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VIEWS OF INTENSIVE CARE PHYSICAL THERAPISTS ON PALLIATIVE CARE

Cuidados paliativos: discurso de fisioterapeutas que atuam em unidade de terapia intensiva

Cuidado paliativo: discurso de los fisioterapeutas que trabajan en una unidad de terapia intensiva

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ABSTRACT

Objective: This study aimed at investigating the views of intensive care physical therapists on palliative care, understanding the main difficulties in decision-making about physiotherapeutic care for patients under palliative care in intensive care units, and determining the enabling and hindering factors in these professionals' behaviors. **Methods:** This exploratory research with a qualitative approach was conducted with 11 physical therapists working in the ICU of a hospital in *João Pessoa* city, *Paraíba* State, Brazil. A form was used for data collection. The empirical material was analyzed by means of the collective subject discourse (CSD) technique. **Results:** The following central ideas were obtained: palliative care aims to provide quality of life, comfort, and relief of suffering for incurable patients; delivery of PC in agreement with the principle of orthothanasia; physical therapists' importance in providing comfort; difficulties in decision-making and adoption of strategies such as protocol development and continuing education**. Conclusion:** The CSDs obtained from the study participants highlighted their understanding of PC delivered in ICUs and possible difficulties encountered during this process. One of the obstacles faced by these professionals was the lack of protocols and consensus on the standardization of the decisions made by multiprofessional teams.

Descriptors: Palliative care, Physical therapy, Intensive care units, Palliative care at the end of life, Terminal patient.

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RESUMO

Objetivo: Investigar a vivência de uma equipe multiprofissional no que concerne a assistência aos pacientes sob cuidados paliativos em fase final de vida. **Método:** trata-se de uma pesquisa exploratória com abordagem qualitativa. O estudo foi realizado em um hospital filantrópico, localizado na cidade de João Pessoa-Paraíba - Brasil, com 15 profissionais de uma equipe multiprofissional. Os depoimentos foram obtidos por meio de entrevista semiestruturada e organizados em categorias temáticas. **Resultados:** da análise do material empírico emergiram duas categorias: I – cuidados paliativos na fase final de vida: ações e condutas da equipe multiprofissional e categoria II – desafios da equipe multiprofissional na promoção dos cuidados paliativos na fase final de vida: integração e capacitação. **Conclusão:** a equipe multiprofissional reconhece que uma maior integração facilite o processo de cuidado e a necessidade de se especializar para o desenvolvimento de competências com vistas à melhoria da qualidade da assistência paliativa.

Descritores: Cuidados paliativos, Equipe multiprofissional, Paciente terminal; Morte, Doença terminal.

RESUMEN

Objetivo: Investigar la experiencia de un equipo multiprofesional con respecto a la asistencia a pacientes bajo cuidados paliativos en la fase final de la vida. **Método:** esta es una investigación exploratoria con un enfoque cualitativo. El estudio se realizó en un hospital filantrópico ubicado en la ciudad de João Pessoa-Paraíba-Brasil, con 15 profesionales de un equipo multiprofesional. Las declaraciones fueron obtenidas a través de entrevistas semiestructuradas y organizadas en categorías temáticas. **Resultados:** del análisis del material empírico surgieron dos categorías: I - cuidados paliativos en la fase final de la vida: acciones y conducta del equipo multiprofesional y categoría II - desafíos del equipo multiprofesional para promover los cuidados paliativos en la fase final de la vida: integración y capacitación. **Conclusión:** el equipo multiprofesional reconoce que una mayor integración facilita el proceso de atención y la necesidad de especializarse en el desarrollo de competencias para mejorar la calidad de los cuidados paliativos.

Descriptores: Cuidados paliativos, Grupo de atención al paciente, Enfermo terminal, Muerte, Enfermedad crítica.

INTRODUCTION

The need for physiotherapeutic follow-up of patients in intensive care units (ICUs) has been recognized due to problems resulting from prolonged immobility, such as muscle weakness. Being quite common in critically ill patients, muscle weakness leads to functional damage, discomfort, reduced quality of life, and increased hospitalization time.[1] Nevertheless, despite this, when assistance reports to patients in palliative care (PC), there is a lot of contradiction concerning the conduct to be performed, in the face of complex questions regarding threats to the patient's comfort and dignity.[2,3] Therefore, it is necessary to discuss ways to promote care for palliative patients and their families.[4]

Despite the changes in the panorama of assistance to patients in PC, there is still a theoretical gap regarding the understanding and perception of physiotherapists concerning the concept and their professional skills in the face of the needs of patients in internal PC in an ICU.[4]

Bearing the aforesaid in mind, this study has the , the following research question: "*what are the views of intensive care physical therapists on PC*?" Therefore, this study aimed at investigating the views of intensive care physical therapists on PC, list the main difficulties, and point out the potential and/or obstacles found in terms of the physical therapy assistance offered to patients in CP in the ICU.

METHODS

This is a descriptive, exploratory study with a qualitative approach. The purpose of exploratory studies is to develop, clarify, and modify concepts and ideas. On the other hand, descriptive studies seek to describe the characteristics of populations or phenomena or establish relationships between variables.[5]

This study was carried out in the adult ICU of a public hospital in João Pessoa city, Paraíba State, Brazil, which provides care for patients with chronic and progressive diseases. Data collection occurred from June to July 2019.

Eleven physical therapists participated in the study. To ensure their anonymity, the study participants were identified with a reference code beginning with PT (physical therapist) followed by a number representing the order in which they were interviewed (1-11).

Physical therapists working in the adult ICU of the aforementioned hospital were included in this study. Those on medical leave and vacation during the data collection period were excluded.

Regarding the data collection instrument, a form containing questions in line with the study objective and the literature was used.

Data collected were analyzed using the collective subject discourse (CSD) technique, which consists of obtaining unique statements with similar meaning written in the first person singular. In this technique, qualitative and quantitative analysis of the verbal material is performed.

The CSD technique can use methodological tools such as "key expressions", "central ideas", "anchors" and "collective subject discourses" to obtain collective thinking from individual opinions. The objective is to obtain social representations with clear, exemplified, detailed, justified, and rich parts of an individual discourse that present similar ideas in a systematic and standardized way. In this sense, CSD corresponds to the formation of social representations through collective thought.[6,7,8]

The data collection phase began after the study was approved by the Research Ethics Committee of the *Universidade Federal da Paraíba* under Legal Opinion No. 3.387.585. Data collection was carried out in a private room close to the ICU after the study participants provided written consent. The confidentiality and privacy of the interviewees were preserved, ensuring the protection of their image and respect for their moral, cultural, religious, social, and ethical values.

RESULTS AND DISCUSSION

Among the professionals who participated in the survey, there was a predominance of females, totaling 8 professionals. Regarding professional experience, most of the study participants (8) had 10-15 years since graduation, which was the shortest period found. This finding indicates that the physical therapists had some professional experience.

ICU work time Most of the participants had 10-15 years of ICU work time, and only three had less than 3 years of ICU work time. Five participants were specialists, four obtained a Master's Degree, and two obtained a PhD.

The analysis of the empirical material allowed the emergence of six central ideas, which will be presented along with their respective CSDs.

Understanding of Palliative Car

Table 1. Central ideas 1 and 2 and their respective CSDs on PC.

Central Idea	CSD
01 = Understanding that PC seeks to provide quality of life, comfort, and relief of suffering for incurable patients and support for their relatives.	PC is targeted at patients with an incurable disease (n = eight; 72.7% - F1, F2, F3, F6, F7, F8 , F9 and F10). PC should be offered to patients without a prognosis of cure or reversion and their relatives in order to alleviate suffering and provide comfort, quality of life, and relief from suffering in the last moments of life (n = two; 18.1% - F7 and F11). PC is a set of precautions that seek to avoid implementing extreme therapeutic measures for patients who do not have the prospect of improving their general clinical condition (n = two; 18.1% - F4 and F9).
02 = Delivery of PC in agreement with the principle of orthothanasia.	PC is delivered in agreement with the principle of orthothanasia, aiming at promoting death without suffering (n = three; 27.2% - F2, F3 and F10). PC is delivered in agreement with the principle of orthothanasia, with the objective of preserving patients' dignity at the end of life (n = two; 18.1% - F1 and F6). PC is delivered in agreement with the principle of orthothanasia since the process of death must occur according to its natural course (n = three; 27.2% - F5, F7 and F11).

Physical therapy care for patients under palliative care in intensive care units

Table 2. Central ideas 3 and 4 and their respective CSDs on PC.

Central Idea	CSD
03 = PC delivered in ICUs	It should be delivered when pain and discomfort need to be alleviated, respecting the patients' wishes and decisions (n = eleven; 100% - All participants).
04 = Physical therapy care delivered to patients under PC in ICUs	Physical therapy care is delivered to patients under PC in ICUs in order to provide them with respiratory or physical comfort (n = eight; 72.7% - F1, F3, F4, F6, F7, F8, F9 and F10). Physical therapists participate in discussions about the cases, acting together with the multidisciplinary team, and providing care for patients and support for their relatives (n = three; 27.2% - F1, F2 and F11).

Decision-making about the physiotherapeutic approach to delivering palliative care to patients

Table 3. Central idea 5 and its CSD on the difficulties in decision-making about the physiotherapeutic approach to delivering PC to patients.

Central Idea	CSD
05 = Difficulties in decision making about physiotherapeutic approaches to delivering PC to patients in ICUs.	I have no difficulties because they are people and should be treated with respect and dignity in the final days of their lives, as long as patients under PC are awake and, together with their relatives, can give consent to any approach proposed by the multidisciplinary team (n = four, 36.3% - F1, F4, F5 and F7). We try to solve the difficulties by discussing the case with the multidisciplinary team. (n = two; 18.1% - F8 and F9). There are difficulties due mainly to the absence of protocols in the ICU where I work, knowing whether or not a patient should receive PC, which is a decision made by other members of the multiprofessional team (n = five; 45.4% - F2, F3 e, F6, F10 and F11).

Strategies to improve palliative care in intensive care units

Table 4. Central Idea 6 and corresponding CSD on the strategies executed to improve PC in ICUs.

Central Idea	CSD
06 = Strategies to improve PC in ICUs.	Developing and implementing therapeutic protocols for patients under PC. (n = three; 27.2% - F3, F8 and F10). Promoting continuing education activities targeted at ICU workers (n = five; 45.4% - F6, F7, F9, F10 and F11). Forming a specific PC team or committee (n = two; 18.1% - F7 and F9). Providing a more comfortable and open environment for the patients' relatives (n = one; 9% - F6)

PCs are a form of assistance and intervention with an emphasis on relieving their physical suffering and meeting their psychosocial and spiritual needs, whose target is the ill person and their families[9,10]

The central ideas 1 and 2 synthesized from the CSD on the understanding of PC demonstrate that this type of care is aimed at providing quality of life, comfort, and relief from pain and suffering. This CSD is in line with a study showing that PC is viewed as a procedure to provide comfort and quality of life for patients with advanced life-threatening diseases.[11]

Herein, the CSD related to central ideas 1 and 2, mentions that the PC agrees with what has been brought up in the literature, where the PC target patients who are in a phase in which incurability becomes a reality in the face of inefficient treatment. In this scenario, a careful evaluation allows the promotion of quality of life to the ill subject.[12]

In general, it is observed that aggravation of symptoms and diseases at advanced stages with no possibility of cure have a strong impact on the structure and family dynamics of patients.[13] Therefore, according to CSDs corresponding to the central ideas 1 and 2, it is important to highlight that family members or caregivers were not considered targets of PC, which is a major obstacle to the good practice of this philosophy.[14]

The central idea 2 highlighted that PC was delivered in agreement with the principle of orthothanasia. According to its corresponding CSD, PC seeks to preserve the natural course of the disease and bring more dignity to patients in the face of their death process. This is based on the concept of PC framed by the Brazilian Association of Palliative Care,

which defines it as a philosophy whose ethical principles are the view of death as a natural process and respect for life and human dignity, which are important premises for health practice.[15]

Given the current scenario, PC workers have been trying to promote the integrated idea of human beings by considering their physical, psychic, social, and spiritual dimensions, through a multi-, inter- and transdisciplinary practice.[16] Thus, one should pay attention to the fact that only one of the study participants emphasized the importance of considering patients in their entirety and caring for them while respecting their wishes and decisions.

The central idea 3 and its corresponding CSD emphasized that PC should be delivered when pain and discomfort should be alleviated, respecting the patients' wishes and decisions. Therefore, multiprofessional teams delivering PC should be attentive to expected and exacerbated signs of suffering, pain, struggles, and avoidance in order to develop strategies for early intervention and adequate reception. Such strategies should be tailored to suit any need, seeking to facilitate the subsequent referral of caregivers and family members for psychological follow-up in bereavement programs or services that can help with this arduous, yet necessary process that restructures families and lives.[17]

Regarding the role of physical therapy in providing PC in ICUs, which was highlighted in the central idea 4, the corresponding CSD obtained from the study participants showed that the main objective of this practice is to provide respiratory or physical comfort for patients. However, physiotherapeutic care in the ICU results in beneficial effects on pain management, sputum clearance and cough effectiveness, reduction of dyspnea and improvement of physical fitness, improvement of functional capacity and reduction of hospital stay, bringing more patient dignity and savings in costs associated with healthcare.[18]

Here, the CSD corresponding to the central idea 5 evidenced that the study participants experienced difficulties in deciding which physiotherapeutic approach to assisting patients under PC should be adopted. Some study participants did not justify these difficulties.

It is known that historically physical therapists have been focusing on improving individual recovery.[19]

However, this scenario has been changing due to the need to meet new demands, requiring physical therapists to expand the focus of interventions. As a result, physical therapy practice can include not only rehabilitation but disease prevention, improving the process of living with the disease and promoting health and quality of life.[19,20]

The adoption of strategies to improve PC in the ICUs is represented in the central idea 6. According to its corresponding CSD, the following actions were considered strategies: the development and implementation of therapeutic protocols for patients under PC, promotion of continued education activities targeting ICU workers, the formation of PC teams or committees, and the promotion of a more comforting and open environment to family members.

In Brazil, the practice of CP is relatively recent. The first groups' work dates back to the year 2000. There has been considerable progress in recent years due to the emergence of self-taught teams without formal education. These teams' actions frequently were not adapted to the reality of Brazil, reinforcing the lack of legislation and assistance policies in public and private sectors.[21]

Corroborating the CSD corresponding to the central idea 6, a review highlighted the importance of conducting discussions with multidisciplinary teams and other professionals involved in patient care. The teams should be prepared to conduct discussions with patients and their families about the limitations of cure technologies and provide comfort care. The study participants also stated that hospitals should develop protocols to solve conflicts with the help of all workers involved in the treatment of patients under PC.[4]

The training of CP teams has already been considered an improvement strategy for this type of assistance in developed countries, where CP has been increasingly established as a symbol of excellence. In the United States of America, it is estimated that most hospitals with more than fifty beds already have specialized teams. In addition, PC teams have been considered a requirement for receiving quality accreditation by health agencies such as the Brazilian Accreditation Organization, the Joint Commission, and the Canadian Association.[22]

Given the aforesaid, the importance of including discussions about death and the process of dying during professional education and teaching strategies during continued education in PC. Moreover, it is important to offer psychological care and support to teams dealing with this clientele.[3]

In addition to the strategies addressed by the CSD corresponding to the central idea 6, a study cited the use of pain scales and other evaluation instruments as strategies for assessing the effectiveness of multidisciplinary treatment of patients under PC and analysis of the impact of the adoption of physiotherapeutic approaches such as Transcutaneous Electrical Nerve Stimulation (TENS), massotherapy, cryotherapy, kinesiotherapy, respiratory control exercises and manual lymphatic drainage on the quality of life of these patients. The study also highlighted the need for professional training and the creation of PC services, given the need for physical and human resources that meet the care demands of incurable patients.[23]

A qualitative research intending to ascertain the use of facilitating communication strategies used to promote PC considered the communication process as an effective element of patient care without possibilities of cure and paramount importance for the promotion of PC, since this care generates ethical challenges, especially regarding

communication between the team, family and patient;[24] and brought as main communication strategies raised by the study participants both the use of verbal and non-verbal communication, with the use of gestures, touch, music, and attitudes for communication. The authors conclude by emphasizing that such modalities of communication are essential to provide humanized and qualitative care.[25]

Still, in relation to communication strategies, an integrative review sought to raise evidence for the use of effective communication strategies used by PC workers. According to its findings, communication strategies are effective and therapeutic methods, which are not intuitive or learned empirically. Also, health care professionals have poor or no training in using these techniques. Hence, the study considered it necessary to recognize communication strategies as a mandatory requirement for seeking humanized and quality health care.[26]

CONCLUSIONS

This study highlighted the CSDs on PC obtained from physical therapists working in an ICU of a public hospital in João Pessoa city. Through their reports, it was possible to verify their understanding of this theme. It was concluded that they still view patients as targets of PC, considering the importance of the attention required within the family context and preparation of caregivers in the face of the imminent threat of loss.

The CSD obtained from the study participants evidenced difficulties encountered in the delivery of care to PC patients in the ICU and the lack of protocols and consensus on the standardization of decisions made by the multiprofessional team, which was one of the most present obstacles faced.

This study has the following limitations: a small sample and the scarcity of studies found in the scientific literature regarding the performance of Physiotherapy in PC. Nonetheless, it is important to highlight that, even though it does not contemplate the large gap that exists regarding the current state of physiotherapy assistance in ICU patients in ICU, it helps to clarify how the professional body of physiotherapists in a teaching hospital in large companies understand and act in this field.

Given this framework, it is concluded that there is still a good path to be followed and many goals to be achieved in the pursuit of excellence in care according to CP, especially when considering that this is still an area little understood even by the professionals who deal with such reality on daily basis. Furthermore, based on this understanding, it is expected that this research will allow new reflections, concerning the present theme, and it is suggested that more studies be done in this area of activity.

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