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Original article

Assistance provided to hemato-oncologic patients in palliative care: perception of health team professionals*

Assistência prestada a pacientes hemato-oncológicos em cuidados paliativos: percepção de profissionais da equipe de saúde

Asistencia prestada a pacientes hemato-oncológicos en cuidados paliativos: percepción de profesionales del equipo de salud

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Abstract

Objective: To understand how health team professionals perceive palliative care in a hemato-oncological hospitalization unit. **Method:** A descriptive, exploratory, qualitative study was carried out with the multiprofessional health team of an adult hemato-oncological hospitalization unit of a university hospital located in the central region of Rio Grande do Sul. The data were collected between August and November 2022, through semi-structured interviews, and submitted to discursive textual analysis. **Results:** 12 professionals participated, three nurses, three doctors, two nursing technicians, a speech therapist, a physiotherapist, a social worker and a nutritionist. From the analysis of the interviews, two thematic categories emerged: Description of palliative care in hemato-oncology; and Multiprofessional vision on palliative care: experiences and implications. **Conclusion:** Professionals perceive and act in the perspective of carrying out actions that contemplate palliative care integrated into the assistance provided in the context of hemato-oncology.

Descriptors: Palliative Care; Patient Care Team; Medical Oncology; Professional Practice, Nursing

Resumo

Objetivo: Compreender como os profissionais da equipe de saúde percebem os cuidados paliativos em uma unidade de internação hemato-oncológica. **Método:** Estudo descritivo, exploratório, qualitativo, realizado com a equipe multiprofissional de saúde de uma unidade de internação hemato-oncológica adulto de um hospital universitário, localizado na região central do Rio Grande do Sul. Os dados foram coletados entre agosto e novembro de 2022, por meio de entrevistas semiestruturadas, e submetidos a análise textual discursiva. **Resultados**: Participaram 12 profissionais, sendo três enfermeiros, três médicos, dois técnicos de enfermagem, um fonoaudiólogo, um fisioterapeuta, um assistente social e um nutricionista. Da análise das entrevistas emergiram duas categorias temáticas: Descrição dos cuidados paliativos em hemato-oncologia; e Visão multiprofissional sobre os cuidados paliativos: vivências e implicações. **Conclusão:** Os profissionais percebem e atuam na perspectiva de realizar ações que contemplem os cuidados paliativos integrados na assistência prestada no contexto da hemato-oncologia.

Descritores: Cuidados Paliativos; Equipe de Assistência ao Paciente; Oncologia; Prática profissional; Enfermagem

Resumen

Objetivo: Comprender cómo los profesionales del equipo de salud perciben los cuidados paliativos en una unidad de hospitalización hemato-oncológica. **Método:** Estudio descriptivo, exploratorio, cualitativo, realizado con el equipo multiprofesional de salud de una unidad de ingreso hemato-oncológico adulto de un hospital universitario, ubicado en la región central del Rio Grande do Sul. Los datos fueron recogidos entre agosto y noviembre de 2022, por medio de entrevistas semiestructuradas, y sometidos a análisis textual discursivo. **Resultados:** Participaron 12 profesionales, tres enfermeras, tres médicos, dos técnicos de enfermería, un fonoaudiólogo, un fisioterapeuta, un asistente social y un nutricionista. Del análisis de las entrevistas surgieron dos categorías temáticas: Descripción de los cuidados paliativos en hemato-oncología; y Visión multiprofesional sobre los cuidados paliativos: vivencias e implicaciones. **Conclusión:** Los profesionales perciben y actúan desde la perspectiva de realizar acciones que contemplen los cuidados paliativos integrados en la asistencia prestada en el contexto de la hemato-oncología.

Descriptores: Cuidados Paliativos; Grupo de Atención al Paciente; Oncología Médica; Práctica Profesional, Enfermería

Introduction

According to the National Policy of Palliative Care (PNPC - *Política Nacional de Cuidados Paliativos*), within the Unified Health System (UHS), palliative care is understood as actions and health services aimed at pain relief, of suffering and other symptoms in people facing diseases or health conditions that threaten or limit the continuity of life.[1] From this perspective, This is a care philosophy that includes a set of therapeutic approaches aimed at monitoring and alleviating the symptoms caused by illness.[1]

These approaches, which should start early, holistic and patient-centered, are considered urgent for people with cancer and other chronic diseases, as they are estimated to provide relief from physical, psychosocial and spiritual symptoms in more than 90% of cancer patients. Thus, the PC, in their origin, refer to the idea of the impossibility of cure, being, today, enlarged and replaced by the concept of treatments that modify the disease, removing, therefore, the mistaken notion of not having more to do.[2]

From this perspective, PC are more than an approach to death and dying. They involve comprehensive care, as early as possible, to people who have serious diseases that limit or threaten life and can potentially generate suffering throughout its course, as occurs in oncological diseases.[3] Depending on the type of neoplasia and stage in which it is found, this approach should be conducted by an interdisciplinary team from the beginning of the course of the disease, along with active cancer treatment, not being limited only to the end of life.[3]

Evidence indicates that in Brazil, 704 thousand new cases of cancer are expected for the three-year period 2023-2025. Except for non-melanoma skin cancer, there will be 483,000 new cases. Female breast cancer and prostate cancer were the most prevalent, with 73,000 and 71,000 new cases, respectively. Then the colon and rectum (45 thousand), lung (32 thousand), stomach (21 thousand) and cervical cancer (17 thousand).[4] These data refer to a context in which the PC may be present during the treatment implemented.

In this sense, it is highlighted that the PC have particular importance to patients with oncological diseases, as these care include and integrate the oncologic therapy, optimizing the performance status, functioning, symptom control and quality of life, in addition to improving adherence, i.e., consent to treatment, and therefore the well-being of patients and their families.[5-6]

By adopting the PC, there is also a humanized look for the family of the cancer patient, which often has direct action in care, in addition to the psychological suffering caused by the diagnosis of their loved one. By understanding that the family scenario is modified to give space to the frail individual and his or her family caregiver, it is identified how PC can help in the adaptations necessary to care for him or her, understanding their demands, as well as welcoming individuals suffering from the diagnosis.[7-8]

In this logic, a study carried out with a multiprofessional team as care mediator emphasizes that there is a need for dialogue on the issue in society and, especially, in the training of professionals contributing to the improvement of assistance to care units.[9] Another investigation, conducted with a multiprofessional intensive care team, points out that the performance of the multidisciplinary team in PC is also essential in this unit.[10]

This integrated approach, involving health professionals from various areas, aims at symptomatic control and provides emotional support, respecting the individual needs of the patient and their families. Effective communication, pain relief and promotion of quality of life are essential pillars in this context, with emphasis on interdisciplinary collaboration to address the complex challenges faced by cancer patients.[10]

Based on the above, this study has as research question: How do professionals of a hemato-oncologic unit perceive palliative care in their practice? To this end, the aim was to understand how professionals of the health care team perceive palliative care in a hemato-oncological hospitalization unit.

Method

This is an exploratory descriptive study with a qualitative approach that followed the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ).[11] Data collection was carried out between August and November 2022, with the multiprofessional health team of an adult hemato-oncologic hospitalization unit of a university hospital located in the central region of Rio Grande do Sul, Brazil.

The institution serves in its entirety by SUS and is defined as a High Complexity Oncology Care Unit (UNACON), with services of Radiotherapy, Hematology and Pediatric Oncology, and since 2017, has the performance of the Matricial Team of Palliative Care.

The hospitalization unit provides assistance to patients with hematological, oncological and cardiovascular diseases. When the study was carried out, the multidisciplinary health team that worked in the unit had 36 professionals, including eight nurses, 14 nursing technicians, four nursing assistants, four medical assistants and one professional from the areas of nutrition, physiotherapy, social assistance, psychology, speech-language therapy and dentistry.

The selection of participants was intentional and not probabilistic and adopted as inclusion criteria: middle and higher health professionals who were working in the service for at least three months. Were excluded professionals on leave, vacation or removed from the service during the period of data collection.

As for the professional groups with more than one member of the same area, it was established that the interview would be carried out with a professional of each shift. Professionals were invited to participate in the research at a service meeting. At that time, the research, objectives and ethical aspects were presented and, with those who agreed to participate, an individual date was scheduled with each participant for the data collection.

The data were collected from a semi-structured interview conducted by the first author, a graduate student, who acts as a nurse in the hospital investigated. An interview script was prepared, which was previously tested, with closed questions about biological sex, religion, occupation/profession, training time, titration and time of action in hemato-oncology, for the characterization of the sample.

There were also questions that addressed the following guiding axes: understanding of palliative care; perception about palliative care actions developed in the unit; what would be considered essential and what was implemented in the care of patients in palliative care; feelings that refer when providing assistance to patients in palliative care; instrumentalization and preparation to care for patients who need palliative care; Interaction of the team when providing assistance to patients in palliative care; actions developed in the unit that could be considered as palliative care; and indication of factors that influence the indication of patients to receive palliative care.

The interviews were conducted in a room reserved in the study setting, ensuring a private, safe and airy environment that provided confidence and freedom for the participant to express himself, and recorded with the aid of a digital device and subsequently transcribed in full. The average length of interviews was 40 minutes.

Each interview was identified with the code referring to the first letter of the interviewee’s professional core followed by an Arabic numeral, in the order in which the interview took place, for example, nursing technician 1 – "NT1", physiotherapist – "P10", in order to ensure confidentiality as to the identity of the participants in the research.

The data treatment was carried out through Discursive Textual Analysis[12].This format of data analysis is organized in four central focuses. The first three make up a cycle, in which they constitute as main elements, being: the disassembly of texts, the establishment of relations and the capture of the new emergent. The fourth focus is presented as the construction of self-organized process.[12]

It should be noted that the treatment of the data had the concepts of palliative care and the performance of the multiprofessional team, to support their analysis.

Starting from the above, objectively, the disassembly of the texts occurred, rewriting the interviews in full, carried out the retrospective movement with the establishment of relations and, subsequently, elaborated a table with the categorization with units of meaning. And, in this way, it was possible to build the self-organized process, which resulted in three final categories. Thus, it was determined the constitution of 89 sense units, resulting in the formation of 10 initial subcategories that supported the organization of two final themes.

Resolutions 466/2012[13], 510/2016[14] and 580/2018[15] of the Ministry of Health regarding research with human beings were respected. The research project was approved by the Research Ethics Committee on September 3, 2022, under the Consubstantiated Opinion n. 5.623.183 and Certificate of Presentation of Ethical Appreciation n. 60576522.3.0000.5346. Participants signed the Informed Consent Form, and were informed about the risks and benefits of the research.

Results

Among the 12 professionals who participated in the survey, 11 were female and one male. As for religion, three self-declared as Spiritists and nine, as Catholics. Regarding the professional group, three nurses, three doctors, two nursing technicians, a speech therapist, a physiotherapist, a social worker and a nutritionist were interviewed. Of these, two had a master's degree and the others, postgraduate in specific areas such as hemato-oncology, oncological nursing, oncology, hematology, hospital management with emphasis on hemato-oncology, health services management and public health. The time spent in the hemato-oncology hospital ranged from 2 to 15 years of care.

The analysis of the interviews resulted in the organization of two thematic categories: Description of palliative care in hemato-oncology; and Multiprofessional vision on palliative care: experiences and implications.

Description of palliative care in hemato-oncology

Health professionals perceived PC as an integral approach to the needs of a person with terminal cancer, with the aim of promoting better quality of life and respect for patient autonomy. They considered that this approach should be instituted from the diagnosis of the disease without a prognosis of cure. They also understood palliative care as a dynamic approach, because the needs of the patient vary according to the evolution of the disease, and the team must organize itself to meet the different demands that may arise in this process.

> *I understand that the care initiated from the patient's diagnosis, where it is assessed that the prognosis may not be so good, and where measures are taken that respect the patient's autonomy and wishes. And that it is always made very clear that there is no prospect of a cure and that the prognosis is not so good. That the family is also involved in this matter. And that its main objective is to maintain the patient's quality of life. (N2)*
>
> *PC refers to the care we must offer when a patient has been diagnosed with an incurable disease, and it will encompass not only the initial treatment for the patient in relation to the tumor, but also considering that this patient will have other needs. As the end-of-life process approaches, they will experience more pain and more difficulty controlling symptoms. It involves assessing the patient's family, how they will be at home; it is a constant assessment that changes throughout the treatment and becomes more attentive, as the patient becomes more symptomatic of the disease and the treatment focused on the disease becomes less focused. It will take care of the psychological aspect, understanding him, the symptoms, etc. (D9)*
>
> *PC, in my view, is about providing quality of life for the patient when there is a diagnosis of an incurable disease, providing support and care in that phase when curative treatment is no longer available. It would be a little before comfort, because, for me, palliative care comes well before comfort. It's when therapeutic treatment is no longer available and you move on to other lines of treatment, which would be to ensure comfort, good nutrition appropriate to the patient's needs and desires, the issue of positioning and movement related to physiotherapy, whatever is most comfortable for the patient, having this line of reasoning to try to improve his quality of life. (P10)*
>
> *PC is patient-centered care, focused on the patient, encompassing the spiritual*

> *and social aspects, but, for me, it's centered on the patient, with a broader, biopsychosocial-spiritual perspective. (Nu3)*
>
> *It's about offering quality of life at the end of the patient's life, so they have more comfort, don't suffer, don't have pain, humanized care. I think that's it. (P4)*

In this perspective, the participants of the research considered that patients eligible and indicated for PC should be evaluated according to the diagnosis, and by criteria based on underlying disease, scales, performance, status, among others.

> *For me, these are all patients who no longer have a chance of curative treatment. These patients begin to receive a type of palliative care, whether short, medium, or long term. We no longer have a chance of a cure. They will have this disease forever and will be our patient until their end. (NT 5)*
>
> *Patients who are indicated for palliative care are all those patients who have a potentially incurable disease, with no expectation of cure in the short or medium term. Probably, in the future, they will be patients who will have no expectation of oncological therapy, that is, chemotherapy, radiotherapy, and surgery. And this is a patient who does benefit, and we generally influence them to bring these patients into the palliative care group for follow-up. Currently, patients undergoing palliative chemotherapy, already experiencing a loss of performance status, are already sensitized to enter follow-up with the palliative care group. (D6)*
>
> *We have several criteria within palliative care to define, for example, Karnofsky Performance Status (KPS) and Palliative Performance Scale (PPS). I have to evaluate them separately. I think this indication is case by case, evaluating the type of disease, the type of treatment received, the patient's performance, and their treatment possibilities. There are no guidelines or algorithms, which I think are even in the institutional protocol, that we will use to select those patients who are candidates for palliative care. But it's really like that, the intensity of palliative care they will need is different as their disease progresses. (D9)*

Humanization in palliative care was a theme emphasized in the manifestations of the research participants. The professionals highlighted aspects of care practice that they considered relevant in caring for patients in palliative care, such as humanizing actions. They mentioned, in this sense, the care of an extended form, the concern not only to be executor of technical procedures, the awareness that through professional action can-to promote comfort, acceptance and opportunities for problem solving and resignification of feelings.

> *I enjoy talking to patients, not just performing the technical aspects that we do, but I like interacting with them, talking about everything, about care, about religion. I like to know a little about them, interact, listen, and provide my care with affection. From when they are well, to when they are bedridden, in the most difficult phase, I give them all the support I can, I try to give my best. (NT1)*

> *What I think is essential is working for the patient. What I try to do, as a nutritionist, is always prioritize comfort, even if the patient says something like: "I want such and such," or the family. I always try to see the comfort of that patient, what will make them feel better and what comforts them most. (Nu3)*

> *I think listening is essential, thinking about humanized care, assisting in the case of my profession, assisting with referrals related to documents, expert opinions, family support, looking at the patient in their entirety. I also think it's important not only to do things mechanically, but to show interest in the patient's history, their needs, to help navigate moments with the family, to give new meaning to certain moments, feelings, and things that the patient finds important. (SW11)*

> *Essential, for me, is to provide support to patients and families, to assist with adaptations they may need for activities of daily living, to provide moments of comfort, listening, and exchange, to try to fulfill any desire that makes sense to them while they are hospitalized, and to help organize demands and activities that they can and want to do, within the possibilities of each patient. (D12)*

In short, the results express that the team had perception of what is palliative care, recognized the importance, reported the methods of indication, had a look at the principles of palliative care, the management of symptoms, pain control, seeking to develop humanizing actions based on the idea of individualization of care. Besides considering that it is essential, in the conduct with these patients, to list concerns related to listening, comfort, and social issues.

A multidisciplinary perspective on palliative care: experiences and implications

Regarding the professional practice in relation to the patient in palliative care, the professionals were reflective of what they had already experienced in the palliative approach within the institution. Expressed interest in the possibility of modifications to some performances, with the reality of current behaviors and believed that there is a need for changes and improvements in the practice scenario, aiming at promoting comfort and well-being, minimizing suffering and improving the health team.

The interviewees brought notes such as the evolution of the conversation about palliative care in the hospital environment, the creation of the the difficulties in the service due to not having a palliative doctor in the assistance team that leads the actions in this direction. In addition, they suggested for the service the need of trainings, conversation rounds involving the team, matrix team, patients and family members. Also, they highlighted the transformations that caring for people in palliative care emerges regarding the vision and reflection on one's own life.

> *What I see, but not in this inpatient unit, but in the hospital as a whole, is that the approach has changed or is changing. Palliative care wasn't talked about much before, and now there seems to be a trend of wanting to characterize everyone as needing palliative care. I notice that palliative care is discussed more, we treat more patients with these issues, and we know that a matrix palliative care team has been created. It's good to provide knowledge to all professionals in the institution, because we have to understand that palliative care isn't just one thing, that there are those who will be well, which is 80% of our patients in the unit, and there are those who are in the final stages of life. They are different types of care, you understand? (D9)*
>
> *We see that they [the doctors] provide palliative care, but it seems like they take a long time to get the person started. That's what I think is missing, but I think this conversation has improved a lot within the hospital, you know. There are more conversations with the patient, they call the family, they understand, they decide together in a multidisciplinary approach, trying to have a broad and differentiated perspective. (Nu3)*
>
> *Before the matrix team was implemented in the hospital, although it wasn't requested, there was more talk about it. But it's not that these precautions weren't taken, you know, and that there wasn't a multidisciplinary team; whether we like it or not, it's important. There's a lot to be said about this. (D12)*

In relation to the feelings that emerge from the palliative approach, it was possible to observe the transformation of looking at daily activities and patients' health status, from the perspective of different professional areas. Realizing the illness allowed the professional to have a look at himself and the other, providing moments of reflection, comparison and compassion for the other.

> *I bring this feeling into my personal life, which is exactly that, that our lives are so important, the appreciation of life, I have that more within me. (D7)*
>
> *There are feelings of gratitude, of thankfulness, because, through my work, I am providing care and comfort in the form of food, something good for this patient,*

> *fulfilling a wish, being able to provide good moments for the patient in their last moments of life with their family, through food. And here the system doesn't guarantee everything the patient wants, what is within my reach I try to do with production. (Nu3)*
>
> *Regarding the dying process, it's no use trying not to compare ourselves. For example, with a patient who has a daughter the same age as me and that mother is dying, and she sees that her mother is dying. Because she, the daughter, is educated, or because she is realizing that her mother is dying, I compare myself a lot: it could be me! It could be me! (N2)*

Regarding the challenges for the development of palliative care, the participants of the research mentioned some difficulties with professional intervention, in the sense that they saw the need to have another medical professional in the team who was guiding the palliative activities, and not hemato-oncology. In addition, it was pointed out that some professional groups started the approach in PC earlier than others.

> *I think all the professionals here provide palliative care, but nobody talks about it or calls themselves a palliative care specialist, and what I perceive is that the multidisciplinary professionals, along with nursing, can't work better than the doctors. That's what I perceive; the doctors still can't grasp this vision and work within this logic, they still see it as separate, but what I notice a lot is that everyone seems to do it, but nobody talks about it. (Nu3)*
>
> *Ideally, there would be an attending physician working alongside oncology. Ideally, it wouldn't be the same doctor who treats with chemotherapy, or who performs surgery, or who does radiotherapy, involved in this end-of-life care. Ideally, it would be a colleague with a different perspective, one that isn't our therapeutic perspective, who would take this approach. If it could be a geriatrician or even a general practitioner, that would be a better way to separate the doctor's role. (D6)*
>
> *It's not the oncologist who has to go to the palliative care rounds; it's the palliative care physician who should provide assistance in the hematology-oncology service. We know that many things change depending on the approach of each specialty, that it's not necessary to prescribe multiple analgesic medications, and that prescribing the right medication will be much more effective than several analgesics that don't improve the patient's pain. In multidisciplinary rounds, there's an exchange because we know the patient and can point out things that doctors don't notice during their visits. The patient can develop a stronger bond with another professional group. The oncology rounds allow us to talk about many things they can't see, but that we, as nurses, point out and are heard because they trust our clinical observation. (N2)*

Based on the findings, it can be said that the multiprofessional team, in general, was perceived as acting to share knowledge and responsibilities that contributed to improve the quality of service, care and bond with the patient and their families. However, it is still possible to see thoughts that suggest a modality of care focused on acting according to the medical specialty, which allows, at some point, if there is no continuity of assistance, the weakening or loss of the patient's and his family's bond with the professionals who were accompanying them along the path of illness, generating feelings of abandonment.

The development of PC demonstrates a paradigm shift, broadening the focus of healing to a holistic approach that meets the integral needs of patients and families. Overcoming these challenges requires a joint effort between managers and professionals in order to ensure dignified and humanized care.

Discussion

Professionals understood PC as a broad, continuous and essential approach to ensure the dignity of the hemato-oncological patient. They recognized the need for well-established criteria for the inclusion of patients in this care and reinforced humanization as a fundamental pillar in palliative practice, assigning perceptions to the palliative approach consistent with the principles advocated by the World Health Organization (WHO), although there is mention of PC being intended for end-of-life care.[16]

The understanding of PC as a holistic approach that prioritizes comfort and quality of life over curative therapies can be implemented in clinical practice and contribute to patient care, highlighting the need for a multiprofessional approach. For this, this team needs to have a clear understanding of the precepts of the PC, which qualify the assistance provided to people with cancer, as they favor the implementation of the palliative approach in an early and integrated manner, what is associated with better quality of life during cancer treatment, especially in patients with advanced disease.[17]

The active participation of the multidisciplinary team in oncology rounds is essential to ensure a broader and integrated approach to patient care. Professionals such as nurses, nutritionists and social workers, due to their proximity to patients, often identify needs that may go unnoticed by doctors during visits. This allows better communication with the patient and his family about their health condition. This fact reinforces the importance of valuing the multidisciplinary team and active listening to all professionals involved in care.[17-18]

In addition, the results show that respecting autonomy, reception and comfort are the main actions aimed at humanizing practices in the palliative approach, with humanization being a fundamental principle of palliative care. These aspects were also identified by a multidisciplinary team in a study conducted in China, which highlighted patient-centered care, the promotion of comfort and the establishment of beneficial patient as concrete actions of humanization in palliative care in oncology.[19]

In the present research, the criteria for indication to PC include no perspective of curative treatment, need for symptom control, identified from an individual assessment of the case and weighting of benefits. The perception that PC begin before comfort and not only at the end of life suggests an important conceptual advance, since historically these cares were erroneously associated exclusively with the terminal phase.[20]

The use of scales to aid decision-making for palliative therapy, although useful as an indicator, is not a determining prognostic factor. Associated with the evaluation of the patient's clinical conditions and the prognosis of the underlying disease, the scales corroborate as elements for decision, and should be applied in an integrated and individualized way in each case. However, as identified in the study, the scales commonly used by professionals are not always specific to identify the need for palliative care.[21] That mentioned the Karnofsky Performance Status (KPS) and Palliative Performance Scale (PPS). These scales are indicated to evaluate the functional capacity of the patient and determine how to conduct treatment, comfort and end-of-life planning, including when to talk with patients and family members.[22] Criteria for applying the scale and, at the same time, evaluate the patient in the general context, not only by indicators, are delimited in the literature and have been identified by other studies.[21-24]

The results of this research showed greater adherence of the unit and hospital staff to the palliative approach, reflecting an advance in awareness of its importance in the context of oncology. However, the need for specific training on the subject was highlighted, especially considering the profile of hospitalized cancer patients, who often present the disease in advanced stages, with few possibilities of modifying therapies. A study conducted in an oncologic hospital in Paraná identified that most hospitalizations occur at this stage, with indications for palliative care, reinforcing the relevance of its early implementation to minimize patients' suffering.[3]

In addition, the professionals recognized the benefits of PC in managing complex symptoms, pain relief and psycho-spiritual support.[25] However, they faced challenges regarding the optimal time for the transition from modifying therapy to the palliative approach, as well as difficulties in communicating the prognosis and indication for PC to patients and relatives. These findings show the urgency of continuing education and awareness, aiming to qualify professionals for a more integrated, humanized and effective assistance.

The professionals also expressed that living with patients in palliative care caused personal transformations, promoting reflections on the ephemerality of life and the appreciation of the present. Feelings of gratitude and emotional connection emerged in practice, by the possibility of providing comfort to the patient or by identification with life stories similar to their own. Thus, it is perceived that caring for the person in PC awakens feelings of empathy, compassion, gratitude and appreciation of life. Acting in the palliative approach scenario implies exposure to human vulnerability, which has repercussions on the emotional well-being of exposed professionals, who begin to reflect on their own finitude.[26]

Another important recognition identified in the study refers to the space that palliative care had been occupying in the institution, with greater discussion on the subject and the creation of a matrix team. However, challenges persisted in the implementation of this proposal, since adherence was not homogeneous among the specialties. The absence of a medical professional dedicated exclusively to conducting the palliative approach within hemato-oncology was identified as an obstacle. This factor may be related both to the lack of recognition of acting as a palliative and to the need for greater presence of a doctor specialized in PC in the unit.

In this context, it should be noted that medical training in oncology is still predominantly based on a curative perspective, which makes it difficult to make decisions regarding the PC since the diagnosis of the disease.23 Furthermore, this issue may be influenced by ethical dilemmas, as the mistaken perception that palliation represents a form of therapeutic obstinacy.[23] The consulting or matrix teams in PC constitute a resource that offers guidance to care physicians and multiprofessional staff, accompanying and assisting in the decisions of therapeutic behaviors that may be useful in the control of symptoms and communication with the patient and family.[21]

Still in relation to the challenges for the development of PC, there was a recognition that different professional groups adopted palliative approaches at different times of treatment, with some areas starting palliation earlier than others. The participants emphasized that nursing and other professionals of the multidisciplinary team often identified needs and promoted palliative actions even before the formal definition by doctors. This suggests that the palliative practice was present, but still lacked a clear and articulated direction. In a study conducted with doctors and nurses of an internal medicine hospital in Singapore, the nursing team was more likely to discuss PC in the diagnosis of a disease without a prognosis of cure.27 concludes that the gaps in understanding and ability to communicate end-of-life issues and present palliative care services to patients and their families make clear the need for a continuing training program.[27]

It is highlighted, as a possible contribution of this study to clinical practice, the relevance of the multidisciplinary team in providing palliative care, ensuring an integral approach, patient-centered and based on humanization and respect for autonomy. In addition, it is emphasized the need for continuous training of professionals to deal with the complex demands inherent in this assistance, promoting a more qualified practice and sensitive to the needs of patients and their families.

Among the limitations of the study, we highlight the non-inclusion of all professional nuclei that worked in the investigated unit and the restriction of the analysis to a specific unit of a hospital with unique characteristics, which may limit the generalization of results to other contexts. In addition, we highlight the sample, which is small and not probabilistic, and a possible bias of the researcher, since it acts on the unit where the data were collected.

In the field of research, the findings reinforce the relevance of investigating strategies to improve the integration of PC in oncology, as well as the need to broaden the involvement of different specialties in this approach. In addition, they highlight the importance of an attentive look at the management of health institutions for the structuring and strengthening of palliative care, ensuring the development of practices and the formation of teams dedicated exclusively to PC throughout the hospital. The performance of management is fundamental to ensure resources, professional training and a model of assistance that contemplates this approach in a continuous and qualified way, promoting a humanized and effective care to patients.

Conclusion

Professionals perceived PC as an essential part of the care provided in the hemato-oncology unit, recognizing their importance for patients' quality of life. However, the reports show that this approach was still in the process of consolidation, with advances in the expansion of practices, but with challenges that needed to be overcome to ensure qualified and effective palliative care.

Given the findings of this study, it is recommended to develop strategies that help health professionals overcome difficulties inherent in palliative care, such as dealing with the end of life of the patient, strengthening the relationship with the family and improving multiprofessional work. In addition, it is highlighted the need for an attentive look from institutional management to the structuring of palliative care, ensuring resources, continuous qualification of professionals and specialized teams that can act in an integrated and dedicated way to this assistance throughout the hospital.

It is concluded that, despite the advances, there were still challenges in the consolidation of PC in hemato-oncology, and it is essential that health institutions strengthen this approach through institutional and structural policies that promote a humanized, qualified and accessible care. Future studies may contribute to the improvement of care practices, providing subsidies for a more effective organization of services and for the development of strategies that ensure a PC of excellence.

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