

Palliative care in medical training

Cuidados paliativos na formação médica

Cuidados paliativos en la formación médica

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The objective of this work was to reflect on the palliative care in medical training. It was based on academic internship experiences of the tenth period of a medical course at a university in the state of Minas Gerais, Brazil, in the months of September and October 2017. The principles of palliative care centered on the person are seen as way to ease human suffering. The lack of preparation in medical training is analyzed from the appearance of the palliative care and the recognition of Palliative Medicine as a medical subspecialty. It also discusses that with the increase in life expectancy and thus, chronic diseases, dealing with topics such as finitude, death and palliative care are presented as a need in medical training. The internship field experience provided the medical students the deepening and reflection about palliative care.

Descriptors: Palliative care; Education, Medical; Humanization of assistance.

O objetivo deste trabalho foi refletir acerca dos cuidados paliativos na formação médica. Se baseou em vivências de estágio de acadêmicos do décimo período de um curso de medicina de uma universidade do interior do Estado de Minas Gerais, nos meses de setembro e outubro de 2017. Os princípios de cuidados paliativos centrado na pessoa são apontados como forma de aliviar o sofrimento humano. O despreparo na formação médica é analisado a partir do aparecimento do paliativismo e o reconhecimento da Medicina Paliativa como uma subespecialidade médica. Aborda-se também que com o aumento da expectativa de vida e com isso, as doenças crônicas, o lidar com temas como finitude, morte e o cuidado paliativo se apresentam como necessidade na formação médica. A vivência em campo de estágio proporcionou aos acadêmicos de medicina o aprofundamento e reflexão acerca dos cuidados paliativos.

Descritores: Cuidados paliativos; Educação médica; Humanização da assistência.

El objetivo de este trabajo fue reflexionar sobre los cuidados paliativos en la formación médica. Se basó en vivencias de pasantías de académicos del décimo período de un curso de medicina de una universidad del interior del Estado de Minas Gerais, Brasil, en los meses de septiembre y octubre de 2017. Los principios de cuidados paliativos centrado en la persona son destacados como forma de aliviar el sufrimiento de los cuidados paliativos y el reconocimiento de la Medicina Paliativa como una subespecialidad médica. También aborda que con el aumento de la expectativa de vida y con eso, las enfermedades crónicas, el lidiar con temas como finitud, muerte y el cuidado paliativo se presentan como necesidad en la formación médica. La vivencia en campo de pasantía proporcionó a los académicos de medicina la profundización y reflexión sobre dos cuidados paliativos.

Descriptor: Cuidados paliativos; Educación médica; Humanización de la atención.

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INTRODUCTION

Humanizing, in the context of health, can be interpreted as make tolerable, affable and is an educational obligation, a condition of professional success¹. It is up to the universities to contribute to this process of character formation in students².

During the undergraduation of a healthcare professional, one expects a relationship with the patient, his family and the context in which he is inserted to know the cause or progress of diseases, including biological, psychological and social factors - care centered in the person and community, called biopsychosocial model. This model prioritizes the care of the person with identification of his ideals and emotions about falling ill and the response to them, besides seeking to identify common searches among physicians and patients about the disease and its approach, to sharing decisions and responsibilities³.

In 2002, the World Health Organization describes palliative care (PC) as an approach that improves the quality of life of patients and their families facing problems associated with illness, through the prevention and relief of suffering by means of early identification, correct assessment and treatment of pain and other physical, psychosocial and spiritual problems⁴.

PC has as principles: reaffirming the importance of life, considering death as a natural process; establishing a care not to accelerate the arrival of death, nor prolongs with disproportionate measures; providing relief from pain and other distressing symptoms; integrating the psychological and spiritual aspects of care strategy; offering a family support system so that it can face the disease. The word *palliative* has strong symbolism: from the Latin *palliun*, meaning mantle, protection and *palliative care* translates the protection to those who curative medicine no longer embrace⁴.

PC is intended for patients with cancer and other chronic-degenerative diseases, when there is no prospect of cure. In this model of care the focus of attention is shifted from the disease to the sick person, in his life

story and family and in his process of sickness and death, giving everyone involved psychological, social and spiritual comfort⁵.

No specialty alone can cover the complexity of human existence; thus, it is necessary a multidisciplinary team to help in adapting to life changes imposed by the disease and promote reflection needed to cope with the irreversible condition and/or death⁶.

The absence of national PC policy, difficult access to opioids, no specific discipline in health professionals undergraduation and the shortage of services and programs specialized in PC are factors that hinder the practice of palliative care⁷.

In Brazil, the history of PC is recent, beginning in the 1980s, and the creation of the Brazilian Association of Palliative Care (ABCP) in 1997, made up of professionals who proposed practices for the dissemination of the new philosophy of care in Brazil. In 2005, it was created the National Palliative Care Academy (ANCP), in order contribute to the teaching, research and optimization of PC in Brazil, in addition to showing the growing concern and involvement of the government and representing a milestone for medicine that is practiced in the country⁸.

The UK was the first country to recognize Palliative Medicine as a medical specialty in 1987⁹. In Brazil, it happened only in 2011. Physicians who joined residency programs in clinical medicine, oncology, geriatrics and gerontology, family medicine and community, pediatrics and anesthesiology, can receive specific additional training in palliative area. physicians interested should attend another year to receive the title of palliative doctor, that will be offered by the Brazilian Medical Association (AMB), according to Resolution 1973/2011 of the Federal Council of Medicine (CFM)⁴.

The lack of preparation in facing situations in which patients are in the final stage of life leads to a large loss in the relationship between health professional and patient. Professionals feel helpless for not meeting the goal in curative medicine and the patient is helpless for not having the

necessary support in a large frailty situation⁷. Issues such as death and PC are poorly addressed in health professionals undergraduation course.

Death came out of the houses and settled in hospitals, which are not always prepared to address this issue and do not have professionals with knowledge and experience to approach it⁸. The development units and PC study groups at universities grows slowly, being of great importance that, even at the university, the students learn both the theory and the practice of PC, to deal with the complexity and challenges of the experienced situations.

According to ANCP data, medicine undergraduation in Brazil does not teach how to deal with the terminally ill patient, how to recognize the symptoms and how to manage this situation in a humanized and active way. In the multidisciplinary team, the physician has the function to provide clarification of diagnosis and prognosis for the patient, guide the team, and maintain good communication with those involved. Therefore, when it can no longer heal, it is still possible to take care and have a good relationship between physicians and patients⁴.

With the increase in life expectancy in recent decades⁴, the process of living was prolonged and, therefore, it is possible to understand that death, most of the time, is no longer a fact, but a process, sometimes long and painful. Along with the extension of life, health professionals began to realize that even with no cure, there is a possibility of care, with an emphasis on quality of life and patient care through interdisciplinary care, and approach to family members who share this process and the final moment of life. The objective of this paper is to reflect about palliative care in medical training.

METHOD

This is a reflection that was based on internship experiences of a medicine course from a university in the state of Minas Gerais.

It is reflected, from the livings of academics of the tenth period, about PC in a referral hospital in oncology, in the months of September and October 2017, during the

Medicine internship. On that occasion, adult patients and family or their companions were interviewed, who had advanced cancer in palliative care.

RESULTS

The experiences with PC were through the weekly activities of the internship, when a group of twelve students subdivided into pairs, being each one responsible for evaluating and interviewing a patient already in PC. After contact with the patient, the students met with the preceptor to discuss the cases covered.

During the discussions, questions as a prognostic, analgesia methods and perspectives of treatment were raised. The students had theoretical lectures previous to the practical approach on principles and origin of palliative care, leading names in the subject, as well as update on what has been practiced in Brazil and worldwide.

The experience allowed the perception of how much can be done to treat someone in PC, far beyond the physical and psychological pain, and dealing with spiritual and social aspects, so important and neglected in conventional health care.

This close and real living experience with palliative care contributed decisively to maturity and emotional control in the face of situations that required many health professionals.

Having contact with these delicate situations even during academic training, with support of experienced professionals leading and guiding the approach, allowed the scholars to building concepts and developing of practical and theoretical background to later cope better with similar circumstances in working life.

DISCUSSION

Academics, when experienced PC in practice, understood how important the person-centered care is and how much should be valued. By proposing a care plan together with the person (patient and his family), in a negotiated manner, the patient shall be understood as an existing and autonomous being¹⁰.

For a long time the biomedical model was constituted so that the health was the absence of disease and, therefore, applied to the formation. Recently, the humanization of health care and the biopsychosocial model has been gaining ground. The attention of human order is more than called than technical knowledge on the part of customers.

In terms of medical training, universities segment knowledge and end up losing focus on the formation of the individual. At the opening of a congress of STFM (Society of Teachers of Family Medicine) in 2005, it was compared the medical education to a horse, in which various anatomical, functional and metabolic metrics are closely studied and presented, but never bother to know the horse - the animal may be dead, but continues to measure it without noticing the fact¹⁰.

The medical school curriculum still lacks human training and thrives for the technical information. This said, the focus is on the treatment and diagnosis. When death is inevitable, the sensation that arises is of professional failure. For academics, this may represent an obstacle in real life, when it is common to not have a conduct to a patient with a poor prognosis.

Talking about death involves mysteries and taboos; however, the definition of dying is changing with time. It was recently introduced the contemporary model of death, marked by the commitment to make the end of life a decent time, with full assistance, giving voice to the patient and allowing him to make choices and guaranteeing a death as possible.

The *good death* is the term used in scenarios involving painless death, in accordance with the patient's wishes, in the home environment without suffering and in a harmony environment. Each physician forms his own conception of death, by means of culture, family traditions and personal research.

Death triggers feelings both in the patient and health professionals. Ideally, the physician should understand what the patient feels, identify with him, but do not suffer as him – a goal rarely achieved. It is said that with time the physician is hardened by death, and

no longer let it affect him. However, considering the students in training, separating the personal from the professional can become a challenge.

In a survey of medical students in 2010, in Porto Alegre, through interviews about their perceptions and knowledge towards death and dying, it was found that students in training learn to compromise with life instead of death. The training received is to heal and, when death presents itself, generates feeling of frustration and failure. As alternatives to try to improve this failure, it was proposed to create discussion spaces of emotions generated before such situations¹¹.

The PC advocate humanizing the professional-patient-family relationship. In practice, they correspond to the interventions in the overall health of the patient performed by a multidisciplinary team that works on several levels, from the home to the hospitalization in institutions.

The Palliative Medicine is not intended to cure, but seeks to provide comfort and control of physical, emotional, social and spiritual symptoms of the patients and their families. It involves skills of a multidisciplinary team that helps the patient and family to adapt to life changes imposed by the disease and pain, and promotes the necessary reflection to face this life-threatening condition. In PC, the focus is out of the disease and on the patient - doctor and patient must work together and it is up to the professional guide without coerce, show the benefits and disadvantages of each form of intervention in an accessible way to the understanding of the patient.

In the current academic education, one of the major shortcomings is the lack of discussion of death and palliative care. It may be hard for the student, taught to mechanically think of the disease and not the patient, accepting and distinguish what can be cared from what is curable. Many doctors feel afraid to address the issue, fearing being misunderstood. Discuss topics such as death, finitude and palliative care openly can help to consolidate the training of the individual as a human being, besides a physician.

CONCLUSION

Living the PC during medical training is essential these days. Being a still new and little known area, it is a challenge for professionals trained in traditional medicine, who did not have preparation and experience with this universe, especially when having to conduct terminal cases in palliative care.

After the regulation of Palliative Medicine as a medical subspecialty, one needs to worry about the academic training, because one realizes that graduation in the current models do not prepare well these professionals to care for patients without conventional therapy perspective.

The process of human terminal illness should not be seen as a problem in health care, since it is a natural process and needs to be inserted in the curricula and approached more times within the disciplines and practice. For this, one must reformulate the teaching, focusing content on subjectivity and humanization. Thus, the professional will find greater security and emotional balance when facing the end of life situations and the patient will live more actively when receiving the quality of care they are entitled, without having his death hurried or delayed.

Therefore, it is essential that there is the union of theory and practice: they are learning faces that complement each other to form a competence that can be applied to challenging real-world situations. Both are equally important and contribute each one in their own way, to help a professional to be better at what he does.

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CONTRIBUTIONS

Aline de Freitas Mateus was responsible for the design, bibliographic survey and writing. **Júlia Bugatti Crepaldi, Raquel da Silva Moreira** and **Milena Dionízio Moreira** contributed with the bibliographic survey and writing. **Adriana Batista Alves Martins** participated in the guidance and review.

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