

THE WORK OF THE PSYCHOLOGIST IN PALLIATIVE CARE IN CARDIOLOGY

ATUAÇÃO DO PSICÓLOGO NOS CUIDADOS PALIATIVOS EM CARDIOLOGIA

ABSTRACT

This is a reflection article that aims to contextualize, based on the literature and practice, the work of the psychologist in palliative care, specifically in cardiology. The palliative care approach in cardiology is still being developed; it originated with terminal cancer patients. The palliative psychologist who works alongside the multidisciplinary team covers various areas such as biological, psychological, religious, spiritual, social and family-related. Their work aims to provide care to patients, families and staff, offering support for the best quality of life at that time. The psychologist participates in family meetings, opens spaces for discussion of cases, promotes multidisciplinary meetings, takes care of team burnout, deals with conflicts, and implements communication skills. The essential tool for the work is the constant improvement of communication, which aims to bring together and fine-tune the team, reduce conflicts and impacts in the relations with the patient, the family and the members, clarifying, guiding and reducing the overall pain. Thus, the psychologist creates a network of moderation and a therapeutic project for the needs of each patient and family.

Keywords: Palliative Care; Psychology; Cardiology.

RESUMO

Trata-se de um artigo de reflexão que visa contextualizar, a partir da literatura e da prática, a atuação do psicólogo nos cuidados paliativos, especificamente em cardiologia. A abordagem dos cuidados paliativos em cardiologia está ainda sendo desenvolvida; teve origem com pacientes terminais de câncer. O psicólogo paliativista que atua junto à equipe multidisciplinar abrange várias áreas, como a biológica, psicológica, religiosa, espiritual, social e familiar. A atuação visa o atendimento aos pacientes, familiares e equipe, oferecendo suporte para a melhor qualidade de vida naquele momento. O psicólogo participa das conferências familiares, abre espaços para a discussão de casos, promove encontros multidisciplinares, cuida do burnout da equipe, lida com os conflitos e implementa as habilidades de comunicação. O instrumento fundamental para o trabalho é a melhora constante da comunicação, que visa agregar e harmonizar a equipe, diminuir os conflitos e impactos nas relações com o paciente, a família e os membros, esclarecendo, orientando e diminuindo a dor como um todo. Desse modo, cria uma rede de continência e um projeto terapêutico para as necessidades de cada paciente e família.

Descritores: Cuidados Paliativos; Psicologia; Cardiologia.

INTRODUCTION

Technological developments and advances in the care of heart disease have changed patient survival. The population needs more care resources and a greater focus on the quality of care. Palliative care is emerging as a new perspective to deal with the disease and consider human beings in terms of their various facets and possibilities. Thus, a new culture and approach must be developed to address suffering and its challenges. Heart disease may have many meanings for patients and their families. One question that arises is the approximation of life's finitude with its various meanings. What is the psychologist's role in this new approach? The psychologist

in Cardiology should be an integral part of the palliative care team to better meet the demands of not only from patients, but also their families and the team assisting them.

OBJECTIVE

This paper aims to reflect on the psychologist's role in the palliative care team in a hospital.

METHODOLOGY

This is a descriptive study based on a literature review and the authors' understanding of the subject. We obtained data from book chapters, palliative care guidelines, and articles on the topic.

RESULTS

After the literature review, we found no data on the psychologist's specific work in Cardiology.

Palliative care began in 1960 with the pioneering work of Cicely Saunders, who focused her care and attention on the end-of-life needs of patients with advanced malignant diseases. Accordingly, palliative care was first defined as an activity in the 1970s.¹ This trajectory began in 1967 at St. Christopher's hospice in London which mostly dealt with patients with advanced cancer. The goal was to facilitate patients' comfort and dignity during the illness until their death.² The hospice was the place chosen to receive patients to ensure they had the right to improve their quality of life through pain control and psychological and social support. This view of end-of-life care expanded across the United States, becoming known as "palliative care." However, this name is being reconsidered in light of the prejudice it has generated.

Palliative care has become a very important area of action that has significantly and positively impacted health, making room to discuss the complexity of various sectors of the population.

The World Health Organization defines palliative care³ as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment, and treatment of pain and other problems—physical, psychosocial, and spiritual." It provides the following principles of palliative care for cancer patients. Palliative care (1) promotes relief from pain and other distressing symptoms; (2) affirms life and considers dying a normal process of life; (3) does not hasten or postpone death; (4) integrates psychological and spiritual aspects in patient care; (5) provides a support system to help patients live as actively as possible until death; (6) provides a support system to help family members cope during the patient's illness and in their own bereavement; (7) is a multi-professional approach to address the needs of patients and their families, including bereavement counseling; (8) improves quality of life and positively influences the course of the disease; and (9) must be applied as early as possible alongside other life-prolonging measures such as chemotherapy and radiation therapy. Furthermore, it includes all investigations needed to better understand and control distressing clinical situations.

Therefore, it is essential that a multidisciplinary team consisting of a doctor, psychologist, nurse, nutritionist, physiotherapist, and social worker carry out palliative care actions, although each service creates its own conditions.

Team work⁴ consists of uniting people for the purpose of joint action. It implies action on a horizontal rather than vertical plane. Thus, each professional occupies the same hierarchy and shares potential behaviors, information, and knowledge. Accordingly, talking and sharing questions, doubts, and procedures regarding patient care are means of taking care of the team.

Other noteworthy aspects in intensive care unit settings are the actions for implementing integrated palliative care. These are differentiating between a planned family conference (information on and verification of the diagnosis, prognosis, and therapy; evolution of potential conflicts/satisfaction/trust), following up on medical records with daily information on

the patient's clinical condition, conducting communication skills training, checking and promoting documentation of guidelines, verifying parties' wishes considering participants' decisions, promoting multidisciplinary meetings, scheduling meetings to review difficult cases, and developing protocols to handle conflicts.⁵

Another point concerns the religiosity/spirituality of those involved, which are important markers in the psychologist's work and decision making.⁶

Maugans⁷ suggested SPIRIT as a potential instrument for the psychologist's action, which considers the belief system, personal spirituality, community integration, ritual practices and limitations, implications for medical care, and planning for end-of-life events. Another more recent instrument is Puchalski's FICA.⁸ The issues addressed concern beliefs and faith, the importance of spirituality in the patient's life, community support, and how the patient wants spiritual issues to be conducted during their care.

The DAM⁹ multidimensional approach diagram is intended to consider all dimensions of human suffering and its causes. It focuses on defining a strategy that emphasizes preparation and relief for the patient and family members during the course of all dimensions of the disease. The course of the disease is discussed in multidisciplinary roundtable meetings to ensure everyone can interact given physical, religious, spiritual, psychological, social, and family aspects.

The psychologist's role is to determine, identify, and take action by recognizing the epistemological field of their work. One duty is to work in a team,¹⁰⁻¹³ and communication with other areas is essential. Their work takes place in the ward, intensive care unit, outpatient clinic, referrals, and during family visits. Psychologists also support the family after the patient's death.

One device used is to record the subject's autobiographical narratives¹⁰ and journey to detail any traumas and anxieties during the course of the disease.

DISCUSSION

Based on the foregoing, it is necessary to reflect on and discuss this clinical practice.

Important is communication with the patient, family, and team, which is fundamental to the psychologist's work. It takes time, listening, preparation, and several meetings to obtain the most appropriate outcome possible. However, it is not always possible to have all the time necessary. It is up to the psychologist to sustain the various facets of suffering in their time, which is always specific, singular, and unique.

The meeting with each patient and their family is unique, and a narrative is created. In this sense, the work is a path to be constructed, followed, and shared for a time. Then comes the story of how the patient sees, feels, and interacts with the world based on their experiences. Another important aspect determining their choices is what makes sense to them at each step. At the onset of the illness, questions that emerge and need to be resolved include: What is the meaning of my existence? Why me? What did I do wrong? How do I deal with the disease? What is death? How am I going to die? What do I do with my remaining time? Is this punishment? What will I leave behind? How do I communicate?

Given this situation, the family will also have questions that need clarification or even verbalization. Arising questions include: Is the patient suffering? Are they going to die alone? Will the team abandon them? Will they be well taken care of? Will they feel pain? How do I make decisions regarding the disease's impact? Will I do what is best? Is the decision right or wrong? Will a miracle happen? How do I deal with grief? With the separation? Losses? This scenario is complex and dynamic and involves the beliefs and meanings of life experiences for each individual involved in the course of the disease at each stage.

Conversely, the team also plays a fundamental role in this interaction. In this sense, clarifying the following questions is important. How can we improve communication? How can we offer the patient more space to express their feelings? How can we better meet the social, spiritual, and emotional needs of the family and patient? Are the patient and family feeling abandoned or cared for in their pain?

In this way, the three spheres of care—the patient, family, and team—are connected in a dynamic network of mutual influence. As a result, they cause changes, new alterations, and reorganizations because of the impacts. These require constant communication. Therefore, the psychologist is also a point of reference for team cohesion, which can often encounter emotional issues that may destabilize it. Since the psychologist's work in the palliative care team was introduced, an improvement in communication has been observed with members of other teams, the family, and patient, despite challenges. A decrease in conflicts and greater support, comfort, and reception were also noted. This provided a greater bond with the team and greater adherence to their

therapeutic protocols. The challenges of the journey are to expand palliative care in Cardiology, encourage other groups to join, conduct research, and provide education.

CONCLUSION

Based on the reflection paper, it was not possible to map the work of the psychologist in a palliative care team in Cardiology, as the literature in the area is scarce. Therefore, further research is needed as work in other areas is well structured and defined.

The palliative care psychologist's work in other areas includes the care of patients, family members, and teams in various institutional sectors. Follow-up begins from the time of the impact of the news of the patient's death and in providing support for the family after death. The following activities are inherent to the psychologist's work: listening actively, creating narratives, providing orientation and clarification to the patient and family, improving support networks, participating in family conferences, opening spaces for case discussions, promoting multidisciplinary meetings, taking care of team burnout, handling conflicts, and implementing communication skills. Most important, they must be personally prepared to manage the end of life. They must know themselves first, as well as their limits and possibilities to be able to play their true role in the hospital.

CONFLICTS OF INTEREST

The author declares that he has no conflicts of interest in this work.

AUTHORS' CONTRIBUTIONS: Cada autora contribuiu individual e significativamente para o desenvolvimento do trabalho. MDN e MTCC foram as contribuintes na elaboração do trabalho. MDN e MTCC realizaram a pesquisa bibliográfica, revisão do trabalho e contribuíram para o conceito intelectual do estudo.

REFERENCES

- Clark D. From margins to centre: a review of the history of palliative care in cancer. *Lancet Oncol*. 2007;8(5):430-38.
- Wheat A. Palliative care- evolution of a vision. *Med Health R I*. 2009;92(1):34-6.
- WHO. Cancer knowledge into cancer. Palliative Care. Module S. Geneva: World Health Organization, 2007.
- Alves EGR. Equipe de trabalho e trabalho em equipe. In: Veit MT. Transdisciplinaridade em oncologia: caminhos integrados. ABRILE- Associação Brasileira de Linfoma e Leucemia. São Paulo: HR Gráfica e Editora; 2009. p. 83-98.
- Moritz RD, Deicas A, Capalbo M, Forte DN, Kretzener LP, Lago P, et al. II Forum of the "End life study group of the southern cone of America": palliative care definitions, recommendations and integrated actions for intensive care and pediatric intensive care units. *Rev Bras Ter Intensiva*. 2011;23(1):24-9.
- Sulmasy DP. Spirituality, religion, and clinical care. *Chest*. 2009;135(6):1634-42.
- Maugans TA. The SPIRITual history. *Arch Fam Med*. 1996;5(1):11-6.
- Puchalski CM. Spirituality and end-of-life care: a time for listening and caring. *J Palliat Med*. 2002;5(2):289-94.
- Saporetti LA, Andrade L, Sachs MFA, Guimarães, TW. Diagnóstico e abordagem do sofrimento humano. In: Carvalho, RT.Parsons. HA. (Org.). Manual de cuidados paliativos. *Ampliado e atualizado*. 2.ed. ANCP: 2012. p. 42-55.
- NunesLV. Papel da psicologia na equipe de cuidados paliativos. In: Carvalho RT, Parsons HA. (Org.). Manual de cuidados paliativos. *Ampliado e atualizado*. 2. ed. São Paulo: ANCP:Academia Nacional de Cuidados Paliativos; 2012. p. 218-20.
- Franco MHP Psicologia. In: Ayer R. Cuidado paliativo. São Paulo: Conselho Regional de Medicina do Estado de São Paulo (CRE-MESP); 2008. p. 74-6.
- Scannavino CSS, Sorato DB, Lima MP, Franco AHJ, Martins MP, Moraes Junior JC, et al. Psico-Oncologia: atuação do psicólogo no Hospital de Câncer de Barretos. *Psicol Hosp* (São Paulo). 2013;24(1):35-53.
- Domingues GR, Alves KO, Carmo PHS, Galvão SS, Teixeira SS, Balduino EF. A atuação do psicólogo no tratamento de pacientes terminais e seus familiares. *Psicol Hosp* (São Paulo). 2013;11(1):2-24. [Acesso em: 10 abr 2018]. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1677-74092013000100002&lng=pt&lng=pt.