Historical Evolution of Comfort in Nursing Care for the End-of-Life Cancer Patients: Integrative Literature Review

https://doi.org/10.32635/2176-9745.RBC.2024v70n1.4437

Evolução Histórica do Conforto no Cuidado de Enfermagem a Pacientes Oncológicos em Fim de Vida: Revisão Integrativa da Literatura

Evolución Histórica de la Comodidad en el Cuidado de Enfermería para Pacientes con Cáncer al Final de la Vida: Revisión Integradora de la Literatura

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ABSTRACT

Introduction: End-of-life cancer patients are prone to experiencing unpleasant signs and symptoms due to the progression of the disease. Along nursing historical trajectory, care was targeted to identify, manage and evaluate the discomfort. **Objective:** To identify the impact of the historical evolution of comfort in nursing care for end-of -life cancer patients. **Method:** Exploratory and descriptive integrative literature review utilizing LILACS, MEDLINE and SciELO databases without time restraints for more comprehensive results. **Results:** The main impacts of nursing theories based on comfort were the valorization of the holistic model, the stimulation of the nurse-patient bond, the control of symptoms, the reduction of suffering and behaviors aligned with the patient's values. **Conclusion:** Comfort is mentioned in state-of-the-art historical texts, theories and nursing care practice. Nursing care to end-of-life cancer patients is guided by theories that address comfort and reduce the patient's discomfort and suffering.

Key words: History of Nursing; Nursing Theory; Hospice Care/history .

RESUMO

Introdução: O paciente oncológico em fim de vida está propenso a experienciar sinais e sintomas desagradáveis em virtude da progressão da doença. O enfermeiro, ao longo de toda a sua trajetória histórica, direcionou o cuidado para a identificação, o manejo e a avaliação do desconforto**. Objetivo:** Identificar o impacto da evolução histórica do conforto no cuidado de enfermagem ao paciente oncológico em fim de vida. **Método:** Revisão integrativa da literatura de caráter exploratório e descritivo utilizando as bases de dados LILACS, MEDLINE e SciELO sem recorte temporal para maior abrangência de resultados. **Resultados:** Os principais impactos das teorias de enfermagem pautadas no conforto foram a valorização do modelo holístico, o estímulo do vínculo enfermeiro-paciente, o controle de sintomas, a diminuição do sofrimento e as condutas alinhadas aos valores do paciente. **Conclusão:** O conforto é mencionado no estado da arte em textos históricos, teorias e na prática assistencial da enfermagem. As teorias que abordam o conforto direcionam o cuidado de enfermagem ao paciente oncológico em fim de vida buscando reduzir o desconforto e o sofrimento do paciente.

Palavra-chave: História da Enfermagem; Teoria de Enfermagem; Cuidados Paliativos na Terminalidade da Vida/história.

RESUMEN

Introducción: El paciente con cáncer al final de su vida es propenso a experimentar signos y síntomas desagradables debido a la progresión de la enfermedad. El personal de enfermería, a lo largo de su trayectoria histórica, dirigió los cuidados hacia la identificación, manejo y evaluación del malestar. **Objetivo:** Identificar el impacto de la evolución histórica del confort en los cuidados de enfermería al paciente con cáncer al final de la vida. **Método:** Revisión integradora de la literatura de carácter exploratorio y descriptivo, utilizando las bases de datos LILACS, MEDLINE y SciELO sin marco temporal para mayor cobertura de resultados. **Resultados:** Los principales impactos de las teorías de enfermería basadas en el confort fueron la valorización del modelo holístico, la estimulación del vínculo enfermera-paciente, el control de los síntomas, la reducción del sufrimiento y los comportamientos alineados con los valores del paciente. **Conclusión:** El confort es mencionado como lo más avanzado en textos históricos, teorías y en la práctica del cuidado de enfermería. Las teorías que abordan el confort dirigen los cuidados de enfermería hacia los pacientes con cáncer al final de la vida, buscando reducir el malestar y el sufrimiento del paciente.

Palabras clave: Historia de la Enfermería;Teoría de la Enfermería; Cuidados Paliativos al Final de la Vida/historia.

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INTRODUCTION

The World Health Organization (WHO) estimates that in 2020, Brazil will be the fifth country with the world's oldest population[1]. This extended longevity comes together with increasing chronic non-communicable diseases (NCD) as cardiovascular, respiratory, cancers and diabetes. Currently, cancer is the second cause of death in the world and the main cause of death in 10% of the Brazilian cities[2].

In 2002, WHO defined that palliative care is an approach that improves the quality-of-life of patients and their families who are facing the problems associated with life-threatening illness, by a multidisciplinary team through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual[1,3,4].

Palliative care should be initiated since the diagnosis of a life-threatening disease while end-of-life care consists in care provided from 72 hours to one week of survival before death, focused to the quality-of-life of the patients and their families and minimizing the four dimensions of suffering elaborated by Cicely Saunders: physical, social, psychic and spiritual[5-7].

The progression of the disease makes comfort measures paramount, since signs and symptoms as pain, nausea, dyspnea, fatigue, constipation, inappetence, depression, somnolence are disabling, quite often, adding complexity to the management of end-of-life cancer patients because the dimensions of suffering in face of the finitude are singular and go beyond the patient, affecting the family and the multidisciplinary team[5,7-9].

Nursing care to end-of-life patients requires early identification and correct management of signs and symptoms in addition to patient-centered priorities and interaction with support network aligned with the therapeutic goal defined with the patient, family and healthcare team[5].

Nursing to cancer patients is multifaceted with specific challenges to nurses further to their basic responsibilities. Oncologic care goes beyond medical treatment comprehending emotional, psychosocial and physical aspects. Nurses play a key role in instructing the patient about the diagnosis and treatment, providing emotional support during the course of the disease.

The approach of oncologic cancer care is patient-centered, respecting its individuality and wishes and special attention to quality-of-life, pain relief and coping should be ensured[10,11].

History has shown that comfort is closely related to nursing care and is influenced by social, economic, political and religious factors. The word comfort comes from the Latin *confortare*, which means to strengthen, fortify. On its turn, infirm in Latin means *infirmus*, weak or feeble. Thus, the nurse is someone who instills strength to the infirm[8,7].

In view of the quality of death in Brazil, the complexity of management of the dimensions of suffering cancer patients live in end-of-life and protagonism of nursing care, the objective is to identify the historical evolution of nurse comfort care to this patient.

METHOD

Exploratory and descriptive integrative literature review, compiling studies found in the literature separately, attempting to present the state-of-art on the theme, in addition to promoting discussions of the results and identify potential gaps. The methodology consisted in six stages: research question, search, data collection, critical analysis of the results, discussion and presentation[12].

The research question followed the PICO strategy PICO (P – Population/Patient, I – Intervention, C – Control/Comparison and O – Outcome) (Chart 1). Topic C – Control/Comparison was not applied in this review because there was no control group[12]. The research question was: "What is the impact of the historic evolution of nurse comfort care to the end-of-life cancer patient?"

Chart 1. Strategy to elaborate the research question. São Paulo, SP, Brazil, 2023

Acronym	Definition	Description
P	Population/ Patient	End-of-life oncologic patients
I	Intervention	Historical evolution of care
C	Control/ Comparison	Not applicable
O	Outcome	Nursing care

Source: Adapted from Santos, Pimenta, Nobre[12].

The second stage comprehended the search of articles indexed at the following databases: Latin American and Caribbean Health Science Literature (LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE) and Scientific Electronic Library Online (SciELO) and other dissertations utilizing the Health Science Descriptors (DeCs): "Nursing History", "Nursing Theory", "Comfort Care". Due to limitations of data

availability, the descriptors related to palliative care, oncology and end-of-life care were not applied, only those associated with historical evolution of comfort and nurse care. Full articles published in Portuguese, English and Spanish in any year were included and studies out of the scope, case reports and duplicate articles have been rejected.

In the third stage, 517 articles matched to DeCs were exported to the software Rayyan to organize and manage the data collected.

The 517 articles were reviewed by two independent reviewers in the fourth stage; 457 not meeting the inclusion criteria and 34 duplicates were rejected. The 26 remaining were reviewed once again when the articles were read in full and six out of the scope were removed. Of the 20 eligible, four were focused to end-of-life patient and 16 were considered because they correlate comfort with nurse care. From those, 17 articles, two master's thesis and one PhD thesis were listed in a table containing the title, year, country, methodology and main results. Figure 1 portrays the flowchart of the methodology according to PRISMA[13].

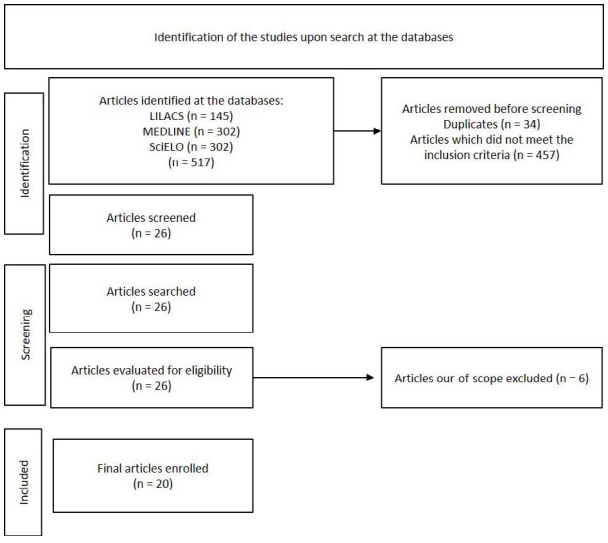

Figure 1. Flowchart of the selection process

Source: Adapted from Page et al[13].

RESULTS

Brazil was the country origin of most of the studies (55%) followed by the United States of America (35%), China (5%) and Italy (5%), predominantly in English from 1991 to 2020.

The characteristics of the 20 articles included in the review are portrayed in Chart 2.

Five studies[14,16,20,25,27] correlated comfort with historical evolution of nursing, the theories of comfort by Florence Nightingale, Callista Roy, Ida Jean Orlando, Jean Watson, Josephine Paterson, Hildegard Peplau, Madeleine Leininger, Loretta T. Zderad, Janice M. Morse and Katharine Kolcaba were quoted by the authors; Katherine Kolcaba was the author of five studies and half of the Brazilian publications were based in her theoretical framework of comfort.

Cardoso et al.[28] emphasized the importance of systematized approaches while Hou et al.[22] presented gaps of humanized care in nurse academic formation and brought up the necessity of discussing the National Policy of Humanization[33], as well as associate and identify the theories of care.

Nine studies[12,13,16,18,21,24,26] concurred that nursing theories are the core of holistic comfort-targeted nursing practices following the four dimensions of comfort and singularity of the individual. Only one study[6] addressed music therapy as intervention within palliative care as strategy to promote comfort.

Four studies[17,19,29,32] aimed the end-of-life patient and three of these[17,19,29] described the patient's context. White et al.[19] listed the required competencies for management of these patients.

The articles consistently converged to the main impacts of nursing theories on the management of end-of-life patients: to encourage the bond patient-nurse, symptoms control, suffering relief and actions matched to the patient's will avoiding futile interventions.

DISCUSSION

The historical evolution revealed that comfort is subjective, mutable, and bound to nursing. Initially, comfort was provided by women because it was believed they were docile, abnegated and gentle which made them naturally fit[34]. Care was empiric and intuitive with actions focused to fertility, and children's rearing and development, support to nurses and in death. Feeding-related instructions, medicinal herbs and management were passed from generation to generation[14,16,29,26].

Renaissance stimulated art and science concomitantly with the dissolution of religious institutions and care-focused actions, delaying advances of nursing[35]. Decay exposed the insalubrity of the environment and exclusion of least socially endowed. And at that moment, the so-called ladyship and charity sisters began visiting the infirm, bringing comfort through food supply, drugs and encouragement to those dying[14-16].

Since Christianity, care was provided by deacons, and it began to be seen as charity and virtue. Comfort meant pain relief and minimizing the suffering of the poor, infirm and prisoners[14-16]. According to Foucault[36], ensure

Chart 2. Characteristics of the studies included. São Paulo (SP), Brazil, 2023

Author and year	Study design	Type	Country	Objective	Results
Kolcaba; Kolcaba, 1991[14]	Analysis of concept and integrative literature review	Scientific article	USA	Analyze the semantics of comfort and correlate with its use in nurse practice, theory and research	The concept of comfort is related to nursing care since the beginning. The term is found in texts, quoted in practice, described in theories by Nightingale, Roy, Orlando, Watson and Paterson. Its definition considers nursing theory, what the individual perceives as comfort and its context
Kolcaba, 1995[15]	Integrative literature review	Scientific article	USA	Identify factors reinforcing comfort as the state-of-art of nursing care	The theory of comfort consolidates nursing care, valuing the holistic model, expanding the creativity and recommending the individuality
Mcilveen; Morse 1995[16]	Integrative literature review	Scientific article	USA	Describe the role of comfort in nursing care between 1900 and 1980	In 1900, comfort was the core of nursing practice. In 1930, comfort takes over the strategic position to reach the objectives related to nursing care. In 1960, comfort stops being the main goal. And in 1980, aspects beyond the physical context were added and initiatives to highlight emotional aspects began
Kolcaba; Fisher, 1996[17]	Descriptive, exploratory and qualitative research	Scientific article	USA	Describe the structure of comfort-based holistic care as interdisciplinary implementation strategy of comfort in caring for the patient and family during the process of death	The structure of end-of-life holistic comfort includes the values of the individual, stimulates the bond among family members and promotes conducts aligned with the patient's values avoiding life-prolonging futile interventions
Vendlinski; Kolcaba, 1997[18]	Integrative literature review	Scientific article	USA	Describe the structure of theory of comfort care that offers definitions and a grid for the art of comfort care that are relevant to hospice nursing practice	The structure of comfort theory allows the evaluation of comfort by means of nursing interventions

to be continued

Chart 2. continuation

Author and year	Study design	Type	Country	Objective	Results
White et al., 2001[19]	Descriptive study	Scientific article	USA	Determine end-of-life care core competencies and educational needs from practicing oncology nurses and to describe the characteristics of the respondents that are associated with selection of the leading core competencies	Nurses' required competencies to manage end-of-life patients are focused to nursing interventions prioritizing comfort, which demands technical-scientific skills about palliative care, symptoms management, communication and conflicts management
Mussi, 2005[20]	Analysis of the literature of nursing	Scientific article	Brazil	Analize the theoretical conceptions about comfort in the history of nursing and its determinants to find clues and bring light into existing theoretical inaccuracies about comfort and contradictions lived in nursing practice and teaching while promoting comfort	Nursing theories reinforce the subjectivity of comfort and discomfort. Institutions looking for theoretical fundaments for comfort-based nursing practice tend to direct comfort to the patient and valuing its trajectory
Silva, 2008[21]	Descriptive, exploratory and qualitative study	PhD thesis	Brazil	Conceptualized comfort in the perspective of the female nurses and patients at hospital admission, classify the characteristics attributed to the semantics of term "comfort" and identify theoretical framework that address comfort	Nurses of hospital admission believe comfort is related to well-being, meeting the patients' needs and reestablishment of the clinical stability
Araújo, 2013[6]	Descriptive, exploratory and qualitative study	Master's thesis	Brazil	Analyze the experiences of comfort of individuals in palliative care utilizing music	Implementation of music-therapy ensures comfort, relaxation and pain relief. In parallel, contributes to a calm environment and brings up affectionate memories and potentializing the bond nurse-patient

to be continued

Chart 2. continuation

Author and year	Study design	Type	Country	Objective	Results
Hou et al., 2014[22]	Descriptive, exploratory and qualitative study	Scientific article	China	Identify nurses' knowledge of care comfort to inpatients	67% of the nurses working in oncology are involved in care comfort but did not acquire respective skills during their formation
Moura, 2015[23]	Descriptive, quantitative approach research	Master's Thesis	Brazil	Identify how author nurses address comfort in oncology; describe factors indicated by cancer patients in outpatient chemotherapy treatment interfering in their perception of comfort; create instruments (consultation scripts and leaflets) supporting the consultation	Kolkaba Comfort Theory favors the implementation of the nursing process in oncology outpatient units, helping the identification, intervention and evaluation of physical, psychospiritual, sociocultural needs and environmental conditions
Ponte; Silva, 2015[24]	Integrative review	Scientific article	Brazil	Identify comfort measures provided by nurses found in articles published by Brazilian nurses in the light of Katherine Kolcaba Comfort Theory	Comfort is addressed in the theories of Nightingale, Hall, Roy, Peplau, Watson, Leininger, Paterson, Zderad, Morse and Kolcaba, that should be the result of nursing interventions. Physical comfort was predominant among the four dimensions described by Kolkaba, mainly due to the necessity of pain relief management. Sociocultural context includes the patient and its interpersonal relationships, education, religion, rituals and beliefs. Psychospiritual context addresses self-concept, emotions appearing in face of the clinical condition and faith. Environmental context reinforces the importance of a clean, calm, aired and noiseless ambient
Mendes et al., 2016[25]	Reflexive analysis	Scientific article	Brazil	Reflect about the theory of comfort and its philosophical-theoretical fundaments as support for nursing care to the individual, family and communities	Comfort-based nursing practice favors customized care and identifying signs of discomfort with interventions and continuous reassessment focused to the patient

to be continued

Chart 2. continuation

Author and year	Study design	Type	Country	Objective	Results
Pinto et al., 2017[26]	Analysis of concept and integrative literature review	Scientific article	USA	Define and develop comfort-based nursing interventions	The concept of comfort is subjective, reinforcing the necessity of theoretical base supporting nursing care
Pereira et al., 2019[27]	Analysis of concept and integrative review of the literature	Scientific article	Brazil	Analyzed the concept of comfort in the light of Rodgers' evolutionary concept analysis and incorporate elements of concept analysis in the structure of nursing diagnosis "Readiness for Enhanced Comfort" (00183)	Initially, comfort was the central core of nursing care, interventions were targeted to provide comfort to the physical body and environment. The Great Depression led to the institutionalization of health following a medication-centered model. With new technologies, the nurse started to manipulate complex devices and improve its own management skills
Cardoso et al., 2019[28]	Integrative review	Scientific article	Brazil	Analyze scientific evidences on the use of Kolcaba comfort theory when the nursing process is being implemented	Kolcaba comfort theory favors the identification of discomfort, allowing the implementation of structured and patient-centered nursing process
Pereira et al., 2020[29]	Literature review	Scientific article	Brazil	Explore the studies about comfort to end-of-life patients to determine evidence patterns in this area	Comfort means well-being, but end-of-life is a fragile moment to the individual, family and professionals involved. Feelings of sadness, fear and impotence pervade this moment. The nurse in charge should promote actions to bring physical, psychospiritual, sociocultural and environment comfort
Cardoso et al., 2020[30]	Cross-sectional study	Scientific article	Brazil	Identify nursing diagnosis of older adults admitted at the intensive care units; categorize according to the dimensions of the comfort (physical, psychospiritual, sociocultural and environmental) following Kolcaba theory	Nursing diagnosis listed for hospitalized older adults relates with Kolcaba's four dimensions of comfort

to be continued

Chart 2. continuation

Author and year	Study design	Type	Country	Objective	Results
Berntzen et al., 2020[31]	Descriptive quantitative approach research	Scientific article	USA	Explore the discomfort patients admitted in intensive care units lived	Patients admitted at intensive care units need comfort that goes unnoticed by the nursing team due to lack of systematized approaches of evaluation of comfort
Angheluta et al., 2020[32]	Descriptive analytical study based in multiple focal groups	Scientific article	Italy	When and how clinical nurses and licensed practitioners adjust nursing care to offer comfort to end-of-life patients	End-of-life comfort planning should ponder the benefits and damages of the interventions. Evidence-based practice involving patient, family and care team

comfort to the infirm granted the own salvation. With the foundation of the Hospital Kaiserswerther Diakonie, the deaconesses resurfaced, tending to poor and infirm while studying theology and nursing. Florence Nightingale was among the women who have been trained and during the epidemics of cholera and after the Crimean War, she consolidated its environmentalist theory, emphasizing that unhealthy environments lead to sickening and discomfort[14, 16,24].

Twentieth century is marked by the substantial growth of nursing theories from Ida Jean Orlando, Hildegard Peplau (1952), Callista Roy (1979), Madeleine Leininger (1978), Jean Watson (1979), Josephine Paterson (1960) and Loretta T. Zderad, Janice M. Morse and Katharine Kocalba (1991).

Lydia Hall[37] defined caring as a process and Ida Jean Orlando (1960) was one of the pioneer nurses who used the term "nursing process"; in her theory, nurse should ensure physical and mental comfort to the patient. Callista Roy utilizes psychological comfort to promote adaptation. Madeleine Leininger relates comfort with caring. Jean Watson considers comfort as a variable influencing development. Josephine Parteson and Loretta T. Zderad advocate that mental discomforts may reverberate in the physical. Janice M. Morse reinforces that comfort should be the final result of nursing actions. Katharine Kolcaba, in her theory of comfort, demonstrates the search for satisfaction of the needs by means of relief states, tranquility and transcendence which develop through physical, environmental, physical, social and psychospiritual comfort[15,24,30].

Currently, it is recommended that the nursing process is grounded on a theory that guides the care as nursing practice requires thorough evaluation of the individual, critical thinking and mastering the area of action[38]. Even if comfort has followed the historical evolution of nursing, Hou et al.[22] noticed that nearly 65% of the nurses working in oncology and caring for end-of-life patients did not have specific formation in that area. The nurses at the admission unit indicated that comfort is associated with clinical stability of the patient according to the study of Silva[21]. Berntzen et al.[31] affirmed that inpatients have some discomfort that the nursing team could overlook due to the lack of systematized approaches.

Katharine Kolcaba[14] comfort theory potentialized the holistic model guiding the nurse look towards signs of discomfort of end-of-life patient through four dimensions of comfort: physical, environmental, social and psychospiritual.

This theory differs from Saunders[39] reflections regarding the multidimensionality of the concept of pain, called as total pain which encompasses four dimensions of suffering and reveals the necessity of thorough evaluation and attention to these aspects.

In the study of Ponte and Silva[24], the physical dimension highlighted the necessity of pain management. The environmental context emphasized the importance of ensuring a pleasant, clean, airy and noiseless ambient. The social context involves interpersonal relations while the psychospiritual raised questions in relation to self-concept and beliefs. The nurse is responsible for the actions that target the comfort in these four dimensions since end-of-life patients management is marked by feelings as sadness, fear and impotence[17,18,23,29,28].

According to Araújo[6], Katharine Kolcaba's theory can warrant the required framework for the implementation of music therapy as complementary and integrative practice able to provide comfort in an environment that promotes relaxation, tranquility and symptoms relief concomitantly with the possibility of the patient

accessing affectionate memories, strengthening the bond with family and health team.

Currently, there is material to apply this conduct by the National Policy of Integrative and Complementary Practices (PNPIC), sanctioned and implemented in the National Health System (SUS). It is possible to notice an array of options of access to and health practices that promote comfort to the patient as music therapy[40]. A recent study published in the American Society of Clinical Oncology (ASCO)[41] emphasized the beneficial role of music as an effective strategy in reducing stress in patients submitted to cancer treatment with chemotherapy. The present study highlights the importance of therapeutic approach of music as an invaluable tool to improve the emotional well-being of these patients along the tough journey of the treatment.

White et al.[19] noticed that nurses caring for end-of-life patient should master the scientific-technical competencies in palliative care, patients' rights, bioethics, communication, conflicts management, further to knowing how to identify and manage discomfort, due to the singularity of the individuals, the variability of symptoms, changes of the clinical condition, reduction of functionality and available resources[39]. Furthermore, it should include family and health team, respecting its will and avoiding futile conducts that could cause even more suffering[18-19].

The theory of comfort needs to be explored continuously in educational settings to ensure professionals are able to incorporate in their caring practice[23]. Mussi et al.[20] reinforce that institutions looking for theoretical foundation for comfort-based nursing practice tend to focus the patient, valuing its journey and safety, contributing to diminish the four dimensions of suffering proactively and holistically.

CONCLUSION

Comfort is inseparable from nursing care. Nursing theories addressing comfort warrant foundation to and guide nursing actions for end-of-life cancer patients in the light of the physical, environmental, psychosocial and spiritual dimensions.

The limitations of the studies are the scarcity of articles designed for end-of-life patients. However, they contributed to the state-of-art in promoting reflections about education and dissemination of the theory of comfort as caring practice to patients in palliative care in order to ensure more comfort and quality-of-life addressed in this type of care. Therefore, scientific productions focused to end-of-life comfort and discussions during the educational formation are necessary.

CONTRIBUTIONS

All the authors contributed substantially to the study design, acquisition, analysis and interpretation of the data, wording and critical review. They 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 7/11/2023
Aprovado em 16/2/2024

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