

Self-Assessment of Knowledge in Palliative Care by Physicians Resident of a University Hospital

Autoavaliação do Conhecimento em Cuidados Paliativos por Médicos Residentes de um Hospital Universitário

Muerte y Luto en Cuidados Paliativos: La Experiencia de los Profesionales de la Salud

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ABSTRACT

Objective: The study's purpose has been to verify the knowledge self-assessment of resident physicians at *Hospital Universitário Lauro Wanderley* (HULW) [University Hospital] regarding Palliative Care (PC). **Methods:** It is a quantitative, observational, and cross-sectional study that was carried out involving resident physicians at HULW who answered a questionnaire with sociodemographic and Palliative Care-related questions. **Results:** From a total of 172 physicians, 99 (57.6%) took part in this research, 47.5% were between 28 and 32 years old and 54.5% were female. Most of the participants claimed to have learned about the control of common symptoms in palliative assistance, although 97% needed improving their PC knowledge. Only 16.2% knew about the current PC Basic Law; However, over 80% understood the bioethical aspects of the research. Yet, over 75% of the answers which were compatible with PC knowledge occurred in only 5 out of the 16 questions (31.2%). **Conclusion:** There is a relative lack of knowledge regarding PC among the interviewed physicians, making further studies on curricular interventions imperative to contribute to the improvement of these professionals.

Descriptors: Palliative care, Medical staff hospital, Medical education, Knowledge, Self-assessment.

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RESUMO

Objetivo: Verificar a autoavaliação do conhecimento de médicos residentes do Hospital Universitário Lauro Wanderley (HULW) acerca de Cuidados Paliativos (CP). **Métodos:** Realizou-se um estudo observacional, transversal, quantitativo, envolvendo médicos residentes do HULW, que responderam ao questionário com perguntas sociodemográficas e conhecimentos em CP. **Resultados:** Dos 172 médicos, 99 (57,6%) participaram da pesquisa, 47,5% entre 28 e 32 anos e 54,5% do sexo feminino. A maioria respondeu que aprendeu sobre o controle dos sintomas comuns na assistência paliativista, embora 97% necessitassem aperfeiçoar seus conhecimentos sobre CP. Apenas 16,2% conheciam a atual Lei de Bases dos CP, porém mais de 80% compreendiam os aspectos bioéticos pesquisados. Contudo, mais de 75% de respostas compatíveis com conhecimento sobre CP ocorreram em apenas 5 das 16 questões (31,2%). **Conclusão:** Existe relativa escassez de conhecimento acerca dos CP entre os médicos entrevistados, tornando indispensáveis estudos adicionais de intervenções curriculares que possam contribuir para o aperfeiçoamento desses profissionais.

Descritores: Cuidados Paliativos, Corpo Clínico Hospitalar, Educação Médica, Conhecimento, Autoavaliação.

RESUMEN

Objetivo: verificar la autoevaluación del conocimiento de los médicos residentes en el Hospital Universitario Lauro Wanderley (HULW) sobre Cuidados Paliativos (CP). **Métodos:** se realizó un estudio observacional, transversal y cuantitativo con médicos residentes de HULW, que respondieron un cuestionario con preguntas sociodemográficas y conocimiento de los CP. **Resultados:** De los 172 médicos, 99 (57,6%) participaron en la investigación, 47,5% entre 28 y 32 años y 54,5% mujeres. La mayoría de los residentes respondieron que aprendió a respecto del control de los síntomas comunes en los CP, aunque el 97% respondieron que necesitaban mejorar su conocimiento de CP. Solo el 16,2% respondieron conocer la Ley Básica de CP actual, pero más del 80% conocían los aspectos bioéticos investigados. Sin embargo, los porcentajes superiores al 75% de las respuestas compatibles con el conocimiento de los CP ocurrieron en solo 5 de las 16 preguntas (31,2%). **Conclusión:** existe una relativa falta de conocimiento en el enfoque de los cuidados paliativos entre los médicos residentes entrevistados y a respecto de la ley actual de CP, haciendo necesidad de estudios adicionales de intervenciones curriculares que pueden contribuir para la mejora de habilidades y competencias de estos profesionales.

Descriptores: Cuidados paliativos, Cuerpo médico de hospitales, Educación médica, Conocimiento, Autoevaluación.

INTRODUCTION

The palliative approach comprises proactive care that fits the quaternary level of health care, to avoid unnecessary suffering between terminally ill patients and their families. From this fundamental notion, the etymology of the word “palliative” appears, which comes from the Latin *pallium* (mantle, protection, with a view to caring) and it is not specifically related to healing, but in the sense of “protection for those who curative medicine no longer welcomes”.^{1,2}

The World Health Organization (WHO) defined Palliative Care (PC) in 1990, redefining them, in 2002, as an approach that improves the quality of life of patients and their families in the face of an illness without a cure, “through the prevention and relief of suffering with early

identification and impeccable evaluation, treatment of pain and other problems, physical, psychosocial and spiritual”.^{3,2}

PC also emerged as a response to the needs of an aging society and, although relatively new, it has been recognized as fundamental, as it aims to alleviate suffering and improve the quality of life of patients and their families, through the approach of physical, psychological, spiritual and social dimensions.⁴ In addition to the benefits towards promoting a better quality of life, PC decrease the length of hospital stay, rehospitalization, curative therapeutic obsessiveness, hospitalizations in the emergency room, and intensive care units and, consequently, the rational reduction of health costs.⁵

However, Brazil has not yet incorporated PC strategies in its health policies, which is considered a country where “one dies badly”⁶, because the end-of-life moments are characteristically marked by pain and suffering. In this sense, a “good death” is considered to be that “free from avoidable anguish and suffering for the patient and their family, occurring according to their wishes, and reasonably compatible with their clinical, cultural, and ethical characteristics”.^{7,8,4}

One of the factors responsible for this complex reality at the end of life is the current technical-scientific training in the health area, which focuses on healing, while “care” is a damaged or even non-existent aspect. During their training process, health professionals, especially physicians, are prepared to “overcome” the disease, and death often means loss, defeat, and frustration⁸. To change this paradigm, philosophy and organization inherent to the practice of PC must be valued and exercised through teaching, assistance, and research in the various sub-areas of health.⁹

According to the WHO, most health professionals worldwide have little or no knowledge of the principles and practices of PC. Besides, PC didactic-instructional content is still rarely included in the curricula of undergraduate courses.¹⁰ In practice, PC teaching has occurred at three levels: basic approach (undergraduate), general PC (postgraduate for professionals dealing with more often with progressive and irreversible diseases) and PC specialized (postgraduate courses for professionals who dedicate most of their work to PC).¹¹

Considering the relevance of the theme and the small number of studies on PC in the medical field of work and research, this study starts from the following question: what is the self-assessment that the resident physicians of a university hospital do about their level of knowledge concerning the theory and the practice of PC? Are the education and training of resident physicians, according to their assessment, aimed at teaching and learning PC?

Based on these considerations, this study aimed to verify the self-assessment of PC knowledge of resident physicians in training at a *Hospital Universitário* (HU) [University Hospital].

METHODS

This is an observational and cross-sectional study, with a quantitative approach. The population consisted of physicians residing at a *Hospital Universitário* (HU) [University Hospital].

In January 2019, all resident physicians who were in training at the HU were invited to participate in this study. Those who refused to participate in the study and those who were on leave or vacation during the data collection period were excluded, as well as those who were working in another service.

According to Resolution 466/12 of the National Health Council for Research Involving Human Beings, this research was initiated after its collegiate approval by the Research Ethics Committee (REC) of the HU (legal opinion No. 3.101.104) (APPENDIX A). Only resident physicians who signed the Free and Informed Consent Form approved by the referred Committee (APPENDIX A) participated in the research.

After signing the informed consent form, the participants completed a structured questionnaire, self-administered and without nominal identification. The data collection instrument was a questionnaire, composed of two parts: the first included sociodemographic variables, while the second contained 16 items about the physicians' opinion about their PC knowledge (APPENDIX B).

The questionnaire was developed by the author, according to a guide for the elaboration of data collection instruments¹², based on knowledge obtained through literature review, also including items from an instrument used in a previous study.¹³ In the second part, the questionnaire had 16 items (16 questions - Q1 to Q16) that met the objectives of the present investigation, being grouped into three thematic blocks. All questions presented dichotomous answer options, in a format of choosing between yes and no.

The questionnaire focused on the following thematic blocks: (1) knowledge about conceptual and procedural aspects of PC (items Q1, Q2, Q10, Q12, and Q13); (2) obtaining PC contents during graduation, medical residency and continuing education (items Q3, Q4, Q5, Q8, Q9, Q11, Q14, and Q15) and (3) bioethical and legal aspects (items Q6, Q7, and Q16). Residents who answered affirmatively to the questions, except for Q2 and Q15, were considered to have a favorable self-assessment about the concepts pertinent to the palliative approach and the indication that they obtained information compatible with PC in their training. The affirmative answers to Q2 ("do you consider that palliative care should only be provided to patients who do not have curative treatment?") And to Q15 ("do you think it is necessary to improve your knowledge in approaching patients in need of palliative care?") indicated an unfavorable understanding of the palliative approach.

Medical residency specialties were categorized into

two groups, (1) basic area (medical clinic, surgical clinic, gynecology, and obstetrics, pediatrics and family and community medicine) and (2) specialties from other areas (residents in clinical and surgical specialties) with prerequisite and with direct access in the admission selection process), as classified by the National Medical Residency Commission.¹⁴

Descriptive and inferential statistical analysis was performed. In the descriptive analysis, absolute and percentage frequencies were determined. The 25th, 50th and 75th percentiles of the response frequencies were determined, as well as the interquartile range. The Mann-Whitney test was used to assess the relationship between items on the PC of the questionnaire with age and undergraduate time. The comparison between the groups corresponding to the areas of expertise was performed using the Kruskal-Wallis test. The distribution between nominal variables such as gender, religion, and ethnicity were tested concerning the variables corresponding to the items on PC in the questionnaire using the chi-square test. All results were considered statistically significant at the 5% level. The software used in the analysis was the Statistical Package for the Social Sciences (SPSS), version 2.0 for Windows..

RESULTS AND DISCUSSION

The sample consisted of 99 resident physicians, who represented 57.6% of the universe of 172 graduate students registered at *Comissão de Residência Médica* (Coreme/CCM) [Medical Residency Committee] and with activities at HULW.

In the sample profile, the following characteristics predominated: age between 28 and 32 years old (47.5%), female (54.5%), mixed-race (47.5%), monthly income above 10 minimum wages (57, 6%), and more than 80% reported some religion, mainly Catholic (61.6%).

Table 1. Sociodemographic characteristics of a sample of resident physicians at the Hospital Universitário Lauro Wanderley (HULW), João Pessoa City, (n = 99)

Variables	Frequencies	
	f	%
Gender		
Male	45	45.5
Female	54	54.5
Age range		
23-27 years old	28	28.3
28-32 years old	47	47.5
Above 32 years old	24	24.2
Ethnic group		
White	47	47.5
Brown	47	47.5
Black	3	3.0
Other/not reported	2	2.0
Family income		
1-3 MW	3	3.0
4-6 MW	14	14.1
7-10 MW	25	25.3
Above 10 MW	57	57.6
Religion		
Catholic	61	61.6
Evangelical	18	18.2
Spiritist	3	3.0
Protestant	4	4.0
Other religiosity	1	1.0
Without religion	12	12.1

MW: Minimum Wage
Source: Primary research data

Considering the practice areas, 13 (13.1%) were studying family and community medicine; 12 (12.1%), medical clinic; 12 (12.1%), gynecology and obstetrics; 11 (11.1%), pediatrics; 9 (9.1%), general surgery; 9 (9.1%), ophthalmology, and 9 (9.1%), psychiatry, while 24 (24.1%) were residents of other medical specialties (anesthesiology - 6; infectious diseases - 4; gastroenterology - 4; rheumatology - 4; dermatology - 2; endocrinology - 2; intensive care - 1; mastology - 1). It was found that 44 (44.4%) had graduated between one and three years ago, and 39 (39.4%), between four and six years earlier, while 16 (16.2%) had graduated more than six years.

The descriptive analysis of the answers to the items in the second part of the questionnaire revealed that answers indicating positive self-assessment showed percentages ranging from 16% to 97%, with a median of 68.7 and amplitude of 81. Percentages greater than 50% of answers suggestive of Positive self-assessment of PC knowledge (answers yes, except for Q2 and Q15) occurred in 14 of the 16 questions. However, percentages equal to or greater than 75% of answers compatible with PC knowledge occurred in only 5 of the 16 questions (31.2%). The 50th percentile was 68.7 (median), and the 75th percentile was 83.2, showing that 50% and 75% of answers were below these values, respectively. The interquartile range of answers suggestive of favorable self-assessment in PC was 30.5.

The questions that affirmative answers indicated that the participants considered themselves to be knowledgeable about the PC approach, that is, which resulted in a higher percentage of “no” answers, were Q3 (“do you believe that during the residency you received enough information about symptom control? most common of patients in

palliative care?”) and Q7 (“do you know the current Basic Law of Palliative Care?”).

Although a very low percentage (16.2%) reported knowing the current Basic Law of Palliative Care (Q7), bioethical aspects, such as the distinction between euthanasia, orthothanasia, and dysthanasia (Q6), as well as the recognition of the autonomy that the patient and their families have to choose the place to die (Q16), they presented percentages above 80%. It was observed that 80 (80.8%) reported knowing the differences between euthanasia, orthothanasia, and dysthanasia, and 89.9% answered affirmatively to Q16.

With regard to the domain categorized as “knowledge about conceptual and procedural aspects of PC”, it was highlighted, due to the higher frequency (84.8%), the understanding that PC should not be aimed only at patients with no possibility of cure (Table 2).

Table 2. Knowledge about conceptual and philosophical aspects of palliative care according to self-assessment of resident physicians at Hospital Universitário Lauro Wanderley (HULW), João Pessoa City, January 2019 (n = 99)

Affirmative answers regarding the knowledge of conceptual and procedural aspects of PC	f	%
Definition of PC according to the World Health Organization	55	55.6
Concept of PC to be provided only to patients who do not have curative treatment	15	15.2
Information on the use of palliative performance scales	48	48.5
Habit of using pain scales to assess the response to analgesia	60	60.6
Self-confidence to initiate analgesia in CP patients with chronic pain	58	58.6

PC: Palliative Care
Source: Primary research data

Concerning the block of items on receiving PC content during undergraduate course, medical residency and continuing education, it was observed that residents responded that they did not obtain enough content on symptom control in PC (Table 3).

Table 3. Receipt of palliative care content during undergraduate course, medical residency, and continuing education by resident physicians at the Hospital Universitário Lauro Wanderley (HULW), João Pessoa City, January 2019 (n = 99)

Respostas afirmativas quanto ao recebimento de conteúdos de CP durante o processo formativo	f	%
Undergraduate course		
Contents about terminally ill patients	69	69.7
Sufficient content on symptom control in PC	23	23.2
Medical Residency		
Contents on symptom control in PC	22	22.2
Content about communicating bad news	67	67.7
Contents on the topic of death	70	70.7
Continuing education		
PC content in recent courses and lectures	51	51.5
Guidelines for the management of patients with chronic pain	71	71.7
Need to improve knowledge about PC	96	97.0

PC: Palliative Care
Source: Primary research data

Comparing the percentages of affirmative answers to the questions regarding knowledge about PC obtained during medical residency and in continuing education events (Q3, Q4 Q5, and Q9) between residents of basic medical areas and those of specialized areas, it was observed that the

respondents of the latter reported more frequently having learned about communication and medical posture to “give bad news” to patients and family members (Q4), as well as having more contact with the topic “death” (Q9). On the other hand, most residents responded that symptom control (dyspnea, vomiting, constipation, cachexia) is not addressed at home, although those in the basic areas responded more frequently than they did during the residency and received the information they considered sufficient about the control of these most common symptoms presented by patients in PC (Q3). The two subgroups similarly referred to obtain recent information about PC in courses and lectures (Q5) (Figure 1). The distribution of affirmative answers did not differ statistically in the four questions according to the area (basic/specialties).

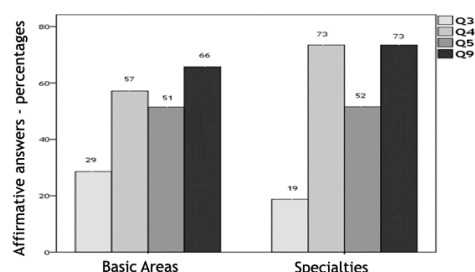


Figure 1. Comparison between the frequencies of affirmative responses from residents of basic areas concerning the obtained PC knowledge during their residency and in continuing education (n = 99).

There were no differences in the distribution of answers to the 16 questions (Q1 to Q16) about age group, undergraduate time, ethnicity, religion and income. There was only a statistically significant difference concerning the comparison regarding gender ($p = 0.030$) and area of residence ($p = 0.015$) with regard to the affirmative report of obtaining knowledge about PC during graduation.

The results of this study showed that resident physicians who carry out training at HULW declared that they were inadequately prepared for PC care. About a little more than half of the sample knew the WHO concept of PC, and the vast majority (97%) reported the need to improve their PC knowledge, indicating a poor perception to deal with end-of-life patients.

These results are in agreement with research carried out among students from Brazilian and foreign universities during their undergraduate course, in which there was a high proportion of references to a scarce knowledge for the management of patients in PC.¹⁵⁻¹⁷

This fact can be associated with the insufficient approach to PC in residency programs throughout Brazil, often with occasional or even non-existent and unappreciated approaches. In a study carried out in 2011, in which 58 medical courses were evaluated through questionnaires answered by school coordinators from all over Brazil, it was found that the relevance attributed to teaching about care at the end of life is still small and that the time this topic is

minimal.¹⁵ In the undergraduate medical course at UFPB, an optional palliative care discipline started to be taught two years ago, and there is no PC unit at HULW, having been formed, only in 2017, a Palliative Care Commission with interconsultation action for patients at the institution.

This reality is present in many medical training centers and hospitals in the country. In our reality, PC are still in an incipient stage, due to the lack of knowledge, attitudes, and skills among health care providers, lack of training and lack of awareness among political managers.¹⁷

On the other hand, in a qualitative study carried out with 19 resident physician only in the area of anesthesia and surgery at HULW, the central ideas of the interviewees' speeches were to improve the quality of life of patients with an incurable and terminal illness, seeking to provide them with comfort and dignity, symptom relief, pain, and suffering, but no statements were corresponding to the lack of knowledge in PC by the interviewees.¹⁸ However, this was a study with a different approach, with data collection by non-directive technique, which must have limited manifestations about difficulties in the care provided to terminally ill patients.

In a study conducted in São Paulo, there was an inconsistency of knowledge about ethics and palliative care.¹⁹ In that study, only 2.6% of the sample of 76 individuals correctly answered the question about the definition of palliative care: Most (59.2%) associated the term only with the relief of physical suffering and quality of life. In another study, carried out with resident physicians at the Hospital of the Universidade Federal de Sergipe, it was observed that only 7% had an “excellent” result in hetero evaluation on PC, with more than 80% of correct answers in the analyzed domains, while 23% were correct less than half of the items surveyed.²⁰

Similar studies have been carried out in other countries, showing among the respondents that they were not very confident in dealing with the terminal patient. Previous studies, published from 2005 to 2015 and synthesized in a systematic review, showed that recent medical graduates do not feel prepared to deal with patients in PC.¹⁶

The answers regarding the items of the questionnaire applied to our sample were similar to the findings of a survey carried out in India, regarding self-declared knowledge and the receipt of PC contents.¹⁷ Less than 25% of a sample of 200 resident physicians linked to the Pontificia Universidad Católica de Chile [Pontifical Catholic University of Chile] received some degree of PC education during their studies, but approximately half of them considered the level of proficiency achieved to be less than 25%.²¹

In a sample of 80 physicians residing in a hospital in Saudi Arabia, only 29.2% indicated that they had previous education in PC.²² The percentage of correct answers in items that reflected knowledge in PC represented 29.9%. In that study, similarly to what was observed in ours, there was no statistically significant difference in the

degree of knowledge among residents, according to their demographic variables or characteristics of undergraduate and training.

In our study, 67.7% reported having received information on how to “give bad news” to patients and family members, a result that is similar to those observed in another study conducted in India²³, where the majority of a sample of 120 resident physicians responded that they felt prepared to discuss prognosis and treatment goals with patients and family members. The communication of bad news is one of the most difficult and most frequent tasks in the practice of health professionals.^{24,25} Borges and Santos Junior²⁵ argue that communication should be a means to create a bond between physician and patient, ensuring confidence in professional work and greater adherence to therapeutic proposals.

Although the majority of the interviewees reported that the present study had received insufficient information about the management of the main symptoms present in PC patients during undergraduate course and medical residency, there was mention of greater knowledge about pain control and the feeling of self-confidence to start the management of analgesia.

Pain is one of the most frequent and limiting symptoms for patients in PC, and the management of this manifestation is one of the fundamental aspects in palliative care. However, in a survey carried out in Canada²⁶ on the practice of prescribing opioids for patients with chronic non-neoplastic pain, 73.2% of the evaluated physicians did not feel safe to prescribe opioids, mainly due to the concern with abuse and dependence pharmacological. In yet another study carried out at the University of Michigan, it was shown that only 10% of physicians had received formal education about pain and its treatment during graduation in medicine, residency and/or continuing education.²⁷ This difference mentioned can be attributed to the differences in study design or assessment tools used.

In the present study, when comparing self-assessment of PC knowledge concerning undergraduate time, there was no significant difference between residents with shorter and longer undergraduate times. This lack of association corroborates a previous study²⁰, which may indicate that the fact of having longer working hours does not always mean greater experience in the treatment of patients under PC. However, our sample had a small range of time to complete the course, between one and six years. Such findings are different from the observations made by physicians in Germany, where it was observed that those with less than five years of professional experience answered more questions correctly than those with more than five years of graduation.²⁸ This finding was attributed by the authors to the fact that there was a recent introduction of PC in the undergraduate curriculum, and thus, those with less than five years of experience studied this type of approach.

When analyzing the answers about PC knowledge

obtained during residency in basic and specialty areas, items related to death and the communication of bad news were answered more frequently in the affirmative among those in the specialties. An early interest in PC was expected to be more frequent among participants in the basic areas, whose attention is considered more comprehensive and generalist. However, among the residents of the specialties, there are those of gastroenterology, nephrology, pneumology, and rheumatology, whose services in the *HULW* wards are mainly aimed at patients with chronic end-stage liver, kidney and lung diseases, as well as more severe cases of systemic lupus erythematosus and other connective tissue diseases, according to the work of Vieira et al.²⁹ in the medical clinic wards of *HULW*, 27.5% of hospitalized patients met the criteria for the need for palliative care, and in these patients such diagnoses are frequent.

CONCLUSIONS

Most residents replied that they do not master the control of common symptoms in palliative care, but there was guidance for pain management, they felt prepared to start medication relief and knew scales for monitoring this symptom, although 97% answered that they needed to improve their knowledge about PC. Only 16.2% answered to know the current Basic Law of PC, but more than 80% knew the researched bioethical aspects. However, percentages greater than 75% of answers compatible with knowledge about PC occurred in only one third of the questions.

These results suggest that there is a shortage in the approach of PC among the interviewees, especially in relation to the control of common symptoms in the palliative approach, due to possible gaps in both undergraduate course and residence itself, making additional studies of curricular interventions that are capable of contributing to the improvement of skills and competences of these professionals, both with the involvement of theoretical and practical activities, as well as the use of methodologies that allow the development of knowledge and attitudes necessary for the good practice of PC.

The main limitation of this study is that it was based on residents' self-assessment, which may not reflect their real ability to provide PC or adequately deal with dying patients. Self-reporting can also lead to memory bias and an inaccurate assessment of past experiences. Self-reporting is subjective and cannot replace objective hetero evaluations of knowledge and skills or direct observation of the behavior of resident physicians by their preceptors and teachers. Besides, these results reflect our local reality and cannot be generalized to residents of other institutions who may have more or less emphasis on PC.

It is also important to highlight that the items referring to specific knowledge about PC covered only a part of its domains, given that this area of medicine has a wide content,

but a questionnaire that is too long could cause less adherence by respondents.

Further studies can help to obtain more information on cognitive aspects related to this formative problem. In this sense, a self-assessment of the residents' needs is a critical first step in the design of a PC curriculum for these physicians in training.

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