

Quality of Life of Cancer Patients in Home Palliative Care and Challenges of Medical Practice Facing the Finitude of Life

doi: <https://doi.org/10.32635/2176-9745.RBC.2020v66n4.423>

Qualidade de Vida de Pacientes Oncológicos em Cuidados Paliativos Domiciliares e Desafios da Prática Médica diante da Finitude da Vida

Calidad de Vida de los Pacientes con Cáncer en Cuidados Paliativos en el Hogar y Desafíos de la Práctica Médica que Enfrentan la Finitud de la Vida

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ABSTRACT

Introduction: Palliative Care (PC) emerges as an important therapeutic approach in face of cancer progress. **Objective:** To identify the factors that affect the quality of life (QoL) of patients in home PC and discuss issues related to medical practice in health care. **Method:** Quantitative, qualitative, cross-sectional and descriptive study, involving 9 patients in home care at Ophir Loyola Hospital (HOL), using the Palliative Outcome Scale (POS), Patient Personal Profile Questionnaire and Quality of Life Questionnaire. **Results:** All the participants were diagnosed for over a year and had been in palliative care for more than six months, and most have already submitted to different therapeutic modalities, especially chemotherapy. Breast was the main site of primary tumor and among the physical symptoms presented, the presence of pain was reported by the majority of the participants. Analytical categories emerged from the theme quality of life, and the maintenance of health, family life, financial balance, importance of faith and hope, performance of daily and work activities and maintenance of autonomy were identified as variables that positively affect QoL. Socioeconomic difficulties were associated with worse performances in POS. All presented positive evaluation of the work done by the PC team. **Conclusion:** Clinical and social problems, especially pain and economic limitations are factors that interfere with the QoL of patients in home care. Despite the advances achieved, medicine still needs to prioritize the terminality of life as an inseparable part of medical education and practice.

Key words: Neoplasms; Palliative Care; Home Nursing; Quality of life.

RESUMO

Introdução: Os cuidados paliativos (CP) despontam como importante abordagem terapêutica diante do avanço do câncer. **Objetivo:** Identificar os fatores que interferem na qualidade de vida (QV) de pacientes em CP domiciliares e discutir questões relacionadas à prática médica no cuidado em saúde. **Método:** Pesquisa quanti-qualitativa, transversal e descritiva, com participação de nove pacientes em acompanhamento domiciliar no Hospital Ophir Loyola (HOL), e utilização do *Palliative Outcome Scale* (POS), do Questionário de Perfil Pessoal do Paciente e do Questionário de Qualidade de Vida. **Resultados:** Todos os participantes foram diagnosticados há mais de um ano e estavam em CP há mais de seis meses, sendo que a maioria já havia realizado diferentes modalidades terapêuticas, destacando-se a quimioterapia. O principal local de tumor primário foi a mama e, entre os sintomas físicos apresentados, a presença de dor foi relatada pela maioria dos participantes. Categorias analíticas emergiram do tema QV, sendo a manutenção da saúde, o convívio familiar, o equilíbrio financeiro, a importância da fé e a esperança, a realização de atividades cotidianas e laborais e a manutenção da autonomia identificadas como variáveis que interferem positivamente na QV. As dificuldades socioeconômicas foram associadas a piores desempenhos no POS. Todos apresentaram uma avaliação positiva do trabalho desenvolvido pela equipe de CP. **Conclusão:** Agravos clínicos e sociais, com destaque para a dor e as limitações econômicas, são fatores que interferem na QV dos pacientes em atendimento domiciliar. Apesar dos avanços alcançados, a medicina ainda necessita priorizar a terminalidade da vida como parte indissociável da formação e prática médica. **Palavras-chave:** Neoplasias; Cuidados Paliativos; Assistência Domiciliar; Qualidade de vida.

RESUMEN

Introducción: Los cuidados paliativos (PC) emergen como un enfoque terapéutico importante frente al progreso del cáncer. **Objetivo:** Identificar los factores que afectan la calidad de vida (QOL) de los pacientes con PC en el hogar y discutir temas relacionados con la práctica médica en la atención médica. **Método:** Estudio cuantitativo, cualitativo, transversal y descriptivo, que involucró a nueve pacientes en atención domiciliar en el Hospital Ophir Loyola (HOL), utilizando el *Palliative Outcome Scale* (POS), el Cuestionario de perfil personal del paciente y el Cuestionario de Calidad de Vida. **Resultados:** Todos los participantes fueron diagnosticados durante más de un año y habían estado en PC durante más de seis meses, y la mayoría ya había realizado diferentes modalidades terapéuticas, especialmente quimioterapia. El sitio principal del tumor primario fue la mama y entre los síntomas físicos presentados, la mayoría de los participantes informaron la presencia de dolor. Las categorías analíticas surgieron del tema calidad de vida, y el mantenimiento de la salud, la vida familiar, el equilibrio financiero, la importancia de la fe y la esperanza, el desempeño de las actividades diarias y laborales y el mantenimiento de la autonomía se identificaron como variables que afectan positivamente la calidad de vida. Las dificultades socioeconómicas se asociaron con peores desempeños en POS. Todos tuvieron una evaluación positiva del trabajo realizado por el equipo de PC. **Conclusión:** Los problemas clínicos y sociales, especialmente el dolor y las limitaciones económicas, son factores que interfieren con la QOL de los pacientes en atención domiciliar. A pesar de los avances logrados, la medicina aún necesita priorizar la terminación de la vida como una parte inseparable de la educación y práctica médica.

Palabra clave: Neoplasias; Cuidados Paliativos; Atención Domiciliar de Salud; Calidade de Vida.

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INTRODUCTION

In the last decades, cancer has reached alarming levels, being considered a severe health public problem and one of the main causes of death for the world population^{1,2}. Estimates indicate that for Brazil in each year of the triennium 2020-2022, 625 thousand new cases of cancer will occur, revealing the magnitude of the problem also in the national context⁴.

Prevention and relief of suffering, early identification, impeccable evaluation, treatment of the pain and other physical, social, psychological and spiritual symptoms are emphasized as major principles of palliative care (PC)⁵. Although strongly related to oncology, PC has expanded to other areas of medical practice, being recommended since the moment the patient receives the diagnosis, extending until even its death in support to the family bereavement⁶.

Because of the increase of new cases and the evolution of the disease itself, the theme of PC has emerged as an important philosophy of health care, in special when chances of cure appear unlikely, even with the formidable therapeutic progress of the last years^{6,7}. Based in the acknowledgment of death as a natural event, PC advocate an active and whole approach promoted by an interdisciplinary team whose goal is to improve the quality of life (QoL) of the patient and its family in face of a life-threatening disease^{7,8}.

PC are intrinsically related to the pursue of better QoL of the patients who face incurable and severe diseases, which is a challenge for health practices, especially due to the close relation to terminality of life⁶⁻⁸. Nowadays, and even in medicine, death and dying related issues still remain bleak and problematic, reflecting in the poor preparation to perform in PC⁹.

According to the definition proposed by the World Health Organization (WHO), it is noted that QoL includes the individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns, allowing opportunities of choices, that is, it mirrors its autonomy and satisfaction with life¹⁰.

In 2018, in Brazil, PC were established as public policy and recognized as part of the continuous care within the National Health System (SUS), can be carried out in several scenarios, including hospital infirmaries, long stay institutions, specialized outpatient and at home¹¹⁻¹³.

The promotion of home PC allows the patients the possibility of remaining in their social and family context^{14,15}, with multi-professional, specialized care, ready to provide support and orientation to the family and/or caretakers, avoid recurring and unnecessary hospitalizations most of the times^{16,17}. However, homecare

are still infrequent in many places, considering its strong predominance in hospital environments¹⁷.

Despite the frequent interest for the theme, it is fundamental to carry out studies about QoL in patients who are in oncologic PC to identify the domains affected and plan the interventions to be performed¹⁸⁻²¹. Studies of this nature have the potential to contribute for the materialization of health public policies, guiding programs and therapeutic conducts, ensuring better dissemination of PC teaching in the Brazilian medical schools²²⁻²⁴.

Considering the importance of the theme and the paucity of scientific production about the subject, the study was designed to identify the factors interfering in the QoL of patients in home PC treated in an oncologic public hospital in Pará. It is a complex theme, but necessary to be problematized, considering the issues involved, in special those related to care in face of human finitude and its implications for medical practice.

METHOD

Quantitative, qualitative, cross-sectional and descriptive study conducted in the houses of the patients treated in home PC by Hospital Ophir Loyola (HOL). The hospital is a reference in oncology and PC in Pará and was the first to inaugurate a state Oncological Palliative Care Clinic (CCPO). Nine patients who were in CCPO systematic follow up during the data collection period and accepted to participate of the study voluntarily were enrolled.

Three instruments were utilized in the clinical trial, including the Palliative Outcome Scale (POS), validated nationally and consisting of 12 items, incorporating aspects about pain symptoms, symptoms in general, psychological well-being, family anxiety, quality of the PC and personal and financial difficulties according to the responses in the last three days. It was also utilized the Questionnaire of Personal Profile of the Patient elaborated by the investigators including sociodemographic data and questions about the clinical profile with information about the type of the disease, time of diagnosis, treatments conducted and time of admission in PC. The third instrument was the Questionnaire of Quality of Life with three open questions: 1) "In your opinion, what is quality of life?"; 2) "In your opinion, what are the factors that help and hamper your quality of life?"; 3) "In what way the care provided by the CCPO team interferes in your quality of life?"

Data collection was conducted through interviews with the patients registered in the home visit after their previous consent and availability, without interfering with the care. The interviews were recorded with a recorder

and fully transcribed, the number of participants was defined together with the health team and according to the clinical demand.

The data were analyzed through descriptive statistics in Excel and Statistical Package for the Social Sciences (SPSS). The analysis of the data of the open questions was done with descriptive categories organized previously according to the objectives proposed. The responses were later presented pursuant to the thematic categories extracted from the data obtained.

The Institutional Review Board (CEP) of the University of the State of Pará (UEPA) and of the HOL approved the study through report number 3,174,496. Prior to the interviews, the participants received two equal copies of the Informed Consent Form (ICF); one copy was given to the participant and the other was kept by the investigators. An alphanumeric code was assigned to each participant to protect their anonymity.

RESULTS

Most of the patients enrolled in the study were females (n=7, 77.7%), Black (n=4, 77.7%), divorced (n=4, 44.4%), Evangelic (n=5, 55.5%). The major part was in the age-range above 80 years old (n=4, 44.4%), followed by 60 to 80 years (n=3, 33.3%) and two patients were aged between 30 and 59 years (22.3%). The sample presented considerable socioeconomic difficulties: four patients (44.4%) earned only one minimum wage, three patients (33.3%) earned from one to two minimum wages and only two earned more than two minimum wages. Six patients were from the capital (66.65%) and three (33.35%) from the countryside (Table 1).

The results obtained with POS indicated higher mean score, less favorable in patients with family income lower than one minimum wage (mean of 20 scores), in comparison with those who earned from one to two minimum wages (mean of 13.3 scores) and above two minimum wages (mean 9). Similarly, it was also verified a mean worse POS score in divorced patients (mean 17.25) in comparison with married (mean of 16.6 scores) and in stable union (15 scores).

In Table 2, the clinicopathological characteristics are presented. Considering the most relevant properties, the main sites of the primary tumor were breast (n=5, 55.5%), rectum (n=2, 22.2%), prostate and oropharynx, both with n=1 (11.15% each). All the patients of the sample (n=9) have been diagnosed for more than 1 year. In relation to the previous treatments, chemotherapy n=1 (11.1%), chemotherapy associated to surgery n=2 (22.25%), chemotherapy associated to surgery and to radiotherapy n=3 (33.35%), surgery associated to radiotherapy n=1

Table 1. Distribution of patients according to the sociodemographic characteristics – absolute and relative frequencies. Belém-PA, 2019

Sociodemographic Characteristics	Categories	N	%
Gender	Female	7	77.7
	Male	2	22.3
Race	Black	4	44.4
	Brown	3	33.3
	Caucasian	2	22.3
Marital status	Married	3	33.3
	Divorced	4	44.4
	Stable union	1	1.15
	Widower	1	1.15
Age-range	30-59 years	2	22.3
	60-80 years	3	33.3
	>80 years	4	44.4
Religion	Evangelic	5	55.5
	Catholic	4	44.4
	< 1 minimum wage	4	44.4
Income range	1-2 minimum wages	3	33.3
	>2 minimum wages	2	22.3
Residence	Capital	6	66.6
	Countryside	3	33.3

Source: Clinical trial.

(11.1%), chemotherapy associated to radiotherapy n=1 (11.1%) and radiotherapy only n=1 (11.1%).

Considering the responses to the POS items, it is noticed that in relation to pain, eight patients (88.8%) reported they felt pain, 33% of mild intensity, 44.4%, moderate and 11.1%, severe. For other uncomfortable physical symptoms, 77.7% of the sample reported some type of symptom, with intensity varying from moderate (44.4%), mild (22.2%) and severe (11.1%).

Most part of the sample (55.5%) reported anxiety or concern about its disease/treatment. Regarding the patient's perception about the family response to the disease, 33.3% observed their family was concerned most of the time, 22.2% noticed sometimes and 11.1%, rarely. However, five patients (55.5%) reported difficulties to express and share their feelings with the family.

Concerning the information the patient receives about the disease, 55.55% of the sample reported they received the necessary information and 44.45%, reported they received information, but had difficulties to understand.

Table 2. Distribution of patients according to the clinicopathological characteristics – absolute and relative frequencies. Belém-PA, 2019

Clinicopathological characteristics	Categories	N	%
Type of cancer	Breast cancer	5	55.5
	Prostate cancer	1	11.1
	Rectal cancer	2	22.2
	Oropharynx cancer	1	11.1
Time of diagnosis	Less than 1 year	0	
	More than 1 year	9	100
	CT	1	11.1
Treatment	CT + surgery	2	22.2
	CT+ surgery + RxT	3	33.3
	Surgery + RxT	1	11.1
	CT + RxT	1	11.1
	RxT	1	11.1
Time in palliative care	1-3 months	3	33.3
	3-6 months	1	11.1
	6 months-1 year	2	22.2
	Above 1 year	3	33.3

Source: Charts of the Palliative Care Clinic of Hospital Ophir Loyola.

Captions: CT=Chemotherapy; RxT=Radiotherapy.

Almost nearly all the patients believe that their life is worthwhile in relation to the items reflecting their psychological well-being, their feelings are expressed as: “all the time” (n=4, 44.4%), “most of the time” (n=2, 22.2%) and “sometimes” (n=2, 22.2%) and “no, not even a little” (n=1, 11.1%). Two patients (22.2%) felt well with themselves “all the time”, three patients (33.3%) felt this “most of the time”, three patients (33.3%) felt “sometimes”, one patient felt well with itself “very few times” (11.1% of the sample).

It was observed that 55.5% of the patients dedicate until half a day to health-related appointments, including self-care and other associated to therapeutic prescriptions.

The financial problems related to the sickening process stood out as one of the main difficulties faced by six participants (66.6%), with emphasis in medication costs and diapers as exemplified in two narratives: “my husband quit his job to take care of me”, “there is no cash for food”. In addition, four patients (44.4%) referred personal problems such as “loss of autonomy and more dependence”.

The data obtained through the interview with open questions about what the patient believed QoL meant, the QoL improving and worsening factors of and the role

of the health team in home PC over the QoL are shown in Charts 1, 2 and 3.

Chart 1. Distribution of categories and content of the responses obtained about the understanding of “quality of life” in the interview with patients in home palliative care. Belém-PA, 2019

Analytical Categories	Empirical Categories	Extracts of the interviews
Understanding about the expression “quality of life”	Maintenance of health	“Be healthy” (P9)
	Family living	“Be with the family” (P1)
	Financial balance	“A life where you can buy anything you want, isn’t it? Food, mostly” (P3)
	Perform daily and labor activities	“Be well to do what I did before (work)” (P4) “With health, we can work” (P9)
	Maintenance of autonomy	“To get my health back, walk as I did before. Now, I can’t make my coffee, I depend from others for anything” (P8)

Source: Clinical trial.

DISCUSSION

Most of the participants were in the age range above 60 years, corroborating other national and regional studies, a fact possibly related to the great incidence of chronic-degenerative diseases in this portion of the population^{3,25-28}. Advanced age is one of the factors that can influence the prognosis of the disease and the necessity of oncologic PC^{12,19}, in special when the diagnosis is delayed and patients had already started the treatment without any chance of cure, a reality quite frequent in the context in question (verbal information).

Chart 2. Distribution of categories and content of the responses obtained about factors influencing the quality of life in the interview with the patients in home palliative care. Belém-PA, 2019

Analytical Categories	Empirical Categories	Extracts of the interviews
Factors influencing the quality of life	Faith and hope	“Faith helps me much, it feeds me” (P1) “Have faith” (P2)
	Family and social support	“First, my quality of life is the well-being with my own family, live together” (P2) “Family support” (P6, P8) “What makes me better is to have my children close to me, don’t like to be alone any moment” (P7) “When my relatives visit me, I feel better” (P4)
	Financial condition	“It helps to have quality of life, good financial life” (P3) “It gets worse when you are worried with debts” (P2) “It gets worse when you don’t have food and other things at home” (P9)
	Lack of autonomy	“What bothers me is to depend from others” (P8)
	Presence of pain	“What bothers me are the pains and having to open the mouth to eat” (P4)

Source: Clinical trial.

Of the total of participants, most of them were females (77.7%), similar result to what was found in the literature^{9,24,26}. In developing countries as Brazil it is expected the predominance of cancer in females because of the high rate of neoplasms in the female population, as cervical and breast cancer of great prevalence in the State.

Chart 3. Distribution of the categories and content of the responses obtained about the influence of the home palliative care team in the quality of life in the interview with patients in home palliative care. Belém-PA, 2019

Analytical Categories	Empirical categories	Extract of the interviews
The influence of the home palliative care team in the quality of life	Access to different professionals	“Soon after they came over, I had things I never had at the hospital, therapist, phonoaudiologist, dentist” (P4)
	Full care	“It helps a lot, I am very well treated and cared” (P1) “Ah, this job is great! Helps, helps, helps! Mainly in Christmas, I didn’t expect, a group came to my house, brought some gifts, basic staples” (P2) “I appreciate what they are doing with me. I feel well” (P8, P9)

Source: Clinical trial.

For each year of the triennium of 2020-2022, 66 thousand cases of breast cancer are anticipated^{3,29}. In counterpart, in developed countries, the occurrence of cancer tends to affect both genders similarly because of the mass prevention programs developed in these countries^{14,18}.

The participants enrolled in the study were Black, mostly (Black, 44.4% and Brown, 33.3%), which can be explained by the fact that 70% of the users treated in SUS were Black³⁰. In the socioeconomic perspective, the great majority of the sample patients had family income lower or equal to two minimum wages and 44.4%, the income was lower or equal to one minimum wage, which is possibly correlated to the profile of the population treated at the hospital²⁶. Although it is a reference public institution in oncologic treatment with the recent creation of several clinics and hospital units, many other patients migrated to these facilities, which explains partially the strong presence of individuals from lower classes treated in this setting. These findings are relevant because social inequities interfere in the QoL³¹⁻³⁵ and mortality in oncologic patients^{32,33}.

The mean score obtained in POS was worse for the patients with family income lower than one minimum wage in comparison to the rest of the sample. The relevance of this finding has important unfolding, since almost all the patients reported economic interference in their QoL. When asked about the personal perception they had about their QoL, financial balance was mentioned as an important aspect affected by sickening, which can be justified by the elevated costs with the maintenance of the health conditions of these patients.

Regarding the origin, 66.6% came from the capital and the rest from other State municipalities, a fact that reflects the potential impact the treatment imposes in the life routine. One of the factors to be pondered lies in the fact that many patients need to travel from their origin place to be treated in the metropolitan region²⁵. As territorial distances are long and there are places of difficult access, several changes resulting from the treatment occur, which could also mean elevated costs for the patient and its family^{25,31}.

In relation to marital status, 55.5% of the patients investigated were married or lived in a stable union and 44.4% were divorced. Although findings in the national literature do not demonstrate clearly the importance of marital status in the QoL of patients in PC, patients with cancer who live in a stable union or are married have more odds of survival than those who live alone^{26,36,37}. In the present study, divorced patients had the worse mean scores of POS (17.25) in comparison with married (16.6) and with stable union (15), which indicates the probable importance of social support provided by persons close to the patient to cope with the disease.

Studies about health and spirituality have demonstrated the importance of faith and religiosity in coping with cancer that are associated to lower levels of anxiety and depression^{8,37,38}. About religion, most of the participants were evangelic (55.5%), followed by Catholics (44.4%) who represent the religious segments characteristics of the population treated in the hospital²⁶.

Faith appeared as one of the factors that best contributes for the QoL of the patients. Many patients in PC search spirituality as a backbone to ensure their well-being⁶. The relations between spirituality and PC have been increasingly investigated indicating a positive relation mostly, helping anxiety and depression during the pathological process^{23,38}.

For the clinical aspects of the patients with cancer in PC, the data presented in Table 2 stand out. Breast cancer had higher incidence (55.5% of the sample) which is consistent with the findings that this is the second malignant neoplasm that most affects women in Brazil, behind only non-melanoma skin cancer^{3,39}. Rectal cancer

was the second cancer most frequent in that sample. Of the non-melanoma skin cancer in males, colorectal cancer is the fourth most frequent in the Northern Region (5.27/100 thousand)³.

All the patients were diagnosed with cancer for more than one year, most of them (55.5%) were already in PC for more than six months. Cancer control involves the promotion of health, recovery and PC^{13,14,20,32}, the latter was ruled by the Brazilian Ministry of Health as part of the integrated continuous care within SUS according to Resolution number 41, dated October 31, 2018¹¹.

The progression of the neoplastic disease imposes the patient several signs and symptoms that affect significantly its QoL. Most of the participants (88.8%) of this study reported the occurrence of pain in the last three days and 77.7% also referred the presence of other uncomfortable physical symptoms. Said findings corroborate a study conducted in João Pessoa, Paraíba where 89.8% of the sample reported pain⁷.

In Latin America, Brazil is listed as second among countries where individuals with cancer report they feel more the symptom of pain and in 26% to 46% of the patients with oncologic pain, the pain is inappropriately controlled^{40,41}.

Understanding that pain causes intense physical and psychological discomfort to oncologic patients and mainly in advanced phase of the disease, the healthcare team must pursue the relief of the symptom, which is one of the structuring principles of PC⁵. When pain is non identified and managed, it potentializes the physical symptoms, leading not only to physical discomfort but also increasing suffering and interfering directly in the QoL^{5,41}.

It was not possible to correlate the findings to deduce that the presence of pain could be connected to the presence of symptoms of anxiety (55.5%) reported by the participants, but possibly, at least in part, may be justified why some of the participants reported frequent concerns about its disease/treatment.

Although great part of the sample (55.5%) have been informed about the disease correctly, 44.45% reported difficulty in understanding them. These findings reinforce the importance that the health team is aware of the patient's needs including information and easy understandable clear explanations. When the socioeconomic profile of the patients treated at the hospital is considered, it is expected that many have difficulties in understanding the information, which is an indispensable condition for full care^{10,11,14,20}, especially when the goal is PC.

In despite of the clinical condition, most of the participants values life (88.8%) and all referred they feel well with themselves, but with different frequencies. The findings indicate that faith and spirituality and family

support and assistance are factors that contribute for the QoL too.

Current data of the literature have shown that family is the pillar of social and emotional support for the patients because they play an important role in the process health-disease^{6,41}. Former studies evaluated the QoL of patients with cancer in different stages of evolution and demonstrated that this was correlated with social support offered positively⁴¹. In the present study, when asked about factors interfering in the QoL, the patients mentioned family support/assistance as one of the response categories.

Nevertheless, it is worth mentioning the possible overload for the family members who care for the patient and feel the burden and the financial toll and a great concern with patients in advanced stage of cancer^{35,40,41}, a question addressed by one of the participants enrolled in this study. The results corroborate one of the guidelines of PC, protect the family as unit of care^{8,32,36}.

As observed in the narratives and application of questionnaire POS, the socioeconomic issue is a relevant factor of the conception of QoL for the patients. In this sense, it is paramount that the physician and the health team understand and consider the life conditions of their patient to plan the treatment. It was noticed that the patients mentioned the financial condition as was one of the categories of response, being a variable that needs to be considered in home consultations.

The findings reinforce the influence of the social determinants of the health-disease process since QoL is directly and indirectly affected by socioeconomic bias and can be a limitation to maintain the QoL of patients treated in home PC corroborating the results found in other national studies^{32,34}.

CONCLUSION

Integrity is a core element of PC and is extremely important in homecare. However, due to the terminality of life, there are still great challenges to be faced to overcome the hegemony of the biomedical model of medical practice. In order to reach this goal, it is necessary to invest in new models of intervention that value the different dimensions of healthcare.

Currently, with rare exceptions, medical colleges fail to instruct the students correctly to deal with the process of life finitude, considering, nevertheless, the strengthening of PC in the Brazilian scenario. Consequently, many doctors not even know what PC actually is, lacking knowledge and techniques of intervention targeted to minimize pain and suffering in the full care to these patients.

PC include the active listening of the patient and its family, considering there is always the possibility of doing something that is technical, loving and sublime. As

such, it is essential that public policies of PC continue to improve as well as the approach of this theme in medical colleges. As it was possible to notice, economic privations deserve special attention in the planning of health actions, specifically when it is considered the reality of the patients treated in public hospitals of the Northern Region.

Regardless of several international studies involving the evaluation of QoL of patients with cancer, in Brazil there are still scarce more comprehensive studies about the QoL of oncologic patients in home PC. This reality results in a limitation about the comparison of the results and deepening the reflections about the cultural and regional influence of the findings obtained with the present study. However, relief the pain and suffering of patients with cancer in PC goes beyond using technical knowledge, it is about opening itself to absorb the human dimension of medical practice, yet death looms as a close and inexorable horizon.

CONTRIBUTIONS

Vânia Nazaré Maia dos Santos contributed substantially for the study design, gathering, analysis and interpretation of the data, wording and critical review. Ana Cristina Vidigal Soeiro guided the study and participated of the wording and critical review. Cristiane Ribeiro Maués contributed substantially for the study design and gathering, analysis and interpretation of the data. All the authors approved the final version to be published.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

FUNDING SOURCES

None.

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Recebido em 23/8/2019
Aprovado em 9/6/2020