

CARE PROVIDED BY THE HEALTH TEAM UNDER THE PERSPECTIVE OF PATIENTS IN PALLIATIVE CHEMOTHERAPY: AN EXISTENTIAL ANALYSIS

CUIDADO DA EQUIPE DE SAÚDE SOB A ÓTICA DE PACIENTES EM QUIMIOTERAPIA PALIATIVA: ANÁLISE EXISTENCIAL

ATENCIÓN DEL EQUIPO DE SALUD DESDE LA PERSPECTIVA DE PACIENTES EN QUIMIOTERAPIA PALIATIVA: ANÁLISIS EXISTENCIAL

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ABSTRACT

The objective of this study was to understand the experiences of patients with cancer undergoing palliative chemotherapy in relation to the care received from the health team since their search for diagnosis. It is a qualitative study, with a phenomenological approach, whose participants were 21 cancer patients in chemotherapy treatment attended by the 16th Regional Health Area of the State of Paraná. Data were collected between November 2015 and February 2016, from the guiding question: tell me about the care you have received from health practitioners since the diagnosis of cancer. From the analysis emerged two ontological themes that address the obstacles faced in the diagnosis, the appreciation of the sincerity of health practitioners before the impossibility of cure and the finding of authentic care after the beginning of the therapy. The understanding of such experiences raises the issue of health care for cancer patients in order to overcome impersonal and inauthentic attitudes.

Keywords: Neoplasms; Palliative Care; Oncology Nursing.

RESUMO

Objetivou-se compreender as vivências de pacientes com câncer em quimioterapia paliativa frente aos cuidados recebidos da equipe de saúde desde a busca por seu diagnóstico. Estudo qualitativo, de abordagem fenomenológica que teve como participantes 21 pacientes com câncer em tratamento quimioterápico atendidos pela 16ª Regional de Saúde do Estado do Paraná. Os dados foram coletados entre novembro de 2015 e fevereiro de 2016, a partir da questão norteadora: fale-me sobre o cuidado que você tem recebido dos profissionais de saúde desde o diagnóstico do câncer. Da análise emergiram duas temáticas ontológicas, que versam sobre os entraves enfrentados no percurso do diagnóstico, a valorização da sinceridade dos profissionais de saúde ante a impossibilidade de cura e o encontro do cuidado autêntico após o início da terapêutica. A compreensão de tais vivências suscita a reflexão acerca da assistência à saúde ao paciente com câncer, a fim de superar atitudes impessoais e inautênticas.

Palavras-chave: Neoplasias; Cuidados Paliativos; Enfermagem Oncológica.

RESUMEN

El objeto del presente estudio fue comprender las experiencias de pacientes con cáncer en quimioterapia paliativa ante los cuidados brindados por el equipo de salud desde el momento del diagnóstico. Estudio cualitativo con enfoque fenomenológico llevado a cabo con 21 pacientes oncológicos en tratamiento quimioterápico atendidos por la 16ª Regional de Salud del Estado de Paraná. Los datos fueron recogidos entre noviembre de 2015 y febrero de 2016 de los testimonios de los 21 pacientes sobre la siguiente cuestión: hableme acerca de la atención recibida de los profesionales de salud desde el diagnóstico de cáncer. Del análisis surgieron dos temas ontológicos que se refieren a los obstáculos enfrentados desde el diagnóstico, la valoración de la sinceridad de los profesionales de salud ante la imposibilidad de curación y el hallazgo del cuidado auténtico después de iniciar el tratamiento. La comprensión de estas experiencias da lugar a la reflexión sobre el cuidado de la salud de los pacientes con cáncer con el fin de superar actitudes impersonales y no auténticas.

Palabras clave: Neoplasias; Cuidados Paliativos; Enfermería Oncológica.

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INTRODUCTION

In spite of the technological development regarding the early diagnosis and the antineoplastic therapies,¹ cancer is currently a progressively incident disease, standing out among the highest morbidity and mortality rates in the world.² In developing countries, the incidence of cancer has been increasing steadily, while the resources available for early diagnosis remain low or medium.³

In Brazil, more than 70% of the cases of neoplasms are diagnosed from stages III and IV, which affects a reduction of the possibilities of treatment and perspectives of cure against cancer.⁴ For these patients, the available therapeutic options aim at relieving symptoms and at quality of life, so there have been investments in necessary treatments in order to achieve this goal. Thus, the cancer patient with no prospect of cure can benefit from the palliative modalities of oncologic surgery, radiation therapy or chemotherapy. It is worth mentioning that palliative therapies aim to reduce the complications of the disease that can cause suffering to the patient, with no intention of interfering in the patient's survival.⁵

Studies that have addressed cancer patients in palliative therapy reveal that the management of symptoms, especially pain, can improve the quality of life of these people and provide better control of the disease.^{6,7} However, for palliative chemotherapy to be beneficial, the pharmacological treatment should be associated with the non-pharmacological monitoring and control of symptoms in order to take into account the psychological, social and spiritual aspects that may cause suffering to patients.⁶

Nevertheless, the absence of palliative care teams in a large part of the health services in Brazil, as well as of specialized places for this type of care, can cause questions and misconceptions regarding the therapies and care, leaving the patient at the mercy of their sufferings.⁸ In this sense, professionals working in chemotherapy services, especially nursing, must be prepared to deal with the feelings and anguish of patients facing the incurability of their cancer, considering that the progression of the disease and the imminence of death become even more feasible with the start of palliative therapy.

In view of this context and considering the importance of the patient being the protagonist of their care, the following question emerges: how have patients in palliative chemotherapy experienced the care provided by the health team since the search for their diagnosis? The realization of this study is justified to the extent that the understanding of the experiences of these people can subsidize reflections on the care provided by the health team from primary care, from the early detection of cancer to the chemotherapy outpatient clinics, in order to increase the assistance to these beings.

Therefore, the objective of this study is to understand the experiences of patients with cancer in palliative chemotherapy in relation to the care received from the health team since the search for their diagnosis.

METHOD

It is a qualitative study based on Heidegger's existential phenomenology, which allows the study of phenomena in the attempt to understand the other in its facticity in a singular way, that is, the man in his existential entirety.⁹

The research was developed with cancer patients assisted by a *Unidade de Assistência de Alta Complexidade em Oncologia* (UNACON) located in the northern part of the state of Paraná, which offers chemotherapy and surgical treatment for adults with malignant neoplasms.

The inclusion criteria used for the participants of this study were: being over 18 years of age, being aware of the diagnosis of cancer and having performed at least three months of palliative chemotherapy. Patients who, during the period of data collection, presented worsening of their clinical condition and/or difficulty in verbal communication were excluded. Inclusion and exclusion criteria were previously checked through the patients' medical records before the initial approach.

Data were collected through in-depth interviews, conducted at the health institution, in a private room. Patients were invited to participate in the study at the intervals between the medical consultation and the chemotherapy applications, which ranged from 15 to 45 minutes. This moment was opportune because after the consultations the patients waited between one and two hours until they were called to the chemotherapy room.

For the interviews, we conducted a sociodemographic characterization of the patients, followed by the guiding question: "Tell me about the care you have received from health professionals since the diagnosis of cancer." The interviews were stored with the aid of a digital recorder and subsequently transcribed in full. Data on the clinical and therapeutic status of the interviewees were later collected from the medical record through a semi-structured script that addressed questions on the oncological diagnosis and antineoplastic treatments performed by the patients.

Because it was a phenomenological research, the number of participants was determined based on the analysis of the statements, which was carried out concomitantly with the data collection. Thus, the sufficiency of meanings capable of responding to the research objective⁹ was confirmed in the 21st interview, this being the final number of study participants. It was emphasized that there were no refusals to participate in the study and data were collected between November 2015 and February 2016.

We chose to analyze each speech individually in order to understand them in their entirety, starting from a trajectory that reveals the ontic until the ontological dimension of the experiences and feelings of the patients in their palliative antineoplastic treatment. In order to do so, first we performed a vague and average understanding, when we tried to under-

stand the daily facts revealed by the participants, seeking those that the individual usually shows to all. At that moment, essential meanings and structures are still veiled, but they help to understand the phenomena.⁹

The second analytical moment, called interpretative understanding, seeks the interpretation of the meanings in order to clarify what was still obscure in languages. It is at this moment that the sense of the Being of each individual before the revealed phenomena is interpreted, culminating in the Heideggerian hermeneutics.⁹ Finally, the ontological themes were established, analyzed in the light of some ideas of the Heideggerian analytics, some Oncology assumptions and authors that deal with such topics.

The research project to which this research is linked was approved by the Standing Committee on Ethics in Research involving Human beings of the *Universidade Estadual de Maringá*, under Opinion 1,328,979. All participants signed the Informed Consent Form in two copies. Participants' anonymity was guaranteed through the use of codes (p1, p2, p3 ... p21) for each interviewee, followed by their age and diagnosis.

RESULTS

Of the 21 patients interviewed, there was a predominance of females (13), of whom 14 were married and 3 were widowers, aged 46 to 77 years. Regarding the occupational situation, eight participants were retired, two were receiving sick pay and the others remained in their pre-illness activity. Treatment time ranged from four months to two years, and 20 patients had undergone other anticancer therapies besides chemotherapy, such as oncologic surgery and radiation therapy.

From the analysis of the subjectivities expressed by the participants, two ontological themes emerged: "Experiencing being-alone in the world in the search for treatment" and "Finding authenticity in caring before the impossibility of cure", which will be presented below.

EXPERIENCING BEING-ALONE IN THE WORLD IN THE SEARCH FOR TREATMENT

The search for the diagnosis of cancer for the participants of this study was permeated by meetings and disagreements in the health services. The patients revealed that before the start of the treatment, the health practitioners remained oblivious to their case. Silence and lack of empathy for the other, regarding their health information, did not provide any information or position on what was to come.

At first it was kind of confusing, I came here, did tests, did not know anything. They could take me anywhere,

anywhere. Some said that I had one thing, others said I had another [...] The nurse who was taking the blood told me that I had nothing! And I kept thinking, "My goodness, everybody talks, but nobody knows what I have, I think I'm going to die any time (p21, 70 years old, prostate cancer).

[...] like the doctor, he does not say anything! He only speaks for sure, after all the tests. But even the day he saw my lung, didn't he notice that it was loaded? He did not say anything! He did not prescribe a medicine, nothing! But I think at least the necessary, he has to talk something. You get to understand more what you're doing! (p06, 71 years old, lung cancer).

Memories of the moment of discovery of a cancer that could not be cured led patients to talk about the pathways they have walked until they found treatment. Their reports bring to light the anguish they experienced when they came across professionals who were not able to suspect the disease that had affected them, which substantially compromised the early diagnosis, clinical treatment and, possibly, their therapeutic possibilities.

[...] a small carob appeared in the source, at the right side, very small. And it started to bother us. I used to go to the geriatricians in our city, I had my rheumatologist, I showed it to everyone. And everyone said it was nothing, it was a small wart. But it started to grow too big and we went outside the city, and we found that the cancer had come back [...]. If the doctors there at the beginning had paid attention, had performed tests, it would not have got where it got... (p05, 77 years old, prostate cancer).

[...] if I had come in an expert, like here, I would have been cured. I would have already removed the breast and I would be cured! The process would be more advanced, it would have been much easier, I would not have suffered as I suffered. [...] And I went to the health unit and the lady said: – No, you do not have to worry about it, that's a little fat you have (p10, 35 years old, breast cancer).

At the moment when they were revealed the diagnoses and the impossibility of cure, the patients had to face the reality that was unfolding and started to be based on the sincerity and accuracy of the information provided, as well as on the clarification of doubts during the care:

Since I started with the doctor, he told me: – That's the treatment! This last time I asked if I could not do another surgery, he took a look at my tests and said that I could not (p03, 62 years old, liver cancer).

And today it is about controlling it [...] When we arrived here it was already in the bones, the doctor told us (p05, 77 years old, prostate cancer).

Look, I think they have always been like this [...] The doctors have always played very clean with us, they have never made up anything or dropped something (p13, 75 years old, liver cancer).

The second time I asked the doctor and he said no, I already came with the complete diagnosis, that the cancer had already passed to the bones and that I had no chance of surgery. Then he cleared up all my doubts. I was well attended and it was well explained (p21, 70 years old, prostate cancer).

It is evident that the journey in search of the diagnosis and treatment of cancer has sometimes been solitary and full of gaps in the care provided by health practitioners. However, once they were informed about their therapeutic impossibility, the patients in this study relied on the truth to face the facts.

FINDING AUTHENTICITY IN CARING BEFORE THE IMPOSSIBILITY OF CURE

When referring to the care received after the beginning of the palliative chemotherapy treatment, the patients talk about an individualized care, which contemplates attention and subjectivity. As a differential, the fact that patients are “called by name” stands out, which seems to be an unusual and remarkable treatment.

[...] I'm enjoying the way they treat us, the service; it is something that, you get at the reception and they call you by your name, it is not that thing of: – So and so! Or: – You, come here! No, they call you by the name and that's already a big deal. It already shows that they take greater care. The oncologist himself, when he meets us in the hall, he greets us, does not pretend he did not see us. He calls us by our name, he says: – How are you? So things like those make us feel good, right? These are the things that make the difference (p03, 62 years old, liver cancer).

[...] there is a great difference in the way they treat us. You get there and any one of them already knows you, knows your name. The first day I came here, then in the second session, even though there are lots of people here, and they learn our names, they know our names. The attention here is different (p11, 44 years old, cervical cancer).

Three years I'm coming here and I cannot complain about no one. Yeah, everybody here knows me, I'm even cherished by them. (p13, 75 years old, liver cancer).

In addition, the patients reveal welcoming and affectionate attitudes by the health practitioners, allied to a work based on science and care. Such attention restores patients' willingness to continue their treatment and promotes well-being to those who are deprived of the possibility of cancer cure.

[...] they are very good to me, they are great! They are very humanized, you know, they treat us very well! They have always treated me with the greatest attention, the nurses and everything. So, to this day I have nothing to tell against them (p13, 75 years old, liver cancer).

The nursing staff is all right, all good, very thoughtful, careful, you know? They work with a lot of dedication and a lot of science! (p14, 76 years old, prostate cancer).

[...] the ladies there from where I take the chemotherapy, wow, excellent! They are very careful, always asking; They know what they need to know, I am well seen. That's why we feel good! (p17, 43 years old, prostate cancer).

What I think that helps us to feel better are the people, who are welcoming, friendly, always with a smile, always talking (p21, 70 years old, prostate cancer).

Similarly, empathic attitudes of genuine care by professionals generate trust and familiarity with patients, who end up following their recommendations unreservedly. This attitude is also supported by a quest for comfort and well-being, which leads to the performance of the treatment in a precise way.

[...] I follow all the rules the doctor asks for. It's the same thing that I did not come in the chemotherapy session. Next week I already know, I have to go back, if I don't, I'll lose the continuity of treatment, it'll get paralyzed. It was made to be strictly attended, I cannot miss any. I think this is helping me to get better (p03, 62 years old, liver cancer).

I have always trusted them so much that we have never sought a second opinion. Always like that, everything they have said to us we have always kind of did it, because it was everything very [...] They are good, we trust the doctors, the reception ladies, who are very nice, treat us right and the nurses are good (p13, 75 years old, liver cancer).

Patients also reveal the recognition of the severity of their case, the impossibility of a definitive cure, as well as the support of the professionals who assist them and their limits of action in the advanced stage of the disease. However, they gather strength and courage to continue clinical treatment in order to maintain life as long as possible.

I think they cannot do more than they already do for me. They are already helping me, there is nothing left to do. My problem, the doctor has explained it, it will [...] There is no cure! It is in the bones and everything and it is already very complicated. So we're going to follow the treatment. He says: "You're reacting well, you can handle it." So it is the treatment now, not for the chemotherapy (p01, 46 years old, breast cancer).

If they ask us, we'll do it! We have to do the right treatment until we can, because if there is a treatment, a medicine, we have to do it, until the end (p02, 65 years old, liver cancer).

Thus, after the beginning of palliative chemotherapy, the patients reported finding a humanized and individualized care that contemplated their physical and emotional needs. This relationship led them to follow the treatment in a comprehensive manner, while recognizing their real therapeutic possibilities.

DISCUSSION

The analytic proposal conceived by the Heideggerian existential phenomenology seeks the understanding of the experiences of the human being when being launched in the world. The human being, as Being-in-the-world, meets with others in his/her daily life, without most of the time differentiating someone properly.⁹ Such a condition is based on the fact that "being-with determines existentially the presence, even when the other is not, in fact, given or perceived".^{9:177}

At this sense, in daily occupation, health practitioners often distance themselves from others who come to them and, consequently, from their care, adopting an impersonal way of being. From this position, the relationship between professional and patient is based on the inauthenticity, that is, the practitioner remains close-to the person who needs care, but does not grant the existential openness necessary to be-with the other in a genuine way.

For the patients in this study, the journey in search of the diagnosis was permeated by an existential void within the health service, which led them to feel abandoned by those who were expected to provide welcome and care. The lack of communication between the health team and the patient, es-

pecially in relation to their diagnosis, left them at the mercy of practitioners who were not committed to their function, often remaining as a spectator of their decisions.

In Heidegger's thinking, the initial encounter between Beings-in-the-world in their daily lives can engage in occupations guided by the circumscription, that is, by intramundane encounters, where one looks away from experiences or significant acts, without worrying about the other in their essentiality.⁹ Moreover, based on the languages of the deponents, it is possible to verify that the communication of the improper Being-there happened from jabbering. It is a behavior that expropriates the individual from the responsibility of what is uttered, only repeating what has already been said.⁹

Jabbering is characterized by a state of permanent non-commitment to the other, which is not part of his/her world and consequently does not receive his/her care. From this perspective, the ontological character of the occupation is not proper to Being-with in these situations in which they live in their inauthenticity in the relations with others.

In this perspective, the participants of this study experienced spatiality in the professional-patient relationship, which deprived them of an assertive diagnosis at first. Practitioners, in turn, apply themselves with their complaints and reports, without analyzing critically the situations presented to them. Thus, these people had their diagnosis of cancer delayed, thus offering to the temporality the possibilities of a future without perspectives or hope of cure.

In fact, the literature reveals that the diagnosis of cancer goes through difficulties in accessing services, in addition to waiting for tests and, consequently, to initiate treatment, which may delay the diagnosis and increase the chances of metastases and limited prognoses.¹⁰ In this context, the patient ends up using the private healthcare network to accelerate the diagnostic process.¹¹ It is believed that the private network is conceived by the population as a complementary gateway to the public network,¹⁰ associated with a way of accessing assistance to their illness with more agility and readiness.

In this regard, it is important to emphasize that the national policy for cancer prevention and control guarantees comprehensive and continuous assistance within the network of health care, funded by the Unified Health System, that is, free of charge.¹² Therefore, there would be no need to resort to private services if this network of care was well established.

On the other hand, once the diagnosis of cancer and its impossibility of cure are established, feelings and relationships change, translated into a new way of looking at others and life. In the Heideggerian phenomenology's thinking, it is stated that, in being-launched-in-the-world, the man can no longer choose between experiencing joys or sufferings, being at the mercy of the events of the world. Such a condition, called existential fac-

ticity, is an involuntary prerogative of living as a human being, who is launched into temporality and vulnerable to all the wonders and difficulties that living in the world can bring.⁹

That said, cancer sickness translates as an existential facticity in the lives of people who participated in this study, who did not have a choice in the diagnosis. Moreover, the facticity of cancer in the other encourages health practitioners to open their own power-to-be, from which they open up to the truth and manifest transparency in the information given to patients. The opening of the Being reveals itself in the importance that is given to the other, who empathically considers their doubts and longings and begins to tread in search of the authentic care in its essentiality.

Open and receptive dialogue to the possibilities of treatment and prognosis facilitates the participation of the patient in his/her therapeutic process. From the recognition of their case and the particularities involved in each therapy, patients can establish with their physicians a relationship between risk and benefit involved in each possibility of treatment.¹³ It should be emphasized that the nursing professional plays a fundamental role in communicating with the patient and his/her family and in their relationship with the multiprofessional team, since it is the professional who remains closest to these subjects during assistance and care.¹⁴

Regarding the principles of palliativeness, it is important to note that, despite being primarily described as end-of-life care, it is a therapy that aims at the quality of life and comfort of chronically ill people since diagnosis.¹⁵ It is noteworthy that the patients in this study were not attended by a palliative care team, nor did they receive non-pharmacological therapeutic follow-up of their symptoms. However, the importance of palliative care for these people translates into its guiding principles, which lead to relief of symptoms of illness and total care, encompassing all the desires and needs of the patient and his/her family.

In transposing the reality of palliative care to Heidegger's thoughts about caring, it is important to consider that the opening of a Being to the other occurs from the way in which the Being-with-others occurs in their co-presence in the world.¹⁶ Concern or care is related to living with others in an authentic way, which is assumed as care in a substitute or antepositional manner. Substitutive care has a dominant character and takes its place in everyday occupations, whereas in the antepositional mode it is done in a liberating manner, in order to help the other to reestablish their possibilities of being, giving care back.⁹ In this sense, the liberating anteposition is translated into authentic care, which cares for the other and at the same time does not withdraw the possibilities of being and caring, which is significant and engaging.¹⁶

Based on these considerations, the languages of cancer patients reveal the individualization of the care received during the palliative chemotherapy treatment, revealing the impor-

tance and differentiated attention that the professionals provided to them in their therapeutic trajectory. Regarding this issue, a study carried out with cancer patients in Europe revealed that the confidence levels of patients in the nursing team are influenced by the provision of individualized care, which indirectly leads to the improvement of health quality in general.¹⁷

Caring for a sick person based on expressions of solicitude is the real expression of authentic care, which allows the health practitioner to enter the world of the other, accessing their existential dimension, which makes them a Being-with-the-other.⁹ Such a relationship is embodied in a shared world, given by the ontological-existential coexistence in which the opening to the other has always occurred.

Turning to the speeches of the deponents, it is possible to verify that the caring and empathetic attitudes depart naturally from the referenced health practitioners, who offer affection and humanization in their professional care. These characteristics gain some prominence on the part of the patients, who associate this behavior with the good professional performance of the health team.

The dedication of health practitioners to their patients reveals the commitment and zeal in their care that transcend the clinical character of chemotherapy and offer joy and affection. By transposing this reality of care into Heideggerian thoughts,⁹ the health practitioner is seen in a way of dedication, from which he helps the other at the same time as he encourages them, with characteristics of delivery, self-giving, affection and diligent creation.

Likewise, the offer of palliative care is a way to offer comfort to the cancer patient without possibilities of cure, in order to help him/her to walk in his/her therapeutic path in the best possible way. The staff offering palliative care should, in theory, conduct open communication in order to effectively achieve the relief of unpleasant symptoms, spiritual and social support, end-of-life decisions, and even assist caregivers in coping with their challenges and difficulties.¹⁸ In this way, the patient and family can experience the disease in a more active and combative way, being protagonists of the choices about their treatment and care.

In the face of authentic care that contemplates their possibilities of being and the subjectivities of their living with cancer, patients also open themselves to the opportunities presented to them and, as in a movement of resignation, unreservedly obey medical precepts and timely treatment, in order to keep to the maximum the life they still have.

For these patients, the impossibility of healing is revealed in their existential condition far from the temporality of life, based on a stable and controlled situation, by which one fights with all his/her power. On this issue, phenomenology states that, facing the possibility of death and non-Being, the affec-

tive disposition of anguish becomes an ontological condition that relates to the experience of being-in-the-world, that is, "thrown into our possibilities of being, without any prior property that determines us, we are constantly facing the threat of not-being".^{16,69} Thus, although it is conceived as an irreplaceable possibility, the human being sees death as a distant possibility, remaining insistently firm in the struggle for life.

The Being-in-the-world-for-death reveals the authentic existence of man through his existential anguish. It is in anticipation of death that Being-there reveals oneself in totality, failing to value the pettiness of daily life in order to recognize oneself deeply.⁹ Thus, anxiety awakens man to his own power-to-be, transcending the condition of Being-launched-in-the-world and becoming a Being of care, who cares for him/herself and with others.

Although the patients in this study have a limited prognosis regarding the possibility of cure, their longing for continuity of treatment is a reflection of their enthusiasm for the possibilities of continuing to live. At the same time, they recognize in the practitioners who assist them and in science the limitations of a disease that compromise the promotion of a complete restoration. The expectations of patients in palliative care about their therapeutic possibilities are a multidimensional and obscure issue, considering their relationship with subjective issues, such as planning for the end of life, offering information about the prognosis, as well as decisions about what is communicated to the patient and family during this process.¹⁹

The support and trust in the health team, as well as the maintenance of the palliative chemotherapy treatment, reflect a desire for life and for a future that permeates one's possibilities of being in their openness to the world. The living of the cancer patient with no possibilities of cure goes through the search for transcendence in their being-in-the-world and clings to the health team and palliative therapy in order to prepare for their death, as well as the consecration of their life, until the possibilities are over.

FINAL THOUGHTS

The understanding of the experiences of cancer patients in palliative chemotherapy reveals a difficult and lengthy route to enter the health service in the face of cancer suspicion. The delay in diagnosis and the mismatch of information are part of the ontic dimension of this phenomenon, which reveals itself ontologically as the cause of the impossibility of healing imposed on these beings. However, after the start of chemotherapy therapy, new possibilities are installed and the patient becomes part of the world of health practitioners, who open themselves to care in an authentic way, demonstrating empathy, solicitude and humanization in their care actions.

Given this situation, the understanding of the details revealed in patients' experiences in palliative chemotherapy

prompts reflection on the health care offered to cancer patients at all levels of care. In particular, there is a professional and bureaucratic privation in the search for the diagnosis of cancer, which could be reduced by practitioners prepared for clinical identification of cancer, as well as through more attention to the complaints and requests of the patients.

This study has as limitation the cut of a specific population of patients with cancer, because although they had undergone the palliative chemotherapy, these people were not attended by a palliative care team. In any case, the results found here indicate the need for health practitioners, especially in nursing, to reflect on their provision of care and to overcome impersonal and inauthentic attitudes that deviate them from their existential plan as health and wellness providers.

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