

Palliative Care in Cardiology



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Introduction

From its origin the science behind medicine seeks as a central objective the regression of symptoms arising from a systemic homeostatic imbalance. Through research and intervention until the return of balance and consequent healing. With the scientific technical advances in the health areas conquered over the last centuries the life expectancy of the human being has grown exponentially.

According to WHO [1] the overall life expectancy is 71.4 years. According to Worldometers [2], a virtual platform that provides real-time statistics of the world population, between 2011 and 2017 the world population grew by half a billion inhabitants reaching the mark of seven billion inhabitants with an increase in the number of elderly people and a decrease in the birth rate. This phenomenon, in addition to modifying the population profile of the nations, increased the incidence of chronic diseases such as diabetes mellitus, arterial hypertension, stroke, heart disease, chronic obstructive pulmonary disease, lower respiratory tract infections and neoplasias [3]. Diseases that have caused many deaths worldwide and have pointed to the demand for palliative care.

The Manual of Palliative Care of the National Association of Palliative Care (NAPC) states that the World Health Organization in 1990 presented the following definition:

“Active and total care for patients whose disease is not responsive to healing treatment. The control of pain, other symptoms and psychosocial and spiritual problems is paramount. The goal of Palliative Care is to provide the best possible quality of life for patients and their families 8:25”.

Subsequently, in 2017, this definition was revised and replaced:

“Palliative care is an approach that improves the quality of life of patients (adults and children) and families facing problems associated with life-threatening illnesses. Prevents and alleviates suffering through the early identification of correct assessment and treatment of pain and other physical, psychosocial or spiritual problems [4]”.

According to NAPC [5], the origin of the palliative philosophy has arisen in antiquity since the first definitions about caring. In the average age the hospices present in the monasteries sheltered travelers, sick, hungry, poor, orphans, lepers and dying. These spaces were meant to welcome, protect and alleviate suffering, rather than the search for healing. In the seventeenth and eighteenth centuries, the creation of charities in the care of this public spread in Europe. The Brazilian Society of Geriatrics and Gerontology (BSGG) describes the term Hospice as a philosophy of care in which intensive palliative care is applied to patients with advanced diseases, near the end of life, encompassing support for their families. A hospice does not necessarily mean a physical place. In this sense, another concept is that the hospice refers to end-of-life care, including care during the dying process, which extends to the reception of bereaved relatives [6].

In the fourteenth century a social worker, nurse and physician named Cicely Saunders, questioned how to care for the relief of human suffering in patients with advanced illnesses. And with the support of one of his patients, end-stage cancer patient David Tasma founded in 1967, St. Christopher's Hospice, the first service to provide comprehensive patient care, from symptom control, relief from pain and psychological distress.5 From the creation of this service emerges from the Modern Hospice Movement [7]. In Brazil, isolated initiatives and discussions on Palliative Care (CP) emerged in the 1970s, but only in the 90s did the first organized services begin to appear in an experimental way, such as the courses and services with a palliative philosophy offered by the Universidade Federal de São Paulo - UNIFESP / EPM, and the National Cancer Institute - INCA, of the Ministry of Health, which inaugurated in 1998 the Hospital Unit IV, exclusively dedicated to Palliative Care.

In the Brazilian scenario, there are still few palliative care services. In the curricula of medical courses and other areas of health, this topic has not been part of the training, although it is a topic of paramount importance to approach and treat patients in this form of care. This

fact may be related to the absence of medical residency and the lack of specialization courses and postgraduate courses [8]. Despite the lack of knowledge and prejudice related to this topic between the various categories of health professionals and judiciary, which often use as an example the erroneous association of palliative care with euthanasia, palliative care over the years has undergone changes that have increased focus [8].

Today it is understood that palliative care occurs throughout the disease process and during mourning. Access to this specialized care should be facilitated and occur even after changing the care environment. When practitioners are fundamentally empowered through continuing education and training programs, a genuine acceptance of the demands of patients and family members occurs. Considering that during this process both patient and family present a variable need for palliative care, because the intensity of problems arise dynamically [6]. The change in the perception of palliative care aimed at the attention of patients who are dying to care for the relief of suffering, pain and improvement of the quality of life throughout the experience of illness and mourning in order to reach the full potential of living when it progressively worsens, was presented as a challenge by the Brazilian Society of Geriatrics and Gerontology [6].

In view of the above, it was defined as the objective of the present study: to discuss palliative care in Cardiology. It is an integrative review of the literature carried out in national and international databases. The justification for choosing the theme is due to the fact that it is an Occupational Therapist residing in a Multi professional Health Residency Program in the area of cardiological care.

Theoretical Framework

Occupational therapy aims to maintain the significant activities of the patient and his / her family even in the in-hospital context, promote comfort measures and control of other symptoms from the illness process, adapt and train daily life activities to maintain autonomy and independence of the subject / patient. In addition to creating possibilities for communication, expression through resources such as alternative communication among other objectives pertinent to this professional [9]. The process of illness and progression to chronicity in cardiovascular diseases have a significant impact on the occupational performance of patients. The occupational therapist performs educational activities and activities with a focus on changing risk factors and replacing them with protective factors. This professional performs the following interventions: cardiac rehabilitation with guidelines, energy conservation training and task simplification applied to daily life activities and instrumental activities of daily living.

Reorganization of daily life with significant activities appropriate to the stage of disease, prognosis and energy consumption, as well as prescription of adaptations and assistive technology [10]. Minimizing the limitations resulting from the disease process, improving the quality of life, recovering diminished functional abilities or losing the patient are the objectives of the mentioned interventions [10]. During the elaboration of the therapeutic plan the occupational therapist implements in its objectives the independence and autonomy of the individual. In order to obtain effective and effective results with

the therapeutic proposal, it is necessary to integrate the patient and his / her family in the treatment process, as well as the support and technical support of a multiprofessional team that, acting together, seeks to minimize the of debilitating symptomatology [10].

Methodology

The scientific production in health linked to the research process is presented in the world context as essential for the production of knowledge related to innovations and technologies. Evidence defined as the use of facts to support a conclusion has gained space in this context because it is derived from scientific research. In general they are more convincing than those derived from random observation. That is, the evidence is used to identify facts that support opinions and can assess the magnitude of such facts on the basis of conclusions. A fact is something known by experience or observation. The process for assessing the reliability of evidence needs to answer the following questions: Which study design was used to arrive at a certain conclusion? What is the quality of the information by means of observations? Have the information been consistently recorded and relevant to the desired effect? How many are and how strong would be the association between the intervention and the observed effect.

Evidence-based practice is an approach that uses the definition of a problem, followed by the demand and appreciation of reliable evidence in the literature, evaluating the intervention of the evidence in practice and the results generated at the end of the process. This practice incorporates in the process, the clinical knowledge of professionals and the preferences of the subjects with the objective of supporting a decision on health care [11].

Systematic review research is defined as a method of choice for evidence-based practice (EBP), such as combining evidence from multiple studies that focus on a specific problem [12].

Another scientific method used in research is called integrative review, in which a synthesis of results generated in research on a given topic or question is carried out systematically, methodically and extensively [13]. It is called integrative because it provides broader information on a subject/problem, thus constituting a body of knowledge" [12]: pg.9. The revision of theories, understanding of concepts, formation of opinion and or analysis of studies are some examples of objectives regarding the use of this research method [13]. The use of the integrative review originates knowledge regarding a research problem, which after careful evaluation can be incorporated into the care practice. Within this context the present work uses the integrative review method to discuss the scientific production about the topic palliative care in cardiology. With descriptive character the bibliographical research was developed during the months of August to September of 2017. The sources of the study came from periodicals in the Portuguese and English languages, indexed in the computerized databases, such as: SCIELO, Pubmed, Medline, VHL. The descriptors: care, palliative, cardiology were used to guide the searches. A total of 1181 articles were found in databases and newspapers. Of these, 25 articles were selected, 2 in Portuguese and 23 in English. The inclusion criteria were: articles dated from 2007 to 2017, with descriptors containing the words care, palliative, cardiology. Exclusion criteria were: articles related to pediatric cardiac palliative care, articles that

contained only oncological palliative care and restricted to Portuguese and English languages.

Results and Discussion

The data are presented by means of graph I, with the quantitative of the articles by years of chronological publication. Legend: quantitative articles by publication year. Among the selected articles, we opted to start the discussion with the presentation of a multicenter and retrospective cohort study carried out in Belgium that compared the hospital cost of the treatment of terminal patients using palliative care with usual care. It suggests in its conclusion that the model of palliative care used in the wards should be encouraged, since this model seems to have a lower cost and better reflects the needs of patients in a terminal situation [14]. Palliative care can be offered in a specialized or primary way. In the first, the specialist in palliative care provides, through consultation or conduction with the responsible clinician, the management of interventions focused on the palliative objectives. The second also known as generalist palliative care occurs when the clinician, i.e, cardiologist, intensivist, or other untrained medical professional in the specialty of palliative care provides the essential palliative domains (basic symptom management, communication and goal planning advanced care, psychological support and care coordination) within the usual care. Despite presenting the primary palliative care model, the authors report that there is no research on this care [15]. The articles found suggest Heart Failure (HF) as the most prevalent disease and incidence in the application of palliative care in patients with heart disease. Due to its syndromic, systemic and high morbidity and mortality characteristics, 15,17,21,22 In their natural course of the disease, patients present decompensations that lead to rehospitalization, increasing the cost of hospital care.

An exploratory documentary study analyzed the territorial distribution of palliative care services in Brazil, the authors identified the concentration of these services in the capitals of the south and southeast regions, mainly linked to oncological institutions. The CP offer in the treatment of patients with HF is incipient and restricted. However, when properly practiced, they can result in: improvement in the quality of life of patients and their relatives, control of symptoms, reduction of rehospitalizations and hospital costs, as well as promotion of integral care and reduction of the risk of dysthanasia [16]. A study in the USA describes that patients with HF rarely receive specialized palliative care [15]. The authors attribute this fact to barriers that make it difficult for the public to make reference to these specialists. This is possibly due to the low supply of palliative physicians, the erroneous perception that this care should only occur in the end-of-life process, the unpredictable course of HF and its difficult prognosis, ambiguity in the differentiation of standard HF treatment therapy and palliative care and the uncertainty as to the best time to perform the referral [15].

In American reality it is estimated that there is only one palliative medical practitioner for every 1200 people living with a serious or life-threatening illness [15]. A qualitative study conducted by the University of Colorado aimed at describing the apprehensions and demands of patients with HF and their families, as well as, at what time this care model would be more beneficial. In general, the

answers found through interviews with 33 patients and 20 relatives referred to the difficulty of dealing with emotional issues, the planning of the future, the adequacy of the limitations of the disease and its progression, and the uncertainty of the prognosis as relevant concerns [16]. The conclusion of the interviewees suggests the application of palliative care both in diagnosis and over time, as this helps the patient's adequacy to their condition. Regarding psychosocial support, they agreed that a team approach could help the patient and the caregiver bringing benefits to both.

An important data in the context of palliative care refers to patients awaiting heart transplantation, who present significant emotional, physical and spiritual symptoms that are not always addressed by care teams [18]. The use of the palliative care model in this public was the object of a study carried out in the USA. In its conclusion, the study describes the importance of a palliative team working in patients who wait from salvation procedures such as transplantation until the end of life [17]. Palliative care affects not only the life of the patient, but that of their caregivers and facilitates the joint discussions on goals of care and maintenance of the continuity of this care. Post-transplant patients continue to have needs and symptoms that can be addressed within an outpatient palliative care team.18 Although there are some data on CP in patients awaiting transplantation, more research needs to be done to prove the efficacy of this model both in patient care and in the fact that its use has a lower cost of treatment [17,18].

Finally, we discuss palliative care in patients with implantable cardioverter defibrillators (ICD) or artificial electrical stimulation. This instrument is implanted when necessary in the treatment of rhythmic changes of the heart from irregular electric shots. An article from the Cardiology Society of Rio Grande do Sul states several prospective multicenter clinical trials demonstrating the effectiveness of ICD use in improving survival in patients with heart disease [19]. In the context of a reserved prognosis, with a probable worsening of the clinical picture and difficult reversion, the discussion about the possibility of deactivation of the ICD device could be taken into account, since shocks cause suffering to both the patient and his family [20-22]. In view of the discussion of these studies, we highlight the importance of this topic in the context of the health of a population that at the same time increasingly demands specialized care while demand for integral care. Highlighting the role of the multiprofessional team that has in its core the specialty of each area in the corollary of a collective and integrative action. Occupational Therapy makes up this multiprofessional team and attentive to the need to explore topics that thrive in the context of modern society.

Final Considerations

The development of the present study allowed an analysis of how palliative care in cardiology has been approached in different studies, the authors addressed the benefits of the use of this care and the difficulties in its implementation in the different cardiac patients (CI, transplantation or CDI), besides of its lower cost when compared to the traditional care model. The possibility of clinicians being trained to use the essential palliative domains is presented as a strategy to minimize the lagged demand for palliatives needed in different hospital spaces, but more studies are needed to prove the effectiveness of this ploy.

The implementation of the palliative care theme in the undergraduate curriculum of the medical course could be the necessary strategy for the expansion of this knowledge and decentralization of CP services to other regions of the country. Thus, patients with HF and other chronic conditions would have easier access to this type of care, due to the fact that these professionals are referred early.

Finally, control of the symptoms of dyspnea, cough, edema, pain, among others, adequate communication with patients and caregivers regardless of level of education, discussion about the prognosis and treatment options, identification of individual needs (fear and concern), respect for autonomy, independence, and promotion of resilience are some of the goals based on palliative care principles that cardiac patients can benefit from.

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