PALLIATIVE CARE IN PRIMARY HEALTH CARE

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Abstract: This study sought to understand the profile of productions on palliative care in primary health care. An integrative literature review was conducted, and articles retrieved from the secondary databases Virtual Health Library, Latin American and Caribbean Literature in Health Sciences, Scientific Electronic Library Online and Online System for Searching and Analyzing Medical Literature were analyzed using the descriptors palliative care, primary health care and basic care. The palliative care movement has been growing and gaining notoriety due to the demographic and epidemiological transition, characterized by the increase in the adult and elderly population and, consequently, by changes in clinical processes, leading to a gradual increase in chronic and complex diseases that affect multiple organs, which sometimes threaten the continuity of life. The studies highlight the need for training professionals, the development of specific protocols and the implementation of strategies that promote more humanized, continuous and person-centered care.

Keywords: palliative care; primary health care; quality of life.

INTRODUCTION

The aging population and the higher prevalence of chronic non-communicable diseases, such as neoplasms and cardiovascular diseases, have highlighted a growing portion of the population that needs end-of-life care (Floriani; Schramm, 2022).

The World Health Organization (WHO) adopted the term palliative care (PC) in 1982, when the Cancer Committee of this Organization created a working group to define policies aimed at pain relief and hospice care for cancer patients, stimulating the creation of support services in all countries (Oliveira; Ferreira; Rezende, 2013). The English Cicely Saunders is responsible for the new conception of specialized care for terminal patients developed in differentiated units, which were called hospices (Floriani, 2009)

PC is, therefore, an interdisciplinary field of total, active and comprehensive care, provided to patients with advanced end-stage diseases and their families. And it was organized in practice and theory at the end of the 1960s.1 In Brazil, this approach to care began to be inserted in services in the late 1990s, which confirms that it is a very recent practice (Palmeira et al., 2011).

PC aims to offer a way of dying that welcomes the patient, their caregiver and their family, giving them support to face this moment of their lives, extending it to the mourning phase. Therefore, there is no better space to discuss and put into practice palliative care than PHC, since it proposes to be and be close to the patient and his family, and to maintain close relationships with them (Floriani; Schramm, 2022).

On the other hand, the training of health professionals should be expanded in its contents, in such a way that it goes beyond merely technical and biological care. To work in the health network and in the SUS, health professionals must consider the global needs of people, who are part of a family, are in a community, lack quality and comprehensive services based on trust. Health professionals must know how to communicate with everyone, making patients owners and responsible for their health.

They must be able to decide which technologies to use based on cost, effectiveness and ethics, and lead by the trust received from the community, managing resources to meet the health needs of the community (Mendes, 2007). In addition, it is necessary to train professionals capable of facing death and dying consciously, being able to interpret them as an integral and inseparable part of life and not as its antithesis (Silva; Ruiz, 2003).

Thus, there are gaps in studies that analyze the profile of quaternary prevention in health care. In this sense, the present study seeks to know the profile of the productions on palliative care in primary health care.

METHODS

An integrative literature review was carried out. This approach was adopted because it allows the combination of data from investigative and theoretical research that can be thus directed to conceptualizations, registration of gaps in the areas of investigation, theoretical review and methodological analysis of studies on a specific subject, allowing the analysis of the literature (Ercole; Melo; Alcoforado, 2014).

In this sense, six interdependent and interrelated phases were considered: elaboration of the guiding question, search or sampling in the literature, data collection, critical analysis of the included studies, discussion of the results and presentation of the integrative review. How the guiding question was defined: What is the profile of studies on quaternary prevention in the country? (Souza; Silva; Carvalho, 2010).

Studies were collected through an electronic search in the following databases available in the Virtual Health Library (VHL), Latin American and Caribbean Literature on Health Sciences (LILACS), the Scientific Electronic Library Online (Scielo) and the Analysis of Medical Literature (MEDLINE).

The inclusion criteria included complete articles available electronically, in Portuguese, English or Spanish and that presented the theme proposed in the title, abstract or descriptors. Regarding the eligibility criteria, letters to the editor, editorials, duplicate articles, and those that did not unequivocally address the theme under study were considered.

The survey of studies was conducted during the months of May to August 2024. As research strategies, the Health Sciences Descriptors (Decs) were used, retrieved through the website: https://decs.bvsalud.org/, which were primary care, primary health care and primary care, for the refinement of the search and better selection of data for analysis, the Boolean and for combination of the selected descriptors.

For data collection, an instrument validated by Ursi (2005) for integrative reviews was developed, covering the following categories of analysis: identification code, title of the publication, author and author's education, source, year of publication, type of study, region in which the research was carried out and the database in which the article was published. After selecting the articles, the information that would be extracted from the studies was defined. To enable the apprehension of the information, a database prepared in the Microsoft Office Excel software 2010, composed of the following variables: title of the article, year of publication, study design, and main outcomes. The data obtained were grouped in a table and in thematic approaches and interpreted according to specific literature.

RESULTS

We included 10 studies in the present review that met the eligibility criteria; The following table describes the titles, methods, and main outcomes of the studies analyzed (Chart 1). In general, there was a reduced number of studies on the subject, especially in view of the impact of the theme on the epidemiological panorama of the country.

Table 1. Studies included in the review and the characteristics evaluated.

Title	Methods	Key outcomes
Palliative care in Primary Health Care: perspective of physicians and nurse preceptors in Family Health	Qualitative study	The results revealed cases experienced in the reports of all the participants, but the lack of formal learning among other main difficulties: the pressure of care, lack of supplies and medicines and the non-prioritization of management at the level represented by the lack of government guidelines. However, the participants were unanimous in stating that palliative care should be offered in primary care and emphasized that both doctors and nurses base their actions on the transfer of knowledge related to practice.
Palliative Care in Primary Health Care: the perspective of health professionals	Descriptive and exploratory study	it was found that the professionals have general and empirical concepts of PC and more specific concepts of PHC. “Empirical training” comes from practice that aims at quality of life and humanized care, with no training and discussion about PC in PHC
Palliative care in primary health care: Discussion of a case	Cartographic approach	The difficulty related to palliative care of the present case is linked to the care model centered on cure, not inclusion family relationships in care and lack of team training of Primary Care for palliative care
Palliative Care in Primary Health Care: Perceptions of physicians from the Family Health Strategy on the subject in practice.	Qualitative study with a descriptive approach	The results point to the need to include subjective dimensions in care and interdisciplinarity as a working method in PC practices
Palliative care in primary health care: team perceptions of interdisciplinary practice	This is a descriptive, qualitative research with an approach to Alfred Schütz’s social phenomenology	In the Reasons-why, the professionals normalize the fragmentation of the work process, as well as that their experiences permeated the immediate consequences of the pandemic, such as the lack of team meetings, which aggravated the already delicate interdisciplinary relationships. In the Reasons-for, it was understood, above all, the importance of resuming team meetings and expanding multiprofessional teams
Building foundations for palliative care in primary care: experience report of the Manto Project	Experience report	The experience of the Manto Project challenges the reality of the interior of the Brazilian Northeast in a context of economic crisis, fragility in the training of professionals and permanent education of health workers.
Conceptions, challenges and competencies of nurses in palliative care in primary health care	Qualitative exploratory study	They suggest that the main challenges comprise incipient knowledge on the subject, lack of technical and scientific preparation, and the absence of a multiprofessional team in the services they work in.

Palliative care in primary care: physicians' and nurses' knowledge of the family health strategy	Cross-sectional, analytical study	Blood pressure and capillary glucose were the most common practices in the care of patients in PC, 46 professionals (69.7%). The health professionals who performed best had a graduation time ≤ 5 years (among physicians) and ≥ 10 years (among nurses)
Palliative Care in Primary Health Care: Perceptions of doctors from the Family Health Strategy on the subject In practice	Qualitative study and descriptive approach	The results point to the need to include subjective dimensions in care and interdisciplinarity as a working method in PC practices
Managers' perspectives on a proposal for continuing education in palliative care in primary care	Action research	It was identified that the educational proposal elaborated, by adding permanent education in health and palliative care, enabled the management to envision a dynamic strategy capable of transforming the practices of primary care service. Involving management broadened the scope of the proposed model, enhancing its appropriation not only at the local level, but in an integrated way with the health care network.

Source: study data.

DISCUSSION

In Brazil, the palliative care movement has been growing and gaining notoriety due to the demographic and epidemiological transition, characterized by the increase in the adult and elderly population and, consequently, by changes in clinical processes, leading to a gradual increase in chronic and complex diseases that affect multiple organs, which sometimes threaten the continuity of life (Gomes; Othero, 2016).

Palliative care (PC) is defined as active holistic care, offered to people who are in intense health-related suffering from serious illnesses, especially for individuals who are at the end of life. Such care aims to improve the quality of life of patients, families and caregivers (International). It is recommended that the aforementioned definition be adopted and used as a model in the construction of health policies and educational initiatives (Santos; Santos-Junior; Pessalacia, 2016).

Considering the intense demographic and epidemiological transition that occurs in Brazil, there is a gradual increase in the number of users of the Unified Health System (SUS) from the perspective of palliative care, highlighting the inherent need to reorganize health services to meet this demand (Souza et al., 2015).

Primary health care (PHC) has been considered the best level of health care for the provision and coordination of palliative care, due to the geographical and cultural proximity and the bond between the professionals who work in these units and the population, which can contribute to care occurring in a humanized way (Silva, 2014).

The integration of palliative care in primary health care (PHC) represents a fundamental strategy to promote more humanized, accessible, and effective care for patients with advanced chronic diseases or those with significant functional limitations. This approach aims not only to alleviate symptoms, but also to offer emotional, social, and spiritual support, promoting quality of life until the end of life (IAHPC, 2018).

Primary care is the first level of contact between the individual and the health system, characterized by its comprehensiveness, longitudinality, and coordination of care. Inserting palliative care at this level allows for early, continuous, and person-centered intervention, facilitating symptom management, shared decision-making, and support for families. Thus, PHC becomes a strategic space for the implementation of comprehensive care for patients in the terminal phase or with complex chronic diseases (Mendes, 2012).

One of the main benefits of integrating palliative care in PHC is the possibility of early identification of patients who need specialized support, avoiding unnecessary hospitalizations and promoting care in the home or community environment. This strategy contributes to reducing costs and reducing suffering, promoting more humanized care that is closer to the patient's needs (Mitchell et al., 2010).

The primary care team, composed of doctors, nurses, community agents and other professionals, plays a central role in the continuous assessment, in the control of symptoms such as pain, dyspnea, nausea and anxiety, in addition to offering emotional support and guidance to families. This multidisciplinary approach ensures a more complete care, respecting the patient's preferences and values, promoting autonomy and dignity (Combinato, 2011).

Another important aspect is the training of PHC professionals in palliative care. Often, these professionals do not have specific training in the area, which can limit the quality of care offered. Investing in training, protocols, and educational resources is essential to expand the team's competence and ensure safe, ethical, and effective care (Arksey; O'Malley, 2003).

Primary care also plays a crucial role in communication and advance care planning, including discussions about wishes, treatment goals, and end-of-life preferences. These conversations help to avoid unnecessary interventions, respecting the patient's autonomy and promoting a dignified death, according to their values and beliefs (Moher et al., 2009).

In addition, the integration of palliative care in PHC favors attention to psychosocial and spiritual needs, often neglected in models focused only on cure. Emotional support for families, psychological follow-up and respect for spiritual issues contribute to the general well-being of the patient and their loved ones (Guedert; Grosseman, 2012).

The implementation of this integration faces challenges, such as lack of resources, adequate training, and specific public policies. However, successful experiences demonstrate that, with the involvement of the community, the strengthening of the health team, and institutional support, it is possible to expand access to palliative care in primary care in a sustainable way (Hermsen; Ten, 2003).

Technology can also be an ally in this process, through teleconsultations, electronic records, and standardized protocols, facilitating continuous monitoring and communication between different levels of care. These tools enhance the performance of the PHC team, promoting more coordinated and efficient care (Cameron; Santos, 2009).

The culture of attention to death and end-of-life care needs to be transformed, promoting a more open, welcoming and humanized vision. Raising awareness in society, involving family members and valuing person-centered care are essential (Meijler et al., 2005).

CONCLUSION

The analysis of the profile of productions on palliative care in primary health care revealed a growing attention to the importance of integrating this care at this level of care. The studies highlight the need for training professionals, the development of specific protocols, and the implementation of strategies that promote more humanized, continuous, and person-centered care. In addition, it was observed that there is an emphasis on the promotion of home care, effective communication and support to families, essential aspects to ensure quality of life for terminal patients. These findings reinforce the relevance of expanding studies and actions aimed at incorporating palliative care into primary care, contributing to a more comprehensive, accessible, and humanized care. Thus, strengthening this area can promote significant improvements in the quality of care offered and in the satisfaction of patients and their families.

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