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EXPERIENCE REPORT

SHORT COURSE ABOUT PALLIATIVE CARE: SPACE OF POTENCY FOR THE DEVELOPMENT OF SKILLS IN HEALTH TRAINING

MINICURSO SOBRE CUIDADOS PALIATIVOS: ESPAÇO DE POTÊNCIA PARA O DESENVOLVIMENTO DE COMPETÊNCIAS NA FORMAÇÃO EM SAÚDE

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Abstract
Object: to report the experience of conducting a mini-course on palliative care conducted by the Academic League of Oncology of a Public University. **Methodology:** this is a descriptive study of the experience report type. The short course took place at a Public University and it was structured by competences and in five stages, with the following themes: historical and philosophical concepts about palliative care; updates and evidence concerning the theme; instruments for evaluating patients in palliative care; comprehensiveness in health and approach on how to communicate difficult news using the SPIKES protocol. For this purpose, dialogued exposition was used as a methodology, as well as active teaching methods, such as cinema-debate, simulation and psychodrama. The short course lasted 4 hours and was attended by 50 people, including students and professionals in Nursing, Medicine, Nutrition and Psychology. **Results:** the methodologies adopted in the mini-course enabled the mobilization of prior knowledge, the collective construction of concepts, reflections on difficult to approach topics, good interaction between participants, knowledge of instruments used in clinical practice in palliative care by the interprofessional team, decision-making, in addition to the acquisition of social-

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emotional and communication skills, according to the participants' reports. **Conclusion:** it highlights the importance of promoting dialogical spaces that deal with palliative care in health training scenarios, and that are structured on competence-based education, to provide humanized, solidary and ethical care to human beings and your family.

Keywords: Palliative Care; Training of Human Resources in Health; Patient Assistance Team; Holistic Health; Competency-Based Education**.**

Resumo

Objeto: relatar a experiência de realização de um minicurso sobre cuidados paliativos realizado pela Liga Acadêmica de Oncologia de uma Universidade Pública. **Método:** trata-se de um estudo descritivo do tipo relato de experiência. O minicurso ocorreu em uma Universidade Pública, sendo estruturado por competências e em cinco etapas, com os seguintes temas: conceitos históricos e filosóficos acerca dos cuidados paliativos; atualidades e evidências concernentes à temática; instrumentos de avaliação dos pacientes em cuidados paliativos; integralidade em saúde e abordagem de como realizar a comunicação de notícias difíceis, utilizando o protocolo SPIKES. Para tanto, utilizou-se como metodologia a exposição dialogada, e métodos de ensino ativos, como cine-debate, simulação e psicodrama. O minicurso teve 4 horas de duração e contou com a presença de 50 pessoas, dentre estas discentes e profissionais de Enfermagem, Medicina, Nutrição e Psicologia. **Resultados:** as metodologias adotadas no minicurso possibilitaram a mobilização de conhecimentos prévios, a construção coletiva de conceitos, reflexões sobre temas de difícil abordagem, boa interação entre os participantes, conhecimento de instrumentos utilizados na prática clínica em cuidados paliativos pela equipe interprofissional, tomada de decisão, além da aquisição de habilidades socioemocionais e de comunicação, segundo relatos dos participantes. **Conclusão:** sinaliza-se para a importância da promoção de espaços dialógicos que versem sobre os cuidados paliativos nos cenários de formação em saúde, e que se estruturem no ensino baseado em competências, para prestação de um cuidado humanizado, solidário e ético ao ser humano e sua família.

Palavras-chave: Cuidados Paliativos; Capacitação de Recursos Humanos em Saúde; Equipe de Assistência ao Paciente; Saúde Holística; Educação Baseada em Competências.

INTRODUCTION

Globally, life expectancy has been increasing annually (approximately 20 years in the last 6 decades), and this increase is associated with the improvement of the population's living conditions and the increase in health care technologies[1]. Technical-scientific advances have made it possible to control and/or eliminate multiple diseases that once led to imminent death[1-2]. In spite of this, there has been a change in the burden of diseases, both in developed and developing countries, which makes people tend to get sick and die in contemporary times due to chronic non-communicable diseases (NCDs), and concomitantly to this, communicable diseases still persist[1-3].

It is pointed out that chronic non-communicable diseases now constitute 7 of the 10 leading causes of death in the world, according to global health estimates, with cardiovascular diseases, cancer, chronic respiratory diseases and diabetes being highlighted. With regard to communicable diseases, malaria, hepatitis B and C, tuberculosis and HIV/AIDS stand out, revealing a scenario that points to chronicity as a major global public health problem, which needs tools to fight and control it[1,3]. In this context, the importance of palliative care is highlighted as longitudinal health care practices, which should be incorporated into health practices in the different care settings of the care network. Palliative care is defined as comprehensive care to improve the quality of life in all aspects and dimensions of the human being, facing a potentially fatal disease. This care is developed through early identification, prevention and relief of suffering, impeccable assessment of pain treatment and other biopsychosocial-spiritual symptoms[4].

They urgently need to be implemented in an effective way at a global level, since, in the case of communicable diseases, they tend to be implemented in the age group between 15 and 59 years old and with regard to NCDs, individuals who need palliative care are over 60 years old[3,5]. It is noteworthy that, regardless of diagnosis or age, patients have similar health needs and symptoms, such as dyspnea, pain, mental, social and spiritual suffering, which need to be approached by health professionals in a competent, resolute and humanized manner[5-6].

In line with the above, it is estimated that annually, more than 61 million people experience health problems which are associated with suffering, which can be significantly improved by the implementation of palliative care. However, approximately 90% of suffering individuals do not have access to even the most basic palliative care interventions, which highlights the gaps related to care practices in Brazilian and global health[3,7].

Based on the above, and given the needs of patients and family members affected by cancer, palliative care is one of the axes of care. Thus, based on the context presented, it is imperative to train human resources in health, in order to develop skills to act in this reality. In this perspective, in order to contribute to comprehensive and holistic care in Oncology, the Academic League of Oncology of a federal public university held, in 2018, a short course on the topic of palliative care aimed at students and health professionals, oriented towards training based on competences (knowledge, skills and attitudes).

In line with what has been discussed internationally, it is important to highlight competency-oriented health education, as it enables a more effective and humanized performance of health care professionals, stimulating and promoting critical reflection, clinical reasoning, the taking of decision, interprofessionalism, attitudinal skills (solidarity, ethics, compassion, respect, qualified listening) and responds to the demands imposed by the scenario of social changes[-9].

In view of the above, this study aims to report the experience of conducting a short course on palliative care conducted by the Academic League of Oncology of a Federal Public University.

METHOD

The present is characterized in a descriptive study of the experience report type, carried out by participants of the Academic League of Oncology. It deals with the experience of conducting a short course concerning palliative care, which took place in 2018 at a federal public university, lasting 4 hours and with the presence of 50 people, including students and professionals in Nursing, Medicine, Nutrition and Psychology.

The objectives of the short course were: to present the historical and philosophical concepts inherent to palliative care; talk about current events and evidence presented in the literature on the subject; present and demonstrate the use of instruments to assess patients in palliative care; reflect on comprehensiveness in health, demarcating the potential of spirituality in the health-disease-care process in palliative care and discuss the approach of how to communicate bad news.

As for the methodologies used, the short course adopted dialogued exposition, cine debate and active teaching methods for a practical approach, using simulation and psychodrama. These strategies were guided by competences, distributed in the four pillars of learning to be, learning to do, learning to live together and learning to know, with the purpose of brokering critical-reflective processes to promote the development of competences to work in palliative care.

The short course took place in five stages, described below: in the first stage, a dynamic entitled: “What is palliative care?” was carried out, aiming to mobilize and bring to light the participants' prior knowledge on the subject. In the dynamics, participants should, in a word, describe what they believed to be palliative care. Afterwards, the conductor of the dynamics read the answers, as a way of informing the group of individual views, aiming at building a collective knowledge/concept. The words that appeared in the dynamics were presented in Figure 1.

Figure 1: Wordle with the words used by the participants to define palliative care.

Font: Prepared by the authors, data from the present study, 2021.

The second stage consisted of a theoretical explanation of the historical and philosophical definitions of palliative care, as well as the current implementation scenario. To support the presentation, the lecturers based themselves on productions from the Latin American Association of Palliative Care and the National Academy of Palliative Care, as well as on articles and books concerning the theme. During the explanation, the participants were able to question and interact with the ministers, making the moment extremely cozy and welcoming to all those present.

In the third stage, emphasis was placed on comprehensiveness in health, especially because holism defines the person as more than the sum of the parts and this includes all dimensions, and it is not possible to exist without any of them. Then, there was a demonstration of the use of some instruments concerning the practice of palliative care, aiming at a more comprehensive assessment of patients. The instruments mentioned and presented were: the Multidimensional Assessment Diagram and the Palliative Performance Scale.

The fourth stage took place through the cine debate, through the presentation of videos and photos of life reports from patients who underwent palliative care. It is noteworthy that it was a moment surrounded by a lot of emotion, where the participants were sensitized and moved. At this stage, the ministers also explained about spirituality, and its benefits in the health-disease-care process of individuals with cancer.

Finally, in the fifth stage of the short course, the theme “Communication of bad news” was addressed. This stage began with the use of simulation and psychodrama, with a fictitious case being explained, in which the physician should communicate the current clinical condition and prognosis of a woman to her husband. After the simulation, the ministers continued the short course, using the case and the actions/reactions of the invited participant in the simulation as a basis for dialoguing about the communication of bad news. It is emphasized that this step was conducted using the techniques reported and complemented by the explanation of the use of the SPIKES protocol, which describes six didactic steps for communicating bad news, as shown in Table 1.

Table 1 - SPIKES protocol steps.

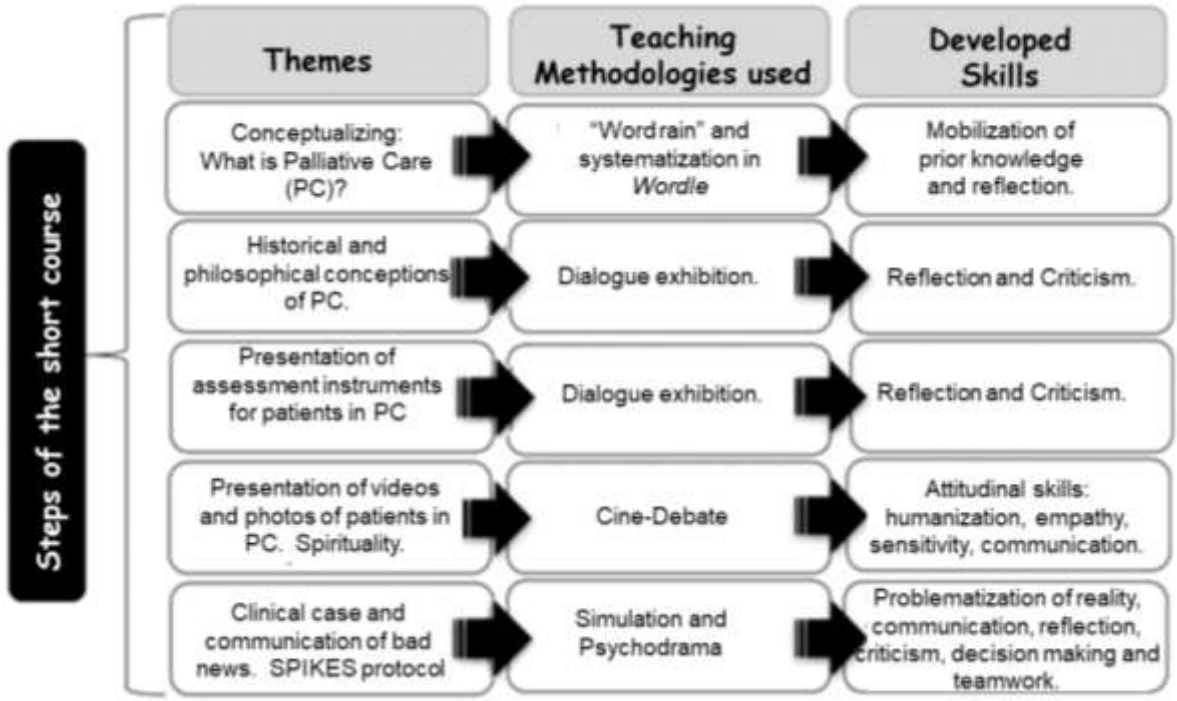
STAGE	DESCRIPTION
SETTING UP *(preparing for the meeting)*	It refers to the preparation of the professional responsible for communication, as well as the physical space where it will take place.
PERCEPTION *(Perceiving the patient)*	It is characterized by checking the understanding of the patient/family in relation to the general state of the central individual.
INVITATION *(Inviting to the dialogue)*	It is configured in the search for understanding how much the patient/family wants to know about their disease and/or condition.

KNOWLEDGE *(Transmitting the information)*	It properly constitutes the transmission of information as "bad news". It is specifically recommended in this step not to do it brusquely, not to use excessive technical terms, and to constantly check the understanding of the patient/family member who is receiving the news. Furthermore, it is essential to make use of introductory phrases that signal the arrival of bad news.
EMOTIONS *(expressing emotions)*	It is based on the empathetic response to the reaction manifested by the patient/family.
STRATEGY AND SUMMARY *(Summarizing and organizing strategies)*	It is characterized as the completion of a summary of the conversation and the construction of the therapeutic plan, pointing out what may happen, this step aims to reduce the anxiety of the patient/family.

Font: CRUZ; RIERA[10] [edited].

The five stages of the short course were systematized in Figure 2.

Figure 2 - Systematization of the stages of the short course: themes, methodologies used and skills developed by the participants in the short course on Palliative Care.



Font: Prepared by the authors, with data from the present study, 2021.

RESULTS AND DISCUSSION

The results expressed in the word cloud (Wordle) used by the participants of the short course to conceptualize palliative care, reveal that there was a stigmatized and limited knowledge regarding the subject. Findings in line with the literature, revealing that words such as “death, loneliness, finitude, terminality and suffering” were used by participants in another study to define palliative care, contributing to a negative view of this moment/care process[11].

It is noteworthy that as it is a graphical representation by Wordle, the size of the words explains the number of times they appeared; thus, the larger the word length, the greater the number of times it was mentioned by the course participant[12]. In the meantime, it is pointed out that the words that appeared the same number of times had similar sizes, which indicates that palliative care is still defined in a very heterogeneous way, signaling the little knowledge/familiarity about the subject[11,13]. Therefore, this question marks the need for investments in professional qualification actions/activities, as reported in this study.

According to Costa, Poles and Silva[13], in fact, the above is related to the deficit of knowledge and experience that professionals/students have in their professional training concerning palliative care. In this perspective, work carried out by Lins et al.[11] point out that palliative care has different dimensions, such as interdisciplinary work, some dilemmas and obstacles, as well as multiple potentialities. Thus, it is demarcated that it is necessary to create strategies that aim to minimize stigmas such as those presented in the participants' concepts about palliative care[14], as well as to expand the knowledge of professionals and future health professionals in relation to this theme.

In line with the above, Costa, Poles and Silva[13] demonstrate that a change can occur in relation to training in palliative care, however, this still poses a major challenge. Especially because it is still difficult to have model-strategies for teaching subjective aspects, which are correlated with attitudinal skills, such as the practice of empathy, providing comforting words and understanding the real needs of patients.

It is pointed out that, in the case of health training, given the rates of bad death in contemporary times[4,15], it is essential to think about the approach to palliative care during the training process, especially because the need for this training in the literature is explained. degrees in health sciences, since professionals in this area will face this reality in their professional practices[16-17].

It can be seen that the first stage of the short course achieved its intent, as it mobilized prior knowledge and promoted reflections in the participants about the theme, and, in addition, it provided opportunities for contact with the new. Furthermore, it is noteworthy that when addressing a little-known subject, it is essential to present its historicity, especially given the fact that even though palliative care has gained notoriety only in contemporary times, its origin is more than 60 years old, having as a pioneer the assistant social, nurse and doctor, Cicely Saunders[18].

During the theoretical explanation, the participants were able to question and interact with the ministers, with a good interaction between them. This exchange of knowledge and good interaction between those involved in the short course resulted from the critical-reflective method, as it encourages collaboration, encouraging interaction between individuals, enabling the expansion of individual and collective consciousness[19].

The importance of making the teaching-learning spaces more dialogued is then confirmed, as described in the second stage of the short course, especially so that those involved in these processes can develop reflection and criticism in relation to the topic addressed, in this specific case, the palliative care.

In the third stage of the short course, some instruments used in everyday palliative care were presented. The importance of these instruments is recognized by health professionals, as they enable the assessment of individuals who no longer respond to treatments that modify the course of the disease, identifying the need for early implementation of palliative care[20].

Regarding the Multidimensional Approach Diagram, this is not characterized as a protocol, but as an interactive and flexible tool, which considers the indivisibility of the indivisible human being and the integrality of care, in addition to facilitating the understanding of professionals involved in this care in relation to the its four basic axes for palliative care (physical, family/social, psychological and spiritual)[21]. In the meantime, it is indicated that the diagram, when completed by the team, based on the observations/perceptions about the patient and their family relationship, enables the formulation of behaviors, which aim to alleviate the suffering presented[21-22].

Regarding the Palliative Performance Scale, its wide use in the indication of palliative care was explained, as it allows the establishment of the patient's prognosis and functionality[22-23]. A recent systematic review explains that the Palliative Performance Scale has been used in different scenarios and contexts to measure the survival of end-of-life patients[23]. The authors confirm that the Scale is extremely important, as it can be used in intensive care settings or at home to identify those who should receive palliative care services earlier[23].

Thus, it appears that the dialogued exposition registered in the third stage of the short course allowed the participants to have contact with new instruments potentially usable in professional practice, enabling them to understand their role as health professionals in identifying the need to implement palliative care. And therefore, become responsible for contributing to the improvement of palliative care assistance. This finding demonstrates the importance and effectiveness of the short course and the methodology used, as it provided autonomy, allowing for a new meaning and direction to carry out new practices[24].

In the fourth stage, participants were sensitized about palliative care, in addition to experiencing practical approaches based on simulation and psychodrama. It is noted that at this stage, many of the participants were emotional, either because of the subjective/emotional demand that involves caring for life-threatening diseases, often without individuals being prepared for it[25], and/or because they are confronted by their inexorable finitude[26].

Because palliative care is strictly related to comprehensiveness and holistic care, even in the fourth stage, the importance of spirituality in the health-disease process was highlighted, signaling the importance of understanding/approaching the human being as a biopsychosocial-spiritual being. In this perspective, Andrade et al[27], explain that not taking such an approach in clinical practice is characterized as negligence, in addition to being related to worse health outcomes[28].

At this stage, socio-emotional/attitudinal skills were worked on (humanization, solidarity, ethics, qualified listening, empathy, awareness and communication), which are essential for health care[25]. In view of this, Carmo and collaborators[25] confirm the importance of professionals remaining in constant improvement, in order to manage the difficulties and challenges related to the care process better.

Finally, the theme addressed in the fifth stage of the short course, the communication of difficult news, constitutes one of the biggest gaps in the care process. Since communication is fundamental for the work of the multidisciplinary team, as well as for the professional-client interaction, professionals often do not feel safe or prepared to carry it out, especially when the focus is on communicating difficult news[29].

Souza, Lacerda and Lira[29] argue that the communication process must be clear and effective, aiming to assist in supporting, guiding, clarifying and solving problems and needs presented by the client. And when the subject to be communicated is related to bad news, professionals need to have qualified and active listening, non-violent communication, emotional control and technical knowledge, in order to know how to behave in the situation they will experience with the patient in the process of loss/grief or end of life[29].

In this perspective, it is possible to demarcate that the use of the SPIKES protocol was configured as positive, as it describes in detail the steps to be followed for an effective communication of bad news. It is noteworthy that SPIKES is not a recipe that, when followed, will result in excellent communication, without negative feelings and suffering[30]. However, it guarantees clarity in the information provided and allows for the systematization of a difficult and complex task in clinical practice[14].

At this stage, the simulation that provides opportunities for real experiences, in a controlled environment, through the implementation of cases that reflect situations of daily clinical practice[31], and psychodrama, which is a method of deep and transformative action, which works on both interpersonal relationships and ideologies private and collective that support them[32], mobilized competences of fundamental importance in health practice (problematization of reality, communication, reflection, criticism, decision-making and teamwork), especially in palliative care.

The importance of training activities such as the one described here is explained, as, for an effective approach to palliative care, it is necessary to teach more than theories, as professionals will have to link theory and practice, in multiple experiential contexts, in order to support the needs of the patient and his family[33]. So, thinking about training based on competences is essential, as these will guarantee the professional the acquisition of critical and ethical reasoning, decision making, interprofessional work, more global knowledge, linked to the acquisition of socio-emotional skills[33].

Finally, it is emphasized that the short course provided participants with contact with the palliative care theme, as this is, according to Silva et al.[14], little addressed in the training of health professionals. Thereby, it is extremely important to strengthen and disseminate activities in the context of university education and continuing education, in order to bring people closer to issues that are essential to the health care process and that touch the lives of individuals and families in the process of oncological illness. Thus, this experience provided opportunities for reflections and discussions related to holistic care, the essence of palliative care, which is an emerging need in health education.

CONCLUSION

This study explains an experience, potentially replicable in other realities and contexts. Furthermore, it is confirmed that the power of the short course is undeniable as a space for the development of health skills (knowledge, skills and attitudes).

It is also indicated that palliative care is a therapeutic approach in imminent evolution and ascension, where, increasingly, there has been an attempt to develop and apply evidence-based care. Therefore, it is concluded that providing spaces and resources for the training and improvement of professionals and students becomes relevant in the academic and professional environment, since it is up to universities to respond to social and health demands, maintaining a dialogue with society through articulation teaching-service.

In view of this, with this experience report, the aim is to disseminate and contribute in general to the realization of new moments of continuing education and training in the university environment, as well as new research, studies and practical applicability that deal with palliative care and comprehensive health care.

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