencia en oncología en el sur de Brasil en el período de abril y mayo de 2015 a través de la aplicación de cuestionario con preguntas abiertas antes y después de la actividad de educación. Se realizó análisis de contenido, del tipo temático. **Resultados:** Participaron 213 profesionales. Se construyeron 5 categorías temáticas: Conocimiento profesional antes de la acción: cuidado al paciente terminal; Conocimiento profesional antes de la acción: cuidado al paciente fuera de posibilidades de curación y tratamiento; Sensibilización para los principios de los cuidados paliativos: el punto de partida; Seguridad para cuidar: entendiendo la propuesta y sus indicaciones; Y sintiendo la necesidad de educarse. **Conclusión:** se identificó la disminución de la inseguridad de los profesionales y la mejora del conocimiento. Se destaca la mayor divulgación sobre esta filosofía de cuidado.

Descriptores: Cuidados paliativos, Educación permanente, Profesionales de la Salud, Conocimiento.

INTRODUCTION

Palliative Care has been the focus of discussions by health professionals and managers in the area of human health, including animal health¹. Realizing that aging with longer longevity and associated with chronic diseases and complex conditions is what characterizes the present and future of human beings² and animals in the world¹ the discussions have demonstrated the urgent need to change paradigms related to this care. Paradigms still tied to the biomedical, hospital-centric, individualistic model (individual work) focused on the cure of the disease, interventionist, and decontextualized^{2,3} and still present in some discourses “I know patients want to be actively treated and improve”^{3: e39} These perceptions have resulted in the very change in the World Health Organization’s first definition of the meaning of palliative care. In 1990, it was understood as “total care and assets directed to patients out of the possibility of cure”^{4:11} In this first

understanding, according to the Cancer Pain Relief and Palliative Care Report, this total and active care are related to care action with a focus on the patient rather than on the disease.⁴ It meant making the patient as active as possible considering his quality of life, his family and the possibility of being initiated early, even in the early stages of the disease and its treatment.⁵ Nevertheless, with the passage of time, it was observed that not all health professionals and managers and future professionals demonstrated the same understanding when showing in studies, difficulties of various origins, to apply in practice.⁶

Consequently, in 2002, World Health Organization (WHO) published the second definition of palliative care describing it as follows:

An approach that aims to improve the quality of life of patients and their families, in the face of a life-threatening illness, through the prevention and relief of suffering, early identification, impeccable assessment and treatment of pain and other physical, social, psychological and spiritual (WHO, 2002).

This definition is considered current and even with the changes in its definition, removing the focus of “active care”, “patient without cure” and including the term “life-threatening disease”, “prevention and relief of suffering” and “early identification” and some advances, there are still difficulties in incorporating this philosophy of care into practice.⁷

This fact can be verified when analyzing the existing Palliative Care services, mainly in Brazil. According to the National Palliative Care Agency, there are about 80 registered palliative care services (approximately 1 service for 2.4 million people) each at a developmental stage, many of these efforts being by health professionals to improve the care provided to their patients.⁸ The standards and guidelines of the European Association for Palliative Care suggest some indicators for a country to meet the demands of palliative care services. For every 50 beds (up to 80) of medical clinic units per million inhabitants, between one and two nurses per bed and 0.15 per bed are necessary.⁹ For the palliative care team: one for each hospital with 250 beds, a home care palliative care team for every 100 thousand inhabitants, having as a core group of staff 4 to 5 professionals in exclusive dedication.¹⁰ According to these data, Brazil would need 10 thousand beds, 12 thousand nurses, 1,500 medical specialists, more than 1,000 teams for large hospitals, 2,000 home care teams and 4 to 5 thousand professionals with exclusive dedication, with the National Health System, a National Palliative Care Program and established education centers and research in the area to reach Level 4 of Palliative Care assistance.¹⁰ A survey conducted by the Global Palliative Care Alliance on the state of care in several countries around the world, considering the provision of services, access to analgesia, level of professional awareness, movements for change and centers

of education and professional association, findings in 4 groups. It has been verified that there has been a modest advance since 2006 in the world and Brazil is in group,3 with isolated initiatives.²

In addition to the issue of infrastructure, another factor indicated as a barrier to the practice of palliative care is the professional training and awareness of public health management organs for the need for palliative care and this is considered as the first step.^{2,11} Studies indicate that there is a difference in the care provided by the professional who has training in palliative care and what he does not have. Health professionals without training in palliative care have unsatisfactory knowledge in relation to those who have previous training and these demonstrate applying knowledge in practice. One of the factors attributed to this insufficient knowledge is the little investment in education at work and professional training on the Philosophy of the Palliative Care.^{2,3,12,13}

The professionals of the nursing team, as well as physicians, psychologists, physiotherapists and other professionals involved in oncology patient care with palliative care, do not have, during the course, at the intermediate or higher level, disciplines focused on the care of the individual of chronic-degenerative diseases out of possibility of cure or reversion of the disease and Palliative Care.^{14,15} As one of the ways to alleviate the deficiency found in this training, permanent education has been considered as a potential factor for the improvement of professional knowledge and its application in practice, especially with regard to safety in action.¹⁶

According to the guidelines established by the National Policy on Permanent Education in Health, permanent education is understood as meaningful learning at work. The term meaningful has a connotation of “conscience”, a necessary factor to incorporate the Philosophy of Palliative Care. The process of teaching and learning are developed in the daily life of organizations (health institutions) and in the work process as a possibility to reach the transformation of professional practice and work organization. By this understanding can also be interpreted as learning-work, as it should happen in the daily lives of people and organizations. It needs to happen starting from the identification of the problems faced in the reality of work considering “the knowledge and the experiences that people already have”,^{17,20} as well as the health needs of the people and populations.¹⁷

Hence, this study aims to understand how a proposal of continuous education can contribute to the improvement of the knowledge of health professionals who work in palliative care oncology.

METHODS

It is an action research type^{18,19} that was performed in 4 stages: planning, action, observation, and reflection.¹⁹ The study was carried out at a referral hospital in oncology that

is located in the Southern region of Brazil during the period from April to May 2015. The research was attended by 213 health professionals who make up the professional staff of the institution, without distinction of professions. The inclusion criteria used were to be a health professional at the Hospital in question and health professionals attending the education activities; the exclusion criteria adopted were health professionals who were covering gaps and crowded in another hospital unit; health professionals who arrived at the place of the activity after the application of the initial questionnaire; health professionals who did not respond to the initial and final questionnaire. The proposed educational activities were discussed and organized with the professionals of the Management Program in Palliative Care aligned with the institutional policy for the area, as well as for education. It was performed by a palliative physician and a nursing student through a study of real clinical cases in a dialogue with projector support in an auditorium with a capacity of 50 seats. Three times were offered to the medical teams and then 14 hours of activity of education to other professionals of the institution. The data were collected through a questionnaire applied before and after the educational action, with open questions that included aspects of Palliative Care addressed during the intervention. For the organization of this reflection and analysis of the data, we opted for the proposal of analysis of content, operative, thematic type, of Minayo (2010) 20 in association with the theoretical reference on the principles of palliative care and permanent education in health. Participants were identified with the initial letter of the training and a number ex: Physician (P1...), Nurse (N1...), with the exception of the profession Speech Therapy (ST1...), Physiotherapy (Ph1...) which has initials equals. The research was submitted to the Research Ethics Committee System of the National Research Ethics Commission - Plataforma Brasil, and was approved by the Research Ethics Committee of the *Universidade Federal de Ciências da Saúde* under *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Appreciation] No. 40234214.2.0000.5345 on March 19th of 2015. After accepting the participation of the study, the participants signed the Free and Informed Consent Term for the application of the questionnaire.

RESULTS AND DISCUSSION

The participation in the activity involved a total of 213 professionals of diverse areas and functions. Nonetheless, only 100 professionals were included in the sample because they met the inclusion criteria. Considering these, 24% were physicians, residents or contractors of the institution, 64% were nurses and nurse technicians; the remaining 12% included other professionals from the multidisciplinary team as well as some professionals with an administrative function. Concerning the gender and age, the majority of the participants were female (72%) and the average age was

33 years old, with a minimum of 18 and a maximum of 60 years old. The average time in the area was 6 years and the performance in the institution was 3 years (Table 1).

Table 1 – Distribution of the health professionals (n=100) according to sex, age group, working experience, working area, and working time at the institution. *Porto Alegre* city, 2015.

Characteristics of the professionals from the sample	Physicians n=24		Nurses n=19		Nurse Technician n=45		Administrative Assistants n=7		Others n=5		Total n=100	
	n	%	n	%	n	%	n	%	n	%	n	%
Sex												
Male	15	62.5	1	5.3	8	17.8	3	42.9	1	20	28	28
Female	9	37.5	18	94.7	37	82.2	4	57.1	4	80	72	72
Total	24	100	19	100	45	100	7	100	5	100	100	100
Age Group												
18-25 y/o	1	4.2	1		6		1		0			
26-33 y/o	13	54.2	13		17		5		2			
34-41 y/o	6	25	3		17		1		1			
42-48 y/o	0	0	2		3		0		1			
49 y/o or more	4	16.6	0		2		0		1			
Total	24		19		45		7		5			
Working experience												
<5 years	13		6		28		4		1			
5 to 10 years	4		6		10		1		1			
10 to 15 years	3		4		6		1		2			
15 to 20 years	1		3		0		1		1			
≥ 20 years	3		0		1		0		0			
Total	24		19		45		7		5			
Working time at the institution												
<5 years	17		11		37		6		4			
5 to 10 years	3		4		6		0		0			
10 to 15 years	2		4		1		1		1			
15 to 20 years	0		0		1		0		0			

Source: Scalei, VC. Continuous Education in Palliative Care: an action research proposal. *Porto Alegre* city, 2015.

Considering the professional training for palliative care, most physicians, speech therapists, physiotherapists, social workers stated that they did not have undergraduate training. The knowledge was reached through participation in events, in the medical residency and in the service itself. Of the 19 participating nurses the training on the subject was cited by the majority as punctual in some classes, lectures or in the development of the work of conclusion of the course. Only 6 reported no prior training. The sole present Dentist stated that he had not had previous training. Of the 45 nurse technicians, 33 reported not having had previous training and those who had the training were performed in the service itself. Of the 6 participants in the administrative area, only 1 reported having prior knowledge, but due to ongoing technical training. No participant had a postgraduate degree in Palliative Care.

Based on the content analysis, the thematic type of Minayo (2010), it was possible to construct the following thematic categories: Professional knowledge before the action: care towards the terminal patient; Professional knowledge before the action: care to the patient without both cure and treatment possibility; Sensitization to the principles of palliative care: the starting point; Safety care: understanding the proposal and its indications; and, Feeling the need to self-learning.²⁰

Care towards the terminal patient

When analyzing the previous knowledge about the palliative care of the professionals to the educative action, it was observed that the majority of these relate the Palliative Care to the care to a terminal patient, the ending process, and the death process, but also focusing on life quality. For professionals, this quality of life is related to comfort, management of symptoms (pain) and inclusion of family support.

Beware of the patient so that he/she obtains a terminality of quality and dignity. (P17)

The care of end-of-life patients in order to bring comfort, support to the patient and their families. (P2)

From what I know, it refers to caring for people who are almost dying. (AA4)

It is the care that the patient has a better quality of life. (AA2)

It is the care that is given to the patient in the terminality of the disease to bring comfort and to avoid measures delaying the death during this moment of “end of life” aiming at the quality of death. (Ph2).

It is the treatment, accompaniment to the patient [...] who needs care that aims at a better quality of life. (ST1)

Care of patients in the terminal phase without the use of invasive measures, measures of comfort. (N1)

Improvement of the quality of life of patients [...] decrease symptoms caused by the circumstances of death, such as pain, increasing comfort. (N3)

These are the care actions towards the “terminal” patients. (NT15)

They are patients who unfortunately have no chance of survival... we give them the greatest comfort, so that they are comfortable, and especially without pain. (NT7)

They are professionals who attend to that patient in whom all the treatments have been done and need follow-up to relieve the pain and get organized for death. (SW1)

Care to the patient without both cure and treatment possibility

The professionals, in addition to relating Palliative Care to terms that resemble “death”, the “terminal phase of the disease”, also associate the impossibility of cure and treatment. They are understood to be a care taken only to patients in the termination phase of the disease and, at the moment, they are without both cure and treatment possibility. They do not distinguish between what kind of treatment, probably the dressing for the disease and emphasize, that in “palliative care”, it is not treated, but “taken care”.

Provide targeted care to a person who has a pathology that has no curative possibility. (P11)

They are given care to patients with a disease with no possibility of cure or treatment. (P14)

It is the treatment, accompanying the patient out of curative possibilities. (ST1)

When, from the medical point of view, there are no more conduits to be added for the cure of the patient. (Ph1)

Palliative care is caring for patients who have no treatment, “cure” in their prognosis. (N10)

Care for the patient in whom the disease is at an advanced stage and has no cure. (N4)

Care for patients [...] without a cure. (D1)

They are professionals who attend to that patient in whom all treatments [...] (SW1)

These are the care actions towards the patients who no longer respond to treatment. (NT13)

It has the purpose of giving comfort to the patient who does not respond to the proposed task. (NT7)

Sensitization to the principles of palliative care: the starting point

The professionals who participated in the education activity reported after the educational activity demonstrated that they have been able to understand the importance of this approach and the possibility of being performed not only in the terminal phase but from the diagnosis and throughout the curative treatment. The education proposal allowed us to rethink the meaning of palliative care in order to better accept the way the treatment is performed in the institution, as well as the legal aspects involved. Some have stated that from this moment on they will also consider aspects related to the patient and family, and not just to the disease, as they were accustomed to acting. In addition to the previous aspects, among the Physicians, autonomy

was also one of the main perceptions about the need for change. Of all higher education professionals, only 1 of the Speech-Language Pathologists reported that they had not changed their knowledge after the activity and that they needed clarification.

The perception about palliative care has changed greatly, I know that it is not only care given to terminal patients, but rather, care since the diagnosis of the disease. (P14)

More clarity on how to deal with patient autonomy. (P3)

Assess and respect more and better the patient's real autonomy. (P1)

That palliative care is coupled with curative care, that we must respect the wishes of the patient and family. Doing “everything” that the PATIENT needs to avoid suffering. (NT5)

Recall what palliative care is to better accept the way of treatment on the floor. (N4)

Palliative care is not only for patients at the end of life, but for all those whose illness threatens life. (N13)

I could understand a bit more about palliative care, which does not mean the terminal phase of a person that can be treated. (A5)

It has changed in relation to care as a whole, not only in special cases, but also in all moments of an illness and to care about what the human being cares about. (A3)

Knowing that palliative care can be done in patients with a possibility of cure too (Ph2)

He clarified doubts about the legality of palliative actions (D1)

The post-action knowledge - Safety care: understanding the proposal and its indications

Another feeling described by the professionals, after the activity, modified was safety. They express in their reports that they feel more secure, less embarrassed, with a more comprehensive view of care and less fear of doing palliative care at the institution. For physicians, physiotherapists and nurses, the poorly written but described safety is also related to aspects of the legislation that support therapeutic decisions to answer “when to go”. Most professionals, who did not know, knew little or had inadequate knowledge about palliative care, stated in their reports that they will change the way they act after this moment. The few who responded did not change their attitude or way of thinking claim to hold their convictions and suggest deeper discussions.

Previously (in other words) before this talk he turned to palliative care with less security. (P12)

Improve my understanding of palliative care. I've had more resources to allow for some medical decisions. (P12)

Legal issues: update on the legitimacy of the possibility of withdrawal of invasive and provoking interventions of death. (P23)

The vision I had about a suspension of hydration and diet. (Ph2)

I get clarification on the ethical and legal aspects that involve palliative care. (N14)

I leave with the mind more open and without fear to take all the measures instituted. (N16)

For me who work on prosthetic face rehabilitation, there were some doubts about what kind of care I performed. This caused me some embarrassment at the time that some patients used the prosthesis with the possibility of recurrence of the lesion. I see that I fit into a more holistic view of medicine. (D1)

Because in my work I was afraid to perform certain care measures because I did not know the performance of certain medications. Now, knowing the subject a little better, I can act more effectively and safely. (NT27)

The post-action knowledge - Feeling the need to self-learning

In the reports, it was possible to identify that the educational practice on palliative care enabled the professionals to perceive the need to educate themselves, but as a continuous and specific action of the areas and not as a process articulated the demands of the work and institutional process. The meaning of "educating" is related to the development of knowledge about palliative care, a moment to add knowledge, to improve understanding, to exchange knowledge and to talk, to awaken to the permanent search for it, the "demystification" of concepts, not only for the content, but for the change of attitudes at work, which translates into care.

It brought new information, added knowledge to discuss the cases. It aroused interest in studying more about palliative care. (P16)

They will improve the attention the doctor should have towards the patient (P12)

The exchange of knowledge is always important for the improvement of our care and for the patient. (P2)

Many professionals do not use it for prejudice, for lack of knowledge. (ST1)

Because in college we have no contact with this care. (N10) Continuing education is essential for updating and qualifying care. (N13)

For all knowledge and debate adds more to and before the patient. (Ph1)

By restricting the focus of the specialty. (D1)

Because we can be in constant learning. (SW1)

Because we work in a hospital. (AA1)

Knowing how to deal with this situation better. (AA4)

The lack of knowledge in palliative care is considered as one of the main barriers to its practice.^{2,21,22} Studies carried out on this topic reveal that the level of knowledge about this care is insufficient or non-existent in undergraduate students as well as in health professionals. One of the factors that contribute to the difficulty in incorporating the philosophy of palliative care in clinical practice is self-awareness.^{2,3} This context emphasizes the urgency to strengthen teaching on palliative care from undergraduate to in-service training, but with proposals that allow for critical reflection about the issue and awareness of the need for change in clinical and professional practice. By the characteristics of each profession, most of the published studies are of nursing and medicine, giving a little possibility of better analysis of the other professionals that compose the health team. The study has similarities with others already performed. Health professionals presented little knowledge or knowledge misaligned national and international public policies.^{2,23,24} Considering three fundamental concepts of palliative care (philosophy and palliative care, pain, and management of signs and symptoms and psychosocial care), professionals presented greater deficits in the philosophy of palliative care. The most focused aspect was the relation of terminality with palliative care. With the new definition of Palliative Care, revised by WHO, where such care is defined as an approach that promotes the quality of life of patients and their families facing life-threatening illnesses through the prevention and relief of suffering⁷ we are no longer talking about terminality but about life-threatening diseases.⁸

Nevertheless, it is still common to verify health professionals affirm that palliative care is performed in the final phase of a disease, where the curative measures adopted will not modify the patient's condition, with a greater focus on the person's comfort, since the cure of the disease it is no longer possible. Few would indicate such care in the

initial phase of the disease.²⁵ In addition to the control of the physical symptoms, in the end, the professionals seek to include in the care psychosocial, emotional and spiritual aspects, since these are usually more outlined at this stage. However, according to the philosophy of palliative care, such care, aimed at comfort, maintenance of quality of life and dignity and care for the family, must be carried out in all phases of an illness, from diagnosis to the death.²⁶

From the first concept of the World Health Organization in 1990 on palliative care whose initial phrase contained the terms total active care for patients whose disease did not respond to curative treatment, it was identified that health professionals related the action of caring actively and totally to patients in the terminal stage of disease, terminality, out of possibility of cure and out of possibility of treatment.⁷ For this reason, the interpretation of the reality associated with the terms used in clinical practice are factors that contribute to the inadequate disclosure of the real meaning of the Palliative Care. These justified the replacement of the terms impossibility of cure, by possibility or not of treatment modifying the disease, in an attempt to dispel the idea that palliative care is caring for clinical situations where there is nothing else to do, since unlike Moreover, there are still many attitudes to be taken impacting on the quality of life of the patient and family.^{8,27}

Another misconception observed in clinical practice is patient out of therapeutic possibilities. When speaking of this term it is affirmed that a patient no longer has any possibility of treatment, because, by treatment, many professionals understand as the search for a cure of the disease and not of a patient with a disease. The types of treatment that are recognized by professionals are those provided in manuals or policies of the ministry of health such as chemotherapy, one of the most common in oncology. Some medical professionals with more time of practical experience have difficulty in accepting that cancer patients can not be treated for curative purposes “if a patient is a candidate for chemotherapy there is no candidate for palliative care”.³: e38 This view is founded on the principle of training for the cure of disease. In the philosophy of palliative care, it is believed that there is always a therapy to be adopted for a patient. In the case of patients in exclusive palliative care, where the curative treatment no longer makes sense, the adopted therapy aims to provide relief of symptoms and better the quality of life until the end of this.²⁸

When health professionals were exposed to knowledge about the philosophy and principles of palliative care through education at work, with a discussion of clinical cases revealed they did not feel prepared to care for patients in palliative care. This perception and awareness were given by the analysis of their own training and clinical practice, because before a different reality, increasingly present patients with a life-threatening disease there is a need to think and act differently. The reality of this study is in line with other studies^{29,30,31,32,33,34} emphasizing the deficit

in training at graduation and at work. As a strategy to overcome the knowledge deficit and the decontextualization of care in Brazil, the National Policy on Permanent Education in Health was created in 2006. It prioritizes work-based learning that should happen in the daily life of individuals and organizations, being the result of to think critically about the work process of the institutions, that is, it should aim to solve the problems faced in the daily practice of the subjects involved. The educational proposal developed in this study allowed the participants to analyze their practices in the reality of work through a meaningful learning process. It is characterized by the process of reflection of the work processes, difficulties, facilities and challenges that the involved actors judge from this if they seek institutional improvement as a whole and not individually as it happens through continuous education and observed in the speeches of the participants of this study.^{17,35}

When it comes to education in palliative care we find the idea that this care seeks to ensure patient and family quality of care as it is believed that those involved in care know what to do and when to do well and able to do so with criticism as they do. This perception is in line with the proposal of permanent health education carried out in this study. This thinking of not doing emphasized characterizes the process of education as “continuous” and different from “training” that ends in attainment, at arrival, as something that ends. It values meaningful, experiential learning at work.³⁶

From the perspective of permanent education in health, education means a process based on the reflection of reality, in other words, the subject must critically evaluate his work process and his daily practices; in dialogue and in the exchange of experiences, trying to create discussions on the subject with their co-workers, managers and clients, seeking to know the vision of the other, establishing counterpoints to their perceptions, and also enabling collective learning. Education also assumes the role of awakening, in itself and in the other, the willness of doing different, and from there to problematize their experiences, valuing past or present personal experiences, enabling them to reintervive in reality in order to improve the care provided.³⁷

CONCLUSIONS

The present study evidences the importance of activities of continuous education in health. These need to be thought and elaborated based on the demands of the actors themselves, thus seeking the change in the health practices observed in the institutions. This study made it possible to identify the knowledge of health professionals about the Palliative Care before an educational activity on the subject, as well as after its accomplishment. The lack of knowledge about the philosophy and principles, as well as the indications of palliative care, the insecurity to deal with the prescribed behaviors and the lack of activities of permanent education, as a process of reflection in and for

the work on the subject were the main aspects scored by the study.

The main findings of this study corroborate both national and international studies, which affirm that a greater dissemination of knowledge and education about the philosophy and principles of palliative care among health professionals is necessary. This process must begin during its formation and extend during the practice, either with the personal search for knowledge or in activities of permanent education in health provided by the institutions where these professionals are inserted.

One of the study's limitations was the research's execution time. It is understood that a greater time for doing the tasks of development, data collection and analysis could allow a better exploration of these for other perspectives.

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