

Educational Needs and Perspectives about Palliative Care in Oncology: Interviews with Primary Care Physicians and Nurses

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Necessidades e Perspectivas sobre Educação em Cuidados Paliativos em Oncologia: Entrevistas com Médicos e Enfermeiros da Atenção Primária à Saúde

Necesidades y Perspectivas de la Formación en Cuidados Paliativos en Oncología: Entrevistas con Médicos y Enfermeras de Atención Primaria de Salud

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ABSTRACT

Introduction: This research was based on the essential components of palliative care provided by the American Society of Clinical Oncology (ASCO). **Objective:** To find out the knowledge primary care physicians and nurses have on palliative care in oncology and to identify the educational needs and perspectives related to the integration of this practice in primary care. **Method:** Semi-structured in-depth interviews were carried out with 17 primary care health professionals from the National Health System in eight Brazilian municipalities from *Médio Paraíba*, State of Rio de Janeiro, Brazil, between March and August 2022. **Results:** The results were analyzed along five axes: palliative care, welcoming in health, communication, health networking and learning. These axes corresponded to the main aspects detected in the research and revealed that professionals expressed a strong need for an adapted training program. **Conclusion:** The need for an educational process in palliative care capable of combining patient and family centered care with strengthening and valuing primary care professionals was highlighted.

Key words: Education, Continuing; Health Personnel/education; Palliative Care; Primary Health Care; Unified Health System.

RESUMO

Introdução: Esta pesquisa foi baseada nos componentes essenciais dos cuidados paliativos fornecidos pela Sociedade Americana de Oncologia Clínica (ASCO). **Objetivo:** Avaliar o conhecimento de médicos e enfermeiros da atenção primária à saúde sobre cuidados paliativos em oncologia e identificar as necessidades e perspectivas educacionais relacionadas com a integração dessa prática na atenção primária. **Método:** Foram realizadas entrevistas semiestruturadas e em profundidade com 17 profissionais de saúde da atenção primária do Sistema Único de Saúde, em oito municípios brasileiros, da Região de saúde Médio Paraíba, Estado do Rio de Janeiro/Brasil, entre março e agosto de 2022. **Resultados:** Os resultados foram analisados em cinco eixos: cuidados paliativos, acolhimento em saúde, comunicação, redes de saúde e aprendizagem. Esses eixos corresponderam aos principais aspectos detectados na investigação e revelaram que os profissionais entrevistados demonstraram interesse em um programa de formação adaptado para atenção primária. **Conclusão:** Destacou-se a necessidade de um processo educativo em cuidados paliativos capaz de aliar o cuidado centrado no paciente e na família com o fortalecimento e a valorização dos profissionais da atenção primária.

Palavras-chave: Educação Continuada; Pessoal de Saúde/educação; Cuidados Paliativos; Atenção Primária à Saúde; Sistema Único de Saúde.

RESUMEN

Introducción: Esta investigación se basó en los componentes esenciales de los cuidados paliativos brindados por la Sociedad Estadounidense de Oncología Clínica (ASCO). **Objetivo:** Evaluar el conocimiento de médicos y enfermeras de atención primaria de salud sobre cuidados paliativos en oncología e identificar necesidades educativas y perspectivas relacionadas con la integración de esta práctica en la atención primaria. **Método:** Se realizaron entrevistas semiestructuradas y en profundidad a 17 profesionales de la salud de la atención primaria del Sistema Único de Salud, en ocho municipios brasileños, de la Región sanitaria Médio Paraíba, Estado de Río de Janeiro/Brasil, entre marzo y agosto de 2022. **Resultados:** Los resultados fueron analizados en cinco ejes: cuidados paliativos, recepción en salud, comunicación, redes de salud y aprendizaje. Estos ejes correspondieron a los principales aspectos detectados en la investigación y revelaron que los profesionales entrevistados mostraron interés en un programa de formación adaptado a la atención primaria. **Conclusión:** Se destacó la necesidad de un proceso educativo en cuidados paliativos capaz de combinar la atención centrada en el paciente y la familia con el fortalecimiento y valorización de los profesionales de atención primaria.

Palabras clave: Educación Continua; Personal de Salud/educación; Cuidados Paliativos; Atención Primaria de Salud; Sistema Único de Salud.

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INTRODUCTION

The acknowledgement of cancer as a public health problem reinforces the development of public policies, intersectoral actions, and the organization of health services to promote universal access to cancer patients, from prevention up to palliative care¹.

The World Health Organization (WHO) declared that palliative care should be incorporated into global healthcare practices, including cancer care². In the same year, the American Society of Clinical Oncology (ASCO) highlighted the offer of palliative care beyond end-of-life support. They pointed out that patients could benefit from palliative care concomitant with the treatments for their tumors³. Besides ASCO, other international organizations, as the European Society for Medical Oncology (ESMO) and the European Association for Palliative Care (EAPC), have acknowledged palliative care as an integral component of cancer care pathways^{4,5}.

Palliative care should be implemented at any time, in any health-related context and across every level of care. From the first approach in primary health care, the patient must be seen as a whole, continuously, throughout all life stages, including the dying process⁶. Therefore, the integration of palliative care into the healthcare system makes the primary care provider a crucial player in the process. The Gold Standards Framework is one important initiative within the community for organizing training in palliative care and structure for primary care physicians and nurses to provide palliative care in the United Kingdom⁷.

In 2011, the ASCO and the American Academy of Hospice and Palliative Medicine formulated a primary palliative care program for oncology⁸. In 2018, the Astana Declaration included palliative care as part of universal health coverage whose focus is based on primary care^{9,10}. In 2019, to facilitate this initiative, the EAPC created a toolkit to help the development of palliative care within primary care settings¹¹.

These tools can help primary care providers to carry out a palliative care approach, matching medical care to the patient's goals, in addition to basic symptom control. Additionally, other more complex skills require more training time to be acquired and applied, and should be assisted by a specialist, as difficult family discussions, dealing with existential suffering, and managing refractory symptoms⁸.

In Brazil, the National Health System (SUS) attempts to warrant universal, integrated care, and equal access to healthcare for all Brazilian citizens, as well as recognizing palliative care as a right that should be ensured to the entire population¹²⁻¹⁴. However, there is a considerable

imbalance in the provision of services in different regions of the country¹³⁻¹⁵. According to a survey carried out by the *Academia Nacional de Cuidados Paliativos* (ANCP) in 2019, there were 191 palliative care facilities in the country, with significant availability inequality, as over half of the services were concentrated in the Southeast region, with less than 10% in the North region¹⁴.

In addition, the profile of palliative care in Brazil was hospital-centered, which goes against Article 3rd of the Brazilian Resolution 41 (2018), which highlights equitable access, involving the entire continuum of care through all healthcare providers, with an emphasis on primary and home care and subsequent integration with specialized services^{14,16}. Further to Resolution 729 of December 2023 which approved the National Palliative Care Policy under the purview of SUS, which determines the integration of palliative care into Health Care Networks, with a health care component in Primary Care¹⁷.

Internationally, the disparity in palliative services provided has resulted in the development of educational programs marked by a wide diversity of offer and content⁴. Nevertheless, there are scarce global reports on the results obtained with the implementation of these educational and teaching initiatives¹⁸ according to the literature. Brazil has been categorized as level 3b (generalized palliative care provision) according to a 2019 study on levels of palliative care, where some training and education initiatives offered by palliative care organizations¹⁹ were found.

However, progress towards achieving full coverage of palliative care in Brazil is limited and SUS and primary health care have faced considerable structural challenges in implementing this type of care effectively in the country²⁰. These barriers are associated with curative-driven diagnosis and treatment educational model which combined with exclusive technical focus strengthens the fragmentation of care and neglect of the patient's holistic context²¹. To achieve ample coverage of palliative care, it is essential to develop educational proposals aimed to strengthen training and education, especially for primary health care professionals¹⁹.

To date, little is known about the prior knowledge and training requirements of primary health care professionals to carry out palliative care actions in oncology in Brazil. The aim of this study was to find out the practices of primary health care physicians and nurses in palliative care in oncology and identify their demands and perspectives on the required educational process.

METHOD

Qualitative research based on the essential components of palliative care provided by ASCO, including the

construction of relationship with patients, family, and caregivers, and investigating the understanding of the disease, prognosis, and treatment goals. In addition, support for coping and symptoms control through interdisciplinary palliative care teams in association with other healthcare providers²². These concepts referenced at international level²² were adapted to the interviewees' statements, reflecting the social and cultural context of primary care in Brazil.

Given the contextual nature of the study, the design utilized was interpretive interactionism, making possible to study and understand the experiences in everyday practice. Through the social interaction between the researcher and the primary health care provider, a relationship of exchange was established. The focus was to understand how physicians and nurses experienced palliative care through an interview, and observing their posture during the approach while interacting with other health team professionals in the primary care setting. In addition to the narrative, the social and cultural interactions within the environment were also considered to clarify the role of the primary healthcare professional in action, and an in-depth comprehension of their knowledge of palliative care^{23,24}.

Data collection took place between March and August 2022. The setting selected was a health region (*Médio Paraíba*) in the State of Rio de Janeiro, Brazil. The research scenario has arisen from the demand for qualification in oncological palliative care detected by the State Health Department of Rio de Janeiro for the nine health regions. The population profile of the region varies according to the municipality, for instance, the population growth in the cities of *Porto Real* and *Pinheiral*, resulted from industrial-driven migrations while *Valença* is characterized by an aging population. The heterogeneity was also seen in primary care, where the Family Health Strategy coverage ranges from 27.50% in the municipality of *Barra do Piratí* to 100% in the municipality of *Porto Real*⁵.

Of the region's twelve municipalities, eight agreed to participate. Each municipality chose the primary health care facility with the largest population coverage as its representative. In each primary health care facility, at least one physician and one nurse, with more than one year of practice, were invited to be interviewed. They were briefed on the purpose, benefits, and risks, and could choose whether or not to take part in the research at any time. The exclusion criterion was not signing the Informed Consent Form. Priority was given to professionals with more experience in primary care. In cases of refusal, other professionals were invited to step in.

Approximately one-hour in-depth semi structured audio-recorded interview was the main data collection method, following a brief profile questionnaire. The

script consisted in sociodemographic data related to palliative care as questions about the meaning in oncology, demands of this approach in primary care, professional and educational experience and proposals for an approach within a training process. Through previously prepared questions, a dialogue was established between the researcher and the primary care professional. In addition to the responses to the interview, topics related to palliation could be discussed freely²⁶. A pilot guiding interview was carried out with professionals working in palliative care in primary health care to check the accuracy.

The sample involved 17 primary healthcare professionals, eight physicians, and nine nurses and its accuracy was assessed by saturation, beyond which the information collected became redundant. As the interviewees were expressing similar perspectives on the topics, becoming repetitive, the sample saturation was reached^{27,28}, through extensive analysis. The interviews were carried out by a single researcher (the first author), who did not know the participants, had knowledge of palliative care and the qualitative approach. At the time of the interview, only the researcher and the professional interviewed were in attendance.

The interviewees' names were coded as RN for nurses and MD for physicians and numbers were assigned according to the chronology of the interviews. Table 1 shows the profile of the study sample.

The interviews were transcribed in full by the main investigator. The standard procedure of categorical content analysis was used to identify, code and categorize the data²⁷. The two researchers read and coded the transcripts independently and met regularly to analyze the interviews. The phases of the thematic content analysis were: a) pre-analysis; b) explore the material collected; c) organize, infer and interpret the data.

First, the floating reading of the interview transcripts allowed to organize the data in an unstructured way, according to the relevance and based on the hypotheses raised during the theoretical foundation, it was possible to identify if there was any omission and whether the sample was representative²⁹. At that moment, the initial objectives were assessed to find whether a revision was required and subsequently, the organized data were coded and attached. Record units were created according to the objectives reviewed in the previous stage.

According to the common characteristics identified by the record units, the review of this material led to the construction of categories *a posteriori*. These categories were divided according to classification, data organization and the definition of common elements (inventory)²⁹. Finally, the results were processed and, based on the inferences made, interpreted according to the theoretical



Table 1. Profile of the professionals interviewed

Interviewees	Sex	Age (years)	Speciality	Experience in Primary Care in years
RN 1	Female	31-50	PHC	14
RN 2	Female	31-50	PHC, health professional, stomatherapy	7
RN 3	Female	31-50	PHC	6
RN 4	Female	31-50	PHC	6
RN 5	Female	31-50	PHC, neonatal intensive care, pediatrics	2
RN 6	Female	31-50	PHC, intensive care	12
RN 7	Female	31-50	Nosocomial Infection Control	8
RN 8	Female	31-50	Intensive care	18
RN 9	Female	31-50	PHC, geriatrics/gerontology, obstetrics	12
MD 1	Male	31-50	PHC, intensive care	4
MD 2	Male	31-50	PHC	4
MD 3	Male	<30	PHC	3
MD 4	Female	>50	PHC	32
MD 5	Male	31-50	PHC	4
MD 6	Male	<30	PHC, palliative care	5
MD 7	Female	31-50	PHC, geriatrics/gerontology	12
MD 8	Female	31-50	No speciality	5

Captions: PHC = primary health care; RN = nurses; MD = physicians.

framework of the research. MaxQda³⁰ software was used for this purpose^{29,31,32} with the creation of word clouds which helped to identify the keywords related to the body of the research. Furthermore, after defining the categories and subcategories related to the content, a hierarchical, articulated, integrated and comprehensive level of conceptual organization was revealed and systematized into five axes³²: palliative care, welcoming in health, communication, health networking and learning.

The results were analyzed by the simple frequency of responses. The suggestions recorded by the interviewees were cataloged and summarized. The data set was compared with the information from the interviews and the available literature to discover new dimensions associated with the research's^{29,31,32} object. Understand what was significant for primary care workers in relation to the process of education in palliative care in oncology was the core principle.

The study was approved by INCA's Research Ethics Committee, CAAE (submission for ethical review 53215321.4.0000.5274), report number 5190844 in compliance with Directive number 580/18³³ of the National Health Council.

RESULTS AND DISCUSSION

The length of time the professionals had worked in primary care ranged from two to 32 years, and the

majority were specialists. Despite their familiarity with the approach adopted in primary care, it did not migrate to palliative care. Only one physician (MD6) was qualified in this area (Table 1).

Faced with the emerging need to support cancer patients in primary care, including palliative care patients, the interviewees' statements identified what should be modified in the work process and build learning compatible with the reality.

The five axes of analysis corresponded to the main aspects detected in the survey and revealed that all the professionals expressed a strong need for an adjusted patient-centered training program, based on modifying the workflow and building knowledge about palliative care.

PALLIATIVE CARE

The first question in this axis was the best time to start this type of care, based on ASCO²² essential components of palliative care, which include support for coping needs and symptom control. For the majority of the interviewees, the ideal time should be when therapeutic options have been exhausted. Despite this, it was concluded that palliative care was associated with life and not death.

Often, the patient needs support that is not just medication, something that complements, for relief, to complement the treatment they are already undergoing to give them quality of life (RN2).



As the interviews had identified, there is still poor understanding of the concept of palliative care among primary healthcare professionals, which has changed in the 20th century, with the recent hospice movement³⁴. What was once seen as end-of-life support has become the best practice of supportive care, recommended at the earliest possible point in the course of the life-threatening illness^{35,36}. Considerations about the patient's early contact with palliative care came up in some interviews, when professionals referred to the importance of integrating these services into the comprehensive care proposed by primary health care.

...Palliative care is a set of comfort measures, which aim to relieve pain and the treatment side effects. This does not mean that it is only for end-of-life patients. Ideally, patients should be assessed from their first contact with the physician (MD5).

Despite the strategies defined by ASCO, which focus on both living and dying well, it is regrettable that, given these different concepts, there is some delay in recognizing patients and their families who need palliative care. This hinders the prevention and relief of suffering advocated by health organizations^{4,22,36}. It is therefore necessary to overcome the concept that palliative care applies only to "patients with no therapeutic possibility of cure", and training for early identification should be a core aspect of primary palliative care for cancer patients.

WELCOMING IN HEALTH

ASCO described building relationships as an essential component of palliative care²², even though some interviewees associated welcoming the patient only with an acute condition, requiring medical prescription.

...sometimes the patient only comes to renew their prescription, but that's not all, they need healthcare (RN2).

Welcoming the patient means creating bonds, being available for working out a therapeutic plan according to the individual's actual demands³⁷. It represents the possibility of building a relationship with the individual, transforming the practice of care based on this opportunity. However, in the narratives, the perception was that the work routine meant that some basic concepts of primary care, such as welcoming the patient, were lost in face of so many tasks.

...palliative care is like an umbrella, you don't wait for it to rain, and for the person to get wet to open it, you must open the umbrella first. Sometimes you

don't need it anymore, but it's good to leave the umbrella there if something happens (MD6).

Using the example of the umbrella, one interviewee made an analogy to the soft technology in healthcare, a process that occurs when communication during the act of welcoming is effective^{38,39}. From this perspective, the focus was on the individual who expresses his/herself, rather than the patient seeking care^{38,39}, and care came to be seen through the expanded concept of health, beyond physical pain, as a tool capable of encompassing the individual's subjective aspects⁴⁰. Faced with a patient who is just looking for a prescription for painkillers, the professional's vision can go beyond the complaint and understand that the patient is much more than a symptom.

Furthermore, analyzing working conditions, the process of welcoming health professionals is fundamental in primary care. Work overload, lack of autonomy, and poor training for the job tend to give rise to a process of psychological distress, resulting from the difficulty of addressing what makes primary care professionals uncomfortable⁴¹.

...in primary care, when you are trained, you can improve the discourse of welcoming and humanizing care (RN1).

With the complexity of a patient in palliation care, it is essential to encourage training and work of multidisciplinary teams at primary health care. The network of relationships among healthcare teams can improve their work, enhancing welcoming. Apparently, adherence to a medical approach rooted in the biomedical framework, guided by established protocols and focused only on the patient's main complaint are limited to the physical manifestation of the disease. This approach tends to ignore the broader biological, psychological, and social aspects of the disease, which is not the aim of a palliative approach in primary care⁴².

COMMUNICATION

The relevance of effective communication came up in the narratives of all the interviewees as already emphasized by ASCO which included this axis, related to the investigation of the patient's understanding of the disease, the prognosis, and the goals of the treatment²².

...the easiest thing to do in primary care is communication with the family. Trying to show them that some interventions are not going to save their relative (RN9).

The primary healthcare providers associated the successful experience related to communication with



training in palliative care, it is a strategy to help to deal with situations connected with bad news. One of them highlighted how having previously attended a palliative care course helped him to cope better with bad news. Improving the communication process must be related to the mastery of the content that the health worker wants to convey and how this can be perceived and interpreted by the patient and their family member. Adapting the topic of conversation to the community's cultural references and the feelings involved in the act of communicating increases the chances of the health professional to be understood^{43,44}.

Educational materials, such as one of the palliative care health guides proposed by the interviewees, could be a potential alternative to perpetuate the communication process started during the consultation, because, given the complexity involved in palliative care, an isolated action, as the guidelines handed out during the consultation, may be inadequate to meet all the demands brought by the patient and their family.

...she came in not knowing what an analgesic was. Patients are not always given advice, sometimes the advice is: if you feel pain, go to the hospital. But the hospital just uses a drug and sends them home (MD3).

Moreover, the necessity to improve the listening process of primary healthcare professionals has become a priority. It should be noted that the word "listening" was not mentioned by any of the interviewees, which is a contradiction considering the complexity of the issue and the need for a comprehensive approach. Improving the communication process among professionals and patients, and among the healthcare team, is fundamental to achieve integrated care.

Primary care providers must be trained to perform their role as a coordinator of person-centered care⁴⁵. The interviews highlighted the importance of communication not only among primary care providers and patients, but also within the healthcare team itself. In their narratives, they referred to interdisciplinary work, which helps to share care through effective communication. A well-informed healthcare team that conveys the same message to the patient and family would be beneficial for internal organization and for improving the coordination of care and the patient's well-being.

HEALTH NETWORKING

Networking with interdisciplinary palliative care teams and other healthcare providers, mentioned in the interviews, is also one of ASCO²² essential components of palliative care. Initially, it is necessary to identify whether a complete team in the primary care facility is available,

and how this team is organized to develop strategies to strengthen care.

In Brazil, team integration has been compromised since the creation of the program "*Previne Brazil*" in 2019⁴⁶, which allowed the inclusion of primary health care teams with a dedication of only 20 hours a week, which, according to the interviewees, has resulted in less engagement and reduced contact time among professionals and community, and the health team itself. Understaffing in a few primary care facilities was mentioned several times in the interviews, causing discomfort due to the inequalities of the care provided.

...it is difficult to keep professionals in primary care, because most of them work for three months and leave (MD1).

The primary care team can act as a facilitator through integrated work, carried out by different actors and in different settings. They can reproduce this flow through other network facilities, whether they provide care or not. Acknowledging local demands and working accordingly are strategies to strengthen the primary health care support network for palliative care in oncology. An example of this can be seen in home visits. Experiencing the patient's actual living conditions and his/her family can transform the approach and therapeutic plan for a patient in palliative care⁴⁷.

Expanding access to different players works as a strategy to expand the support network beyond the services provided by the health network. Mentioned by some professionals, spirituality as a tool for supporting care, and not a synonym of religiosity, can act as part of the support network. Recognized by the ASCO as one of the components of care practice in palliative care, spirituality can represent a mechanism to cope with the disease, providing a level of well-being and improving the patient's quality of life^{22,48}.

...so, the church people went to her house and left some oil there. This part of the church was very important, because when you have faith, you still have hope (RN7).

Organizational coping strategies, inside or outside the health network, also aim to encourage the autonomy of the caregiver and the patient within care management. "Caring for the caregiver" emerged as a topic in some interviews, mainly because cases of caregiver burnout are not uncommon among those involved in supporting cancer patients⁴⁹. The work and connection with the primary health care team are essential in this caring process.

...a week after this patient died, her daughter came to the facility. She was sad, in the process of mourning. But she said: 'Oh doctor, I have looked after my mother so much, now I'm going to start taking care of myself' (MD6).

In addition to the support network for patients, families and caregivers, the network of primary healthcare professionals should be highlighted. The interviewees emphasized the support for themselves as well while dealing with disease related suffering and the condition of social vulnerability experienced on a daily basis and closely monitored by primary care professionals. Moreover, these professionals stressed that to "fulfill all their tasks, be in perfect health, immune to disease"⁵⁰ is important as well, which is not always possible.

LEARNING

The interviews emphasized that specialized training in palliative care should be adapted to primary care. They pointed out that the educational process in oncology should begin with measures beyond palliative care, so that, in a complementary way and after a primary approach to cancer, the development of palliative care learning can begin.

There was a consensus among the interviewees that the ability to provide effective palliative care depends on access to educational programs that addressed knowledge gaps and facilitated meaningful learning. These gaps associated with oncology/palliative care education are also present on the world stage. In 2018, the Lancet Oncology Commission reinforced that educational strategies through integrated standardized care pathways and multidisciplinary teams⁴ are relevant. The progressive training in oncology for primary care professionals was also expressed in a previous survey carried out in Canada⁵¹.

Considering that learning in palliative care is a global priority for the training process, the professional would have to reconcile humanization, scientific evidence and previous knowledge related to primary health care³⁵. The learning starting point is the professional's interest, their perception of the difficulties inherent to the practice of palliative care, and the presence of content consistent with their clinical practice⁵². An educational activity that generates experimentation and reflection on the reality of working in primary health care, in situations where palliative care occurs, enters this context as a transformative and learning-promoter tool⁵³.

...they need professional awareness. The training of medical students has to change (MD5).

Despite the professional demand for training in palliative care in oncology, many of them reported

difficulty in accessing this type of education process, and only one had previous training. Poor access to palliative care training for undergraduates' students, as well as non-exposure to palliation, was found in some interviews. That type of knowledge gap was not restricted to health professionals. Reports of patients seeking care only at an advanced stage of the disease were attributed, among other causes, to the health professional's lack of information. This reinforced the role of qualified health professionals in being able to guide their peers and the community⁴.

...the population doesn't know what palliative care is. Many think that they could be in hospital, that they would be better looked after, better cared for (RN5).

In learning related to the health education process, the proposal is also for the community to own the concept of palliative care so that primary care users can exercise their autonomy in building health services in a way that meets their demands⁵⁴. Learning for everyone, including other care providers and the population, is a strategy to be developed, but the focus of this research was restricted to primary care physicians and nurses.

The content analysis of the interviews did not confirm that discern professionals into physicians and nurses during the research process is required, as previously reported that emphasized the different perspectives of physicians, more focused on the prescriptive act⁵⁵. Instead, both professional categories brought up that change of the work process is a necessity, which would imply in a new practice focused not only on patient-centered care, but also on patient-centered learning, beyond the traditional prescriptive aspects of medical practice.

One of the study limitation was the impossibility of including other municipalities and interviewees. Nevertheless, it was noticed the occurrence of saturation of the topics enunciated, which led to the conclusion that the professionals facilitated an adequate review of the phenomenon investigated.

In addition, the context of the municipalities involved in the research did not directly influence the results, and most likely the sample may not have reflected the diversity of the country which limits the value and generalization of the results. However, the study brings advances to the existing knowledge on the subject.

Future studies should be organized involving not only the health regions of Rio de Janeiro but other Brazilian states. The exchange of experiences should also be extended to the entire primary care and management teams. Broadening the categories involved could help in the analysis and interpretation of the data, increasing the validity and applicability of the results obtained.



CONCLUSION

The necessity to jointly develop an educational process that enhances longitudinal learning emerged as the core domain of the interviews along with the investigation of the primary care providers' perceptions of palliative care in oncology.

The demands presented in the interviews were compatible both with the reality of these professionals and with the essential components of palliative care envisaged by ASCO. ASCO has been developing an educational process for the identification of patients who are eligible to palliative care before therapeutic options are exhausted, as well as a reformulation of the reception of the patient and family in this context, through more effective communication and support networks. Special emphasis should be placed on healthcare professionals who need care, support, and better communication in order to develop improved working practices.

Therefore, understanding the motivations of these professionals for the palliative care learning process has opened up a path to making them protagonists of their own learning journey and active participants in its development. Involving agents capable of producing health and education through listening was the first step towards an educational process related to palliative care, adapted, and empowered to transform working practices in primary healthcare.

CONTRIBUTIONS

The authors have contributed to the study design, data analysis and interpretation, wording and critical review. They approved the final version for publication.

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DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interest to declare.

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