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PAIN RELIEF AS A POTENTIAL TOOL IN PALLIATIVE CARE: A HOLISTIC AND MULTIDISCIPLINARY ANALYSIS

Richardson Lemos de Oliveira^{1-4-7,*}; Wilder Kleber Fernandes de Santana²; Alessandra Teixeira³; Kesia Gomes de Gouveia⁴; Carolinedo Nascimento Pacheco⁴; Gessika Alves⁵; Karina Maria Fernandes Portella⁶; Leonara Leite Vidal⁷; João Batista Lucena⁸; Cícero Thiago Moreira Alves⁹; Regina Lucia Napolitano Felício⁴; Fábio José Antonioda Silva¹⁰; Neyla Cristina Carvalló Viana¹¹; Maria Cleudiane de Souza Santos⁴⁻¹²; Amanda Santana Góes da Silva¹³; Cristiane Moreirade Sousa¹⁴ and Paula Paraguassu Brandão¹⁴⁻⁴

¹Universidade Nacional de La Plata (UNLP); ²Universidade Federal da Paraíba (UFPB); ³Universidade Federal de Juiz de Fora (UFJF); ⁴Universidade Estácio de Sá (UNESA); ⁵Centro Universitário UNIABEU; ⁶Universidade Paraense (UNIPAR); ⁷Universidade do Estado do Rio de Janeiro; ⁸Universidade Federal do Rio Grande do Norte (UFRN); ⁹Universidade Municipal São Caetano do Sul; ¹⁰Universidade Norte do Pará; ¹¹Universidade Federal de Pelotas (UFPEL); ¹²INCA; ¹³Instituto Israelite de Ensino e Pesquisa Albert Einstein; ¹⁴Universidade Federal do Estado do Rio de Janeiro (UNIRIO)

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*Corresponding author:

Richardson Lemos de Oliveira

ABSTRACT

Introduction: This study addresses proposals related to pain as an analysis tool and vital sign, as well as the participation and importance of the multidisciplinary team in full participation in the development of comfort measures at the end of life. As an **Objective:** The study aims to recognize the importance of the participation of interdisciplinary team members in an active way in the patient in palliative care. **Method:** this is an integrative review that allows the search, critical evaluation and synthesis of available evidence on the topic addressed. **Result:** The discussion resulted in the creation of 3 discussion categories. 1: Policy and the strengthening of palliative care actions in Brazil; 2: The importance of the interdisciplinary team in the treatment of patients with restriction of therapeutic alternatives; 3: Pain relief as a humanization and comfort mechanism in palliative care. **Conclusion:** However, we can conclude and elucidate the importance of multidisciplinary participation of team members, highlight the importance of the participation of each actor in care and the role of different levels of health care.

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INTRODUCTION

According to the International Association for the Study of Pain (IASP), pain is defined as an unpleasant sensory and emotional experience associated with actual or potential injuries. Concomitantly, with the other senses, from 1996 onwards, it became part of the list of vital signs, such as: blood pressure, temperature, heart and respiratory rate by the American Pain Society. (MOCCELIN *et al*, 2018). The World Health Organization (WHO), through the document entitled Cancer pain relief and palliative care: report of a WHO Expert Committee, developed the first concept of palliative care aimed at cancer patients.

According to the 1990 text, it is about the active and total care of patients with diseases that no longer respond to curative treatment. The focus was established on the control of pain and other physical, psychological, social and spiritual symptoms, with the aim of improving the quality of life of patients and their families (GOLDIM and PACHECO, 2019). The World Health Organization, in 2002, redefined as a concept for palliative care, care that consists of assistance provided by a multidisciplinary team, which aims to improve the quality of life of patients and their families, in the face of a life-threatening disease. , through the prevention and relief of suffering, through early identification, impeccable assessment and treatment of pain and other physical, social, psychological and spiritual symptoms.

The concept of terminal patient through therapeutic evaluations in the course of treatment and diagnosis of diseases is not something simple to be established. Although we are often faced with consensual assessments by different professionals, perhaps the greatest difficulty lies in objectifying this moment, not in recognizing it (GUTIERREZ, 2001). The devastating burden of physical, emotional and psychological symptoms that increase in terminally ill patients makes it necessary to adopt early dynamic and active therapeutic approaches, respecting the patient's own limits in the face of their incurable situation (INCA, 2021). In this way, terminality seems to be the central axis of the concept around which the consequences are situated. It is when the possibilities of rescuing the patient's health conditions are exhausted and the possibility of imminent death seems inevitable and predictable. The patient becomes "unrecoverable" and walks towards death, without being able to reverse this walk (GUTIERREZ, 2021). Therefore, this study aims to recognize the importance of active participation of interdisciplinary team members in palliative care patients.

METHODS

This is an integrative literature review that for Whitmore *et al* (2005) is defined as a research method that allows the search, critical evaluation and synthesis of available evidence on the topic addressed. Searches were carried out through the VHL database with the description of the descriptors: pain; palliative care; multidisciplinary team. Initially, 136 articles were found, available and in full text. Search filters were introduced: "Articles in Portuguese", "5-year time frame (2017 to 2021)". After applying the inclusion criteria, 16 articles remained. After a thorough reading of the studies, 8 were excluded because they did not approach the theme, 3 studies were presented in duplicate and 2 did not meet the inclusion criteria. Remaining 3 for the discussion and construction of the integrative review. Below, we present a flowchart in order to streamline and clarify the way the searches were carried out:

Collection of the authors themselves: Next, a table with qualitative data from the studies that were selected for the construction of the integrative review will be presented. This will contain data such as: Authors, study title, publication journal, language and year of publication, respectively.

Integrative Review

Policy and strengthening of palliative care actions in Brazil: In Brazil, the topic of Palliative Care began to gain visibility through humanization policies. The detection of problems in the Health Care Network led the Ministry of Health (MS) to work intensively on national humanization programs and policies (Waldow, & Borges, 2011). In Brazil, PCs began to be consolidated around 1980. In 1997, the Brazilian Association of Palliative Care (ABCP) was founded; in February 2005 the National Academy of Palliative Care (ANCP), together with the Brazilian Medical Association (AMB) (Carvalho & Parsons, 2012). Between 2000 and 2002, the MS inaugurated the humanization policies in health through the National Program for the Humanization of Hospital Care (PNHAH) with actions in hospitals to promote the creation of humanization committees that sought to improve the quality of care and also the attention to the worker; and, the humanization of childbirth and child health. The 11th National Health Conference, held in December 2000, entitled "Access, quality and humanization of health care with social control", further strengthened the discussions and initiatives for humanization was the main focus on health practices (Pasche, & Passos, 2008). Hospitals end up becoming a depository of patients with no possibility of cure and treating them inappropriately, always focused on the attempt to cure, with invasive and high-tech methods, which are often exaggerated, insufficient and only cause even more suffering, while what these people most want is to relieve the pain they feel (Matsumoto, 2012). The Brazilian Society of Family and Community Medicine (SBMFC) created a competency-based curriculum, which seeks to determine the skills expected of the family and community physician.

Among these competencies are: pain management in terminal patients, management of pressure ulcers, guidance to family members regarding measures related to the patient's death, management of intercurrents in palliative patients and the approach to mourning (MATTOS AND DERECH, 2019). In Brazil, most patients in need of PC in PHC are of advanced age and have non-malignant diseases. Marcucci *et al.* 6 showed that the provision of multidisciplinary care was limited, with only 10% being seen by physical therapists, 3% receiving social workers, and none receiving psychological consultation. In the present study, there was also a deficiency of multidisciplinary PC, almost 87% of the participants reported not having the help of a multidisciplinary team trained in PC in their workplace. Home care by a team trained in PC is capable of reducing hospital readmissions and improving symptoms of palliative patients who were recently discharged from hospital (MATTOS AND DERECH, 2019). The World Health Organization (WHO, 2002) published a list of principles that govern the performance of the multidisciplinary team of Palliative Care. Thus, the following table indicates proposals to be followed by the multidisciplinary health team:

Promote relief from pain and other unpleasant symptoms; Affirm life and consider death as a normal process of life; Do not hasten or postpone death; Integrate psychological and spiritual aspects in patient care; Offer a support system that allows the patient to live as actively as possible until the moment of death; Offer a support system to help family members during the patient's illness and to cope with grief;

- Take a multi-professional approach to focus on the needs of patients and their families, including grieving follow-up;
- Improve the quality of life and positively influence the course of the disease;
- It should be started as early as possible, along with other life-prolonging measures, such as chemotherapy and radiotherapy, and include all
- investigations necessary to better understand and manage stressful clinical situations.

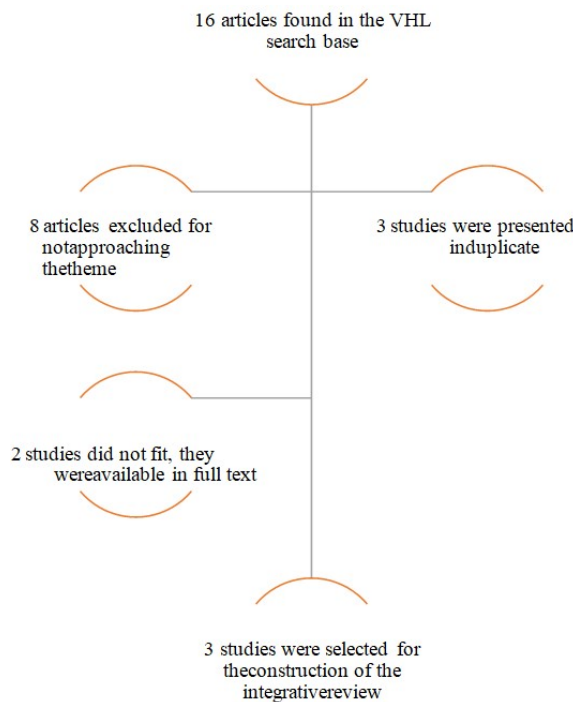
WHO, 2002 in ALVES *et al.* 2019: "It is not about cultivating a posture contrary to technological medicine, but questioning technolatriy and reflecting on our conduct, in the face of human mortality, trying to find the necessary balance between scientific knowledge and humanism, to rescue the dignity of life and the possibility of if you die in peace" (Matsumoto, 2012, p.23). However, for Alves *et al.* (2019) the PC should not be based on protocols, but on principles; that the term terminality should be changed to life-threatening disease; that care must be initiated from the moment of diagnosis and that the impossibility of cure must be avoided. Instead, work with the possibility of non-disease-modifying treatment, moving away from the idea of having nothing else to do. This approach includes spirituality among the dimensions of the human being and assistance to the family, after the patient's death, in the period of mourning. In this sense, techniques, protocols and ways of doing it seem to be in the background, when the most important thing is to look at the human being in an integral way, in his experience, understanding him completely in that moment so difficult to be lived.

The importance of the interdisciplinary team in the treatment of the patient with restriction of therapeutic alternatives: For Pires *et al* (2020) the multidisciplinary team experiences a change in the care paradigm, seeking to improve the quality of life (QoL) of those who face problems associated with life-threatening diseases. It involves caring for suffering in addition to physical symptoms, including the support of a multidisciplinary team and meeting the basic needs of the patient and their family. The professional categories, especially the psychologist, physiotherapists, nurses and nutritionists exposed the importance of psychological comfort, perceived through dialogue related to fears at this stage, demonstration of affection, attention, words of courage and strength (MATTOS and DERECH, 2019). Professionals also emphasized the promotion of comfort aimed at physical needs to relieve symptoms common to PC patients, such as dyspnea and nausea, adequate nutritional therapy, respiratory

Information Table of Qualitative Data of the Selected Studies

Título	Autores	Periódico	Idioma	Ano
Conforto no final de vida na terapia intensiva: Percepção da equipe multiprofissional	Isabella Batista Pires; Tânia Maria de Oliva Menezes; Bruna Borges de Cerqueira; Rebeca Santos de Albuquerque; Halanna Carneiro Guimarães Bastos Moura Raniele Araújo de Freitas; Alana Libânia de Souza Santos; Emanuela Santos Oliveira	Acta Paulista Enfermagem	Português	2020
Cuidados paliativos providos por médicos de Família comunidade na atenção Primária à saúde brasileira: um survey nacional	Caroline Wassmansdorf Mattos; Rodrigo D'Agostini Derech	Revista Brasileira de Medicina de Família e Comunidade –RBMFC	Português	2019
Cuidados Paliativos: Alternativa para o Cuidado Essencial no Fim da Vida	Railda Sabino Fernandes Alves; Elizabeth Cristina Nascimento Cunha; Gabriella César Santos; Myriam Oliveira Melo	Psicologia: Ciência e Profissão	Português	2019

FLOWCHART OF SEARCH OF STUDIES WILL BE PART OF THE DATA ANALYSIS



The World Health Organization (WHO) definition of PC, and are:



1. Promote relief from pain and other unpleasant symptoms;
2. Affirm life and consider death as a normal process of life;
3. Do not hasten or postpone death;
4. Integrate psychological and spiritual aspects in patient care;
5. Offer a support system that allows the patient to live as actively as possible until the moment of death;
6. Offer a support system to help family members during the patient's illness and to cope with grief;
7. Take a multi-professional approach to focus on the needs of patients and their families, including grieving follow-up;
8. Improve the quality of life and positively influence the course of the disease;
9. It should be started as early as possible, along with other life-prolonging measures, such as chemotherapy and radiotherapy, and include all investigations necessary to better understand and manage stressful clinical situations.

assistance and the use of sedation for difficult-to-control ventilatory discomforts. (PIRES *et al.*, 2020). A possible alternative for building a more comfortable environment is investing in supportive, trusting and ethical relationships between team members and patients, based on simple attitudes such as sensitive listening, welcoming and ambience. (PIRES *et al.*, 2020)

Pain relief as a humanization and comfort mechanism in palliative care: To promote pain relief, in addition to prescribing analgesia, it is necessary to adopt non-pharmacological measures, addressing psychosocial and spiritual aspects.

Pain relief was considered by all professional categories a fundamental aspect in palliative patient care. PIRES *et al.* (2020). According to the WHO, there is limited availability of strong opioids in Brazil and worldwide. Only 7% of countries have adequate access to these drugs. (MATTOS and DERECH, 2019). The availability of opioids must be foreseen in local public policies for the development of quality PC. Per capita consumption of opioids was positively associated with the number of palliative services per population. (MATTOS and DERECH, 2019). The care of terminally ill patients in the ICU is complex, conflicting and challenging. The current biomedical model, technological advances and frequent coping with death are common obstacles, requiring professionals to provide a foundation for clinical care in order to promote Quality of Life for these patients. PIRES *et al.* (2020) Addressing psychosocial and emotional needs is an important role for the PHC team, and many patients complain of not being able to talk to their doctor about their end-of-life wishes (MATTOS AND DERECH, 2019).

CONCLUSION

However, we can conclude and elucidate the importance of multidisciplinary participation of team members, highlight the importance of the participation of each actor in care and the role of different levels of health care. In addition, we can observe in the development of research important points that caught our attention. First, the approach to the theme with patients from Primary Health Care (PHC), giving autonomy to their power of choice and decision in this process, bringing the discussion to other levels of health as not only the approach to the theme in tertiary care. Another important point is the strengthening of policies that provide the basis for achieving comprehensive care, comfort and quality of life for patients.

It is worth mentioning the importance of family members' participation in this process, respecting the decision-making process, offering comfort and psychological support in order to optimize the integral processes of comfort to patients.

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