

The essence of interdisciplinary practice in palliative care delivery to cancer patients

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Abstract

Objective. To get to know interdisciplinary practice in the Oncology Interdisciplinary Home Hospitalization Program (PIDI) health team. **Methodology.** This qualitative research involved nine professionals working in this program, in the South of Brazil, who delivered palliative care to cancer patients. Data were recollected in 2009 through observation and focal groups, and analyzed through the thematic analysis technique. **Results.** Two categories emerged: interdisciplinary practice in the PIDI is a permanent construction process and palliative care in interdisciplinary practice. This program was characterized by: workers' interaction in an interdisciplinary focus, integration of actions and knowledge, establishment of dialogue, horizontal power relations in the team, respect for other people's knowledge, colleagues and limits of their performance, collective and continuous learning, and internal motivation to defend a practice based on the quality of patients' life and death. **Conclusion.** The integration of interdisciplinary palliative care practice is innovative and can improve care quality and contribute to the satisfaction of professionals working with patients who need this type of care.

Key words: nursing; patient care team; hospice care.

La esencia de la práctica interdisciplinaria en el cuidado paliativo a las personas con cáncer

Resumen

Objetivo. Conocer la práctica interdisciplinaria en el equipo de salud del Programa de Internación Domiciliar Interdisciplinario (PIDI) Oncológico. **Metodología.** Investigación cualitativa realizada con nueve profesionales en este programa, en el sur de Brasil, que proporcionan cuidados paliativos a las personas con cáncer. Los datos fueron recolectados en 2009 mediante la observación y grupos focales. Se analizó con la técnica de análisis temático. **Resultados.** Surgieron dos categorías: la

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práctica interdisciplinaria en lo PIDI es un proceso en construcción permanente y, los cuidados paliativos en la práctica interdisciplinaria. Este programa se caracterizó por la interacción de los trabajadores en un enfoque interdisciplinario; integración de acciones y conocimiento; establecimiento del diálogo; relaciones horizontales de poder en el equipo; respeto al conocimiento de otras personas, compañeros de trabajo y límites de su rendimiento; aprendizaje colectivo y continuo; y, finalmente, motivación interna para defender una práctica basada en la calidad de vida y muerte de los pacientes. **Conclusión.** La integración de la práctica interdisciplinaria en cuidados paliativos es una acción innovadora, capaz de mejorar la calidad de la atención, y de contribuir a la satisfacción de los profesionales que trabajan con los pacientes que requieren este tipo de cuidados.

Palabras clave: enfermería; grupo de atención al paciente; cuidados paliativos.

A essência da prática interdisciplinar no cuidado paliativo às pessoas com câncer

■ Resumo ■

Objetivo. Conhecer a prática Interdisciplinaria na equipe de saúde do Programa de Internação Domiciliária Interdisciplinaria (PIDI) Oncológico. **Metodologia.** Investigação qualitativa realizada com nove profissionais neste programa, no sul do Brasil, que proporcionam cuidados paliativos às pessoas com câncer. Os dados foram coletados em 2009 através de observação e grupos focais e, analisou-se com a técnica de análise temática. **Resultados.** Surgiram duas categorias: a prática interdisciplinaria no PIDI é um processo em construção permanente e, os cuidados paliativos na prática interdisciplinaria. Este programa se caracterizou por: a interação dos trabalhadores num enfoque interdisciplinario, integração de ações e conhecimento, estabelecimento do diálogo, relações horizontais de poder na equipe, respeito ao conhecimento de outras pessoas, colegas de trabalho e limites de seu rendimento, aprendizagem coletiva e contínuo e, motivação interna para defender uma prática baseada na qualidade de vida e morte dos pacientes. **Conclusão.** A integração da prática interdisciplinaria em cuidados paliativos é uma ação inovadora, capaz de melhorar a qualidade do atendimento, e de contribuir à satisfação dos profissionais que trabalham com os pacientes que requerem este tipo de cuidados.

Palavras-chave: enfermagem; equipe de assistência ao paciente; cuidados paliativos.

Introduction

Interdisciplinarity is understood as an intrinsic need to refer health practices, through knowledge integration, permitting diverse perspective, the acknowledgement of the complex nature of phenomena and greater coherence in the materialization of integrality.¹ This assertion triggers new challenges for researchers and health professionals, in the epistemological as well as methodological and care spheres, without leaving aside the support for health production practices and organization. In response to this reality, the different specialties offered in health services have contributed to understand workers' thinking,

knowledge and actions, in a complex task that implies agreements among various scientific knowledge areas and articulated action among different professionals, as a fundamental condition for health care.² In this sense, the aim of palliative care is to deliver specific actions to cancer patients, who are in physical, psychological, spiritual and social suffering, demanding a set of active and holistic multiprofessional actions for people whose disease no longer responds to curative treatment, with the main goal of guaranteeing the best possible quality of life and

death, through symptom control for users as well as their respective relatives and caregivers.³

That is the perspective for the actions of the Oncology Interdisciplinary Home Hospitalization Program (PIDI) health team, set up in 2005, which accomplishes its different professional tasks in search of a common goal – to deliver palliative care to their work object – human beings with terminal cancer, completing the holistic care cycle. The Program is located in Pelotas, South of Brazil, at the teaching hospital of Universidade Federal de Pelotas (UFPel). The hospital is a referral institution for cancer treatment in the Unified Health System (SUS). The physician who coordinates the program and an administrative aid work at the PIDI headquarters. In addition, the referral team consists of: one physician, nurse, social worker and two nursing technicians, who visit hospitalized patients twice a day, and a matrix team: nutritionist, psychologist, surgeon, theologian, who visit patients weekly. It should be highlighted that the aims of the Program are to complement cancer care offered at the UFPel units; act within an interdisciplinary perspective; humanize palliative care to users and relatives; deliver global care; include teaching, research and community service in the care process; and permit the expansion of the ten hospitalization beds in the home context.

Thus, palliative treatment for cancer patients, a chronic and progressive disease that increases with the aging of the Brazilian population, presupposes continuous and comprehensive care, which implies interdisciplinary actions, aimed at individuals, families and caregivers. Hence, the interdisciplinary nature and different perspectives of care should be understood, acknowledged and used with a view to more comprehensive knowledge and action.⁴

In view of the above, this study aimed to get to know interdisciplinary practice in the Oncology PIDI health team. This study is considered relevant as a better understanding of this practice can contribute to health and cancer nursing, understanding situations that emerge in the flow of human interactions in the care process, enhancing reflections about elements inherent in interdisciplinary actions, such as knowledge integration among professionals, recognizing different

subjects' limits, respecting other people's and colleagues' knowledge and horizontal power relations in the team; it can also provide quality of life and death in palliative care delivery to cancer patients.

Methodology

This qualitative study involved nine health team professionals working in the Oncology Interdisciplinary Home Hospitalization Program (PIDI) health team located in Pelotas, a city in the South of Brazil. Participants were: nurse, nursing technician, nutritionist, team coordinator-physician, surgeon, social worker, theologian, administrative aid and graduate psychology student. The research received approval from the Research Ethics Committee at the School of Nursing, Universidade Federal de Pelotas/RS (UFPel), protocol number 16/2009. All ethical procedures required in National Health Council Resolution No. 196/96⁵ were complied with. Participants were identified through abstract terms they had chosen.

Data were collected in June 2009 through passive observation and focal groups, which consists in a study of different health groups and work processes' representations and relations.⁶ It should be informed that the research aim was addressed through a 50-minute meeting and 50 hours of observation in the morning shift. Thematic analysis was chosen to treat the data, which refers to the transcription of conversations recorded in the focal group, data interpretation, ordering, classification and final analysis,⁶ revealing the following themes: interdisciplinary practice in the PIDI: a process in permanent construction and palliative care in interdisciplinary practice.

Results

Interdisciplinary practice in the PIDI: a process in permanent construction

The participants mentioned their experiences in the constitution of the PIDI team and, thus,

refer to the characteristics and changes in their work processes, with a view to the collective construction of interdisciplinary practice. Some essential elements of interdisciplinary palliative care practice were appointed in the group: *At the ICU, you may even consider “biprofessionalism”, in which the physician and nurse can stand out in that environment but, in home hospitalization and palliative care, interdisciplinarity is essential. When we aim to improve the user’s performance, you are unable to work at the level of physical, spiritual and social symptoms without working in group [...] without different professionals’ activities [...] interdisciplinary is our flagship (Vocation).*

In the following statement, the collective construction of care in the team is identified: *In another team experience, multiprofessional, it works too, we even give our opinion [...] but it’s not as organized as in the PIDI, because here we’ve got clinical case discussion rounds and other group activities (Charity). As if it were support, [...] a place as a team member, open, each with his own importance, but all in the same way. You need to work interdisciplinarily, but always respecting and accepting that each has a knowledge sphere and that this knowledge should join instead of compete. And, thus, the PIDI has an interdisciplinary team. Thus, through this respect and joint work, interdisciplinarity is achieved, otherwise it’s just multiprofessional and, sometimes, people mix up things (Rescue).*

In the following testimony, the collaborative work that is peculiar to interdisciplinary practice is appointed: *I find this interdisciplinary integration important, which enhances comprehensive care to users’ needs (Sympathy).* The professionals highlight some significant devices for care management in an interdisciplinary focus: *we proposed interdisciplinarity, but we didn’t call it Singular Therapeutic Project, referral and matrix team, we used other names: support team, which is name that Gastão Campos [expert in the area] also describes today as interdisciplinary work and how the work method happens. Because interdisciplinarity really gives strength to keep up teamwork, the team meeting itself and clinical*

case in view of the user’s terminality – our italics (Solidarity). This interdisciplinarity issue has been described in decree 2.529, issued in October 2006, which established Home Hospitalization in the SUS context and was founded by the main and matrix team. The main team should include a physician, nurse and social worker, while the matrix team is defined according to the service’s vocation, and may consist of a psychologist, nutritionist and physiotherapist (Vocation).

The following statements illustrate the recognition of the means PIDI workers used to adapt to interdisciplinary work: *My PIDI activity is as a volunteer, integrating this project [...] of all of us who like the them, motivated by the personal desire to put in practice [...] I think that things are coherent and show results (Sympathy). I’ve already worked in a hospital and perceived that the central figure of the physician exists, while other professionals are the rests of the team. Today, the physician is no longer the core figure in the team (Sincerity).*

Palliative care in interdisciplinary practice

Palliative care in interdisciplinary practice involves the multidimensionality of cancer patients when death is imminent, demanding some singularities of health care delivery by PIDI professionals. One professional appoints the recognition of the activity space: *We came from a culture that is strongly based on the biomedical model. In the PIDI, even when acting in the support theme, we feel that we have a place. That is very important and I haven’t seen that anywhere else (Rescue).*

Palliative care aims to grant users quality of life and death, as one participant highlights: *What’s important is that you are able to make the user’s terminality dignified (Solidarity).* In that sense, PIDI professionals express the holistic nature of palliative care delivery to users, caregivers and relatives, through interdisciplinary practice: *[...] seeing to individual patients and in group to mourning caregivers and family members, besides accompanying them and orienting them with regard to their rights in social policies (Sincerity).*

[...] I stimulate, help hospitalized patients [...] to develop their own and their relatives' spirituality. Because, the PIDI has a professional to address the mind, body and [...] the spiritual. As the team acts with comprehensive care to human beings, PIDI professionals are aware of that (Hope).

Palliative care integrates care peculiarities, as evidenced in the following report: *I would like to have more time to better address the post-mourning with users' relatives. It is important to be able to respect to user's space and will (Hope).*

Discussion

Concerning the theme of interdisciplinary practice in the PIDI, as a process in permanent construction, the participants' testimonies express **professional recognition in the care environment** put in practice in the PIDI. When the PIDI is compared with other work places, the valuation of workers becomes visible, with their different scientific knowledge inherent in various specialties and possibilities of clinical and therapeutic interventions among cancer patients in view of an imminent death.⁷

These reports highlight that oncologic palliative care addresses the control of multiple symptoms, with a view to improving the condition and relief of suffering – performance of its clients, entailing the need for various professionals' actions and for the organization of the work process, considering instruments like clinical case discussions, aka *rounds* – which allow workers to study the case of each hospitalized user.

Also, distinct characteristics⁸ of multidisciplinary and interdisciplinary teamwork modes are highlighted. In the first, professionals from different areas act separately, generally without cooperation and information exchange. In interdisciplinary work, on the other hand, reciprocity and mutual enriching exist, tending towards the horizontality of power relations among the professionals involved, permitting the exchange of affection

and knowledge about the knowledge areas. In this mode, also, clear and common objectives need to be established in palliative care delivery to cancer patients. The testimonies permit the understanding that one learns to work in teams, joining different professions, with a view to the collective construction of languages or a common work organization culture.⁹

In this respect, interdisciplinary actions approach theoretical formulations, in which terminal cancer patients are conceived with several difficulties, like the control of pain and other physical, emotional or spiritual symptoms. That is, multidimensional, demanding each team member's competency in his/her activity area, besides the establishment of an **efficient communication process**, based on dialogue, which represents an important instrument for interdisciplinary palliative care practice.¹⁰

Therefore, dialogue represents an existential need, in which people mediatized by the world meet in solidarity, with a view to pronouncing and transforming it, so that it cannot be reduced to one subject's simple deposit of ideas into the other, but a joint construction, an act of creation, as it is not in silence that individuals are constructed, but in words, work, action and reflection.¹¹ The dialogue is envisaged as a tool that facilitates interdisciplinary practice, as it can approach professionals, avoiding oppressive relations that impair the dynamics of work.

One report shows essential elements of interdisciplinary work, including knowledge integration, the recognition of each professional's activity limits in view of the goal of user care, respect for other people's and colleagues' knowledge and horizontal power relations in the team. The PIDI reveals a privileged space in which workers' individual contributions go beyond scientific and specific knowledge, towards partnerships among the stakeholders.

In the collective construction process of interdisciplinary work, it is fundamental to consider the role of each professional in the team, understanding the potentials and limitations of each subject area, without hierarchical judgement,¹² representing the horizontality of power relations, a

characteristic that is capable of enhancing group activities and the democracy process in decision making.¹⁰ In one testimony, collaborative work is appointed, through **integration, the coordination of actions and knowledge and interaction among professionals**, with a view to reaching the common goal – holistic care delivery to cancer patients' health needs, characterizing peculiarities of interdisciplinary practice.

Knowledge integration and articulation among actions picture connections among different activities, which are active and consciously evidenced by the performing agents.⁹ And interaction among the subjects is based on communicative practice, characterized by the search for consensus, through which professionals can mutually discuss the daily work performed, furthering joint action planning in the constitution of a common care project.⁹

Team interaction, integration and communicative practice were elements identified in the PIDI, based on which interdisciplinary practice can be improved as through work tools, like the unified and integrated patient file, used during professionals' joint care delivery – the inter-consultation, the Singular Therapeutic Project (PTS), matrix support team, round. The construction of the PTS takes place in experience exchanges, like clinical case discussions, which are consolidated through team meetings. Also, the formation of Referral and Matrix Teams is considered a relevant proposal due to the combination between the objectivity of clinical care and the singularity of subjects and groups. Thus, workers reach the diagnoses and establish palliative treatment in view of terminal cancer patients' symptoms, in a shared manner. The testimonies evidence the professionals' concern with and commitment to the insertion of interdisciplinary practice into their work process, based on adherence to spaces that enhance discussions and reflections on the users' health condition, with a view to contributing to care continuity. These spaces aim to enhance each team member's autonomy, active participation and co-accountability, in the attempt to preserve the singularity and multidimensionality of cancer patients as human beings who need care.

Also, the permanent education and efforts of the stakeholders involved in professional qualification is highlighted, including the legal bases for the constitution of the PIDI team in the Unified Health System (SUS). This investment in the stakeholders' professional development can derive from interdisciplinary practice itself, when the subjects are motivated to gain new technical and pedagogical skills and to improve actions jointly.

It should be mentioned that the PIDI members, through the knowledge a professional gained in the specialization program in SUS Humanization and Management, incorporated concepts recommended by the Ministry of Health's Expanded Clinic,¹⁴ whose proposal to reorganize work processes originated in the National Humanization Policy (PNH) document. In the PNH, the diagnosis is multidimensional, permitting conclusions about users' risks and vulnerabilities, paying attention to how individuals behave in view of forces like diseases and desires, under the influence of family members and caregivers. This process refers to a joint construction, loaded with professionals' feelings and desires, in a cycle that self-stimulates them to act in defense of terminal cancer patients' quality of life and death. They also envisage comprehensive care, which goes beyond the hierarchized organizational structure of health care, extends into the problem-solving ability of individual and collective care guaranteed to SUS users and demands commitment to continuous learning through interdisciplinary contact.¹³

Collective learning in the PIDI, based on the great problem-solving potential and satisfaction it can provide to users and professionals,¹⁴ is revealed in the annual elaboration of seminars about interdisciplinary practices, palliative care, home care to cancer patients, and workers' recycling in *lato sensu* and *stricto sensu* graduate courses. Thus, the sense of collective construction attributed to learning distances it from practices that promote one person's depositing of information in the other, in which knowledge is characterized as a donation by those who consider themselves wise to those who consider they know nothing.¹¹

The subjects' interaction and knowledge integration permit collective learning, which

disseminates **growth, mutual enrichment and professional satisfaction** in the PIDI team, as interdisciplinary actions demands two or more people with their different knowledge, who are interested in interacting and socializing their knowledge. This point seems to be determining: the internal motivation, i.e. wanting to transfer knowledge to affirm teamwork. In this process, it is essential to recognize the means by which individuals constructed their interactions with other people throughout their lives, excelling by overcoming their individuality in their thinking, knowing and acting, as a result of their education, or being able to reconstruct them collectively in the team, with a view to adapting the subjects to interdisciplinary work.¹⁵

In the constitution of interdisciplinary work, the core figure of a single professional does not exist, as a group of linked subjects share multiple and common objectives, defined under the coordination of a superior hierarchical level,¹⁶ introducing the horizontality of power relations and the finality notion of palliative care for cancer patients in the program analyzed.

In the theme about palliative care in interdisciplinary practice, it is important to consider the multidimensional nature of cancer patients. These people are at home and face the imminence of death, which permits the **expanded construction of holistic care**, attending to health needs in different professional interventions, as holistic care delivery is opposed to the fragmentary and reductionist approach of individuals. Thus, comprehensive, interactive and high-quality care production breaks with the biomedical education model, transforming professional practices and the organization of the service network.¹⁷ Therefore, a complementary professional perspective is needed to adapt or maintain the models to understand life and health, to the extent that these groups participate actively in decisions about care delivery to cancer patients.¹⁸ Team members need to promote dialogical practices in their work environment, which facilitate the exchange of knowledge, affections, co-accountability, with some decision power in the organization, mainly regarding the teamwork process,¹⁴ including the recognition of the activity space.

In view of this situation, a meeting space exists where care actions are elaborated, in which each professional can have decision power. Thus, the professionals demonstrate interaction and the subject's view, the object of their work, on broader bases, attending to interdisciplinary activities in the palliative care team. The PIDI team executes health actions within a new focus, adopting a work process that permits palliative care delivery to cancer patients in a continuous and comprehensive manner, expanding the interfaces to be managed and to raise new difficulties and challenges in the field of professional competences.¹⁹ In that sense, the production logic of the PIDI service is not centered on the medical-curative conception, but on palliative care, whose aim is to provide **quality of life and death to users**, guided by the integration of procedures, care humanization and the singularity of health actions.

In the PIDI, another goal is maximum comfort and understanding, without the intent of cure, due to its impossibility, emphasizing the adequate control of symptoms and the different aspects involving human beings. Every two weeks, the Program also organizes a therapeutic group for caregivers and relatives of hospitalized users and another group for those in the mourning process. These groups provide support and information to these individuals at different times. Professionals contribute in their specific area to the common and final product of their work. In addition, during **care delivery to users, families and caregivers**, PIDI professionals are concerned with and respect the maintenance of the subjects' autonomy in decisions about the therapeutics, with the required needs, with their wellbeing in its different dimensions. Important and innovative scales are applied to reassess the care delivered and the interdisciplinary articulation among the stakeholders in this process, including the ESAS (Edmonton Symptom Assessment Scale), which included nine visual analogue scales on the following symptoms: pain, fatigue, nausea, depression, anxiety, sleepiness, appetite, wellbeing and dyspnea; and the Zarit Caregiver Burden Scale, which permits assessing the caregiver's objective and subjective burden and includes

information about health, social life, personal life, financial situation, emotional situation and type of relationship with the user. Thus, in the PIDI, holistic care, through interdisciplinary practice, is present through committed, humane and ethical care for users, families and caregivers.

The palliative care delivered to cancer patients involve a singularity that demands the consideration of several factors: social, economic; the physical, spiritual and psychic suffering of each person in view of his/her finiteness, so that they are valued and included in individual and family care. It is highlighted that the interface of each specialty with palliative care happens as needed and according to the clinical evolution, emotional condition, spirituality and particular social network in each case, as the objective of curing the individual no longer exists, as (s)he faces terminality, when the disease is progressing, irreversible and non-responsive.³ It is important to highlight that the key to humanized palliative care is each professional's ability to acknowledge the limit of his/her activities, so as not to cause suffering or create expectations of cure among users and their families, improving team care, which corresponds to the extrinsic interface of each specialty, i.e. it needs other professionals to be able to solve the problem.²⁰ In view of the above, it should be mentioned that the PIDI team practices a distinguished work process because it involves palliative care delivery to cancer patients, excelling by the quality of life it grants to users, families and caregivers through comprehensive and continuous care.

In view of the above, the PIDI team has potential elements of interdisciplinary practice, like the integration between knowledge and actions and interaction among professionals, i.e. experience exchange, knowledge socialization, joint planning, use of common language and effective communication. It was evidenced, though, that interdisciplinary practice only becomes possible when work division is reorganized, permitting joint and consensual decision making as a result of the horizontal development of power relations in the team, in which professionals feel that they have space to exert their opinion and autonomy

regarding the best form of palliative care delivery to cancer patients, enhancing holistic care and quality of life for users, families and caregivers. These characteristics favor and stimulate workers towards growth, reciprocity, mutual enrichment and personal satisfaction, in a collective and continuous learning movement that can be conducted by the subjects' internal motivation, as well as by respect for the other's discipline in the search for complementariness and the acknowledgement of each member's specific personal contribution in the team and of the different disciplines' limits.

The results strengthen the importance of this work proposal, making it fundamental to rethink humanized and interdisciplinary work in health and seeking continuous contributions to action-reflection, in which health is a right guaranteed by law, through the SUS. Although practice reveals a huge contradiction between these legally established social conquests and the crisis reality health users and professionals experience, strategies like comprehensive and multidimensional care delivery to users, families and caregivers can be pled, always promoting the relief of pain or symptoms deriving from degenerative, chronic and refractory diseases. Thus, the interdisciplinary team aims to enhance patients' quality of life and, nevertheless, also further the quality of death, promoting the best possible practice of patients' daily activities. Also, the deinstitutionalization of death needs to be conceived, giving terminal patients the possibility of choosing to stay at home during their agony and of a less sufferable and more dignified death.

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