

# Nurses and physicians' perception of the care of oncology patients in the emergency department

*Percepção de enfermeiros e médicos sobre a assistência aos pacientes da oncologia no pronto-socorro*

*Percepción de enfermeros y médicos sobre la asistencia a los pacientes de la oncología en el puesto de primeros auxilios*

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## ABSTRACT

**Objectives:** to understand nurses' and physicians' perceptions of the care of people with cancer admitted to an emergency department of a general hospital. **Methods:** descriptive study with a qualitative approach. Data collection took place from September to November 2017 through semi-structured interviews in which participated 12 professionals from the emergency department, including nurses and physicians. The data were analyzed using Minayo's operative proposal. **Results:** three categories emerged: 1) The person with cancer from nurses and physicians' perspective; 2) Comprehensive care of people with cancer or deconfiguration in the emergency department?; and 3) The context of the emergency department and the repercussions on the care of people with cancer. **Final Considerations:** we identified that the care provided to people with cancer in the emergency department is carried out differently regarding the overall population due to the disease's particularities, which lead us to reflect on the quality and humanization of care.

**Descriptors:** Delivery of Health Care; Medical Oncology; Emergency Service, Hospital; Nurses; Physicians.

## RESUMO

**Objetivos:** conhecer a percepção de enfermeiros e médicos sobre a assistência a pessoas com câncer atendidas em um pronto-socorro de um hospital geral. **Métodos:** estudo descritivo, com abordagem qualitativa. A coleta dos dados ocorreu de setembro a novembro de 2017 por meio de entrevista semiestruturada com a participação de 12 profissionais do pronto-socorro, entre enfermeiros e médicos. Os dados foram analisados por meio da Proposta Operativa de Minayo. **Resultados:** emergiram três categorias: 1) A pessoa com câncer na perspectiva de enfermeiros e médicos; 2) Atendimento integral à pessoa com câncer ou descaracterização do pronto-socorro?; e 3) O contexto do pronto-socorro e as repercussões no cuidado à pessoa com câncer. **Considerações Finais:** identificou-se que a assistência prestada às pessoas com câncer no pronto-socorro é realizada de forma diferenciada em relação à população em geral, devido às particularidades da doença, o que faz refletir sobre a qualidade e humanização do cuidado.

**Descritores:** Assistência à Saúde; Oncologia; Serviço Hospitalar de Emergência; Enfermeiras e Enfermeiros; Médicos.

## RESUMEN

**Objetivos:** conocer la percepción de enfermeros y médicos sobre la asistencia a las personas con cáncer atendidas en un puesto de primeros auxilios de un hospital general. **Métodos:** estudio descriptivo, con abordaje cualitativo. La recogida de los datos ocurrió de septiembre a noviembre de 2017 por medio de entrevista semiestructurada con la participación de 12 profesionales del puesto de primeros auxilios, entre enfermeros y médicos. Los datos han sido analizados por medio de la Propuesta Operativa de Minayo. **Resultados:** emergieron tres categorías: 1) La persona con cáncer en la perspectiva de enfermeros y médicos; 2) Atención integral a la persona con cáncer o descaracterización del puesto de primeros auxilios?; y 3) El contexto del puesto de primeros auxilios y las repercusiones en el cuidado a la persona con cáncer. **Consideraciones Finales:** Se ha identificado que la asistencia prestada a las personas con cáncer en el puesto de primeros auxilios ha sido realizada de forma diferenciada en relación a la población en general, debido a las particularidades de la enfermedad, lo que hacer reflexionar sobre la calidad y humanización del cuidado.

**Descriptorios:** Asistencia a la Salud; Oncología; Servicio Hospitalario de Emergencia; Enfermeras y Enfermeros; Médicos.

## INTRODUCTION

The Ministério da Saúde (MS - Ministry of Health) created the National Emergency Care Policy and instituted the Emergency Care Network in Brazil, in which the priority lines include care of cardiovascular and cerebrovascular diseases and traumas, which converge on problems that were not resolved and diagnosed at other levels of Health care<sup>(1)</sup>.

This scenario also includes cancer illness. Data reveal that cancer was the cause of 189,454 deaths in 2013, and, for 2018 and 2019, it estimates that more than 600 thousand new cases of the disease would occur in the country<sup>(2)</sup>, many of whom would seek assistance in the emergency services. This perspective highlights cancer as one of the most significant challenges on the world scene and, therefore, constitutes an important public health problem<sup>(3)</sup>.

Given this context, in 2005, the National Policy for Oncological Care was created to promote prevention, diagnosis, treatment, rehabilitation, and palliative care to people with cancer<sup>(4)</sup>. According to a set of obligations and criteria, the Federal District and municipalities are responsible for organizing cancer care and defining reference flows for care.

Thus, health institutions that carry out cancer treatment receive a qualification from the MS, which can be: *Unidades de Assistência de Alta Complexidade em Oncologia* (UNACON - Oncology High Complexity Assistance Units), comprising hospitals with technical support, infrastructure and human resources adequate to provide care for the diagnosis and treatment of the most prevalent types of cancers in Brazil; and the *Centros de Assistência de Alta Complexidade em Oncologia* (CACON - Oncology High Complexity Assistance Centers), which refer to hospitals that have such conditions for the diagnosis and treatment of all types of cancer<sup>(5)</sup>.

UNACONs must guarantee access to clinical diagnosis of cancer, determine the extent of cancer, treat, care for, and ensure quality following established routines and procedures. Institutions are also responsible for providing comprehensive care to all people undergoing treatment through a 24-hour emergency care unit<sup>(5)</sup>. That is because people undergoing cancer treatment may have complications that require more frequent care in health services, especially in hospital units, for emergency care<sup>(6)</sup>.

The care to people undergoing cancer treatment can be complex, lengthy, and unsettling because it covers several phases, new terms not often used by patients, and debilitating side effects to the human body. These factors, added to the development of technologies that provide a better quality of life, lead to changes in social life and the need for attending complications, such as oncologic emergencies<sup>(7)</sup>.

Oncologic emergencies may result from the disease itself or complications related to cancer treatment<sup>(8)</sup>. From this perspective, studies indicate that most cancer patients experience at least one emergency episode during their treatment for the disease, resulting in complications and aggravations, resulting in death. Therefore, rapid and invasive interventions<sup>(6-7,9)</sup> are required. Pain, nausea and vomiting, weakness, lack of appetite, fever, dyspnea, and pleural effusion are usually the main signs and symptoms presented by cancer patients seeking care in emergency departments<sup>(7)</sup>.

Thus, this service plays an essential role in the care of this group of patients, providing early diagnosis and adequate treatment for the restoration of quality of life<sup>(9)</sup>. Given this complexity of cancer patient care, professionals need to be prepared not only to provide qualified care based on technical-scientific knowledge but also to understand the uniqueness of care demonstrating attention, commitment, and emotional support<sup>(3)</sup>.

Therefore, the justification of this study endures in public health policies that consider the principles of equity, integrality, and universality of the *Sistema Único de Saúde* (SUS - Unified Health System), and it is necessary to recognize the health and social realities through surveillance actions, to respond to demands and reduce health inequities. The relevance of the theme is precisely due to the current emphasis on public health policies such as the Plan of Strategic Action on Fighting Chronic Noncommunicable Diseases (NCDs)<sup>(1)</sup>, which articulates three combating courses of action related to surveillance, monitoring and evaluation; prevention and health promotion; and comprehensive care.

Thus, we believed that the study contributes to the strengthening of care actions as it understands how nurses and physicians provide care when attending people undergoing cancer treatment in emergencies. Considering the matter exposed, the questioning that guided this research was: How do nurses and physicians perceive the care of people with cancer admitted to a general hospital emergency department?

## OBJECTIVES

To understand nurses' and physicians' perceptions of the care of people with cancer who are admitted to the emergency department of a general hospital.

## METHODS

### Ethical aspects

The research project was approved by the Research Ethics Committee of the Federal University of Santa Maria, under opinion 2,121,624, in compliance with Resolution 466/2012 of the National Health Council. The participants were informed about the research objectives, and They authorized the use of the information for scientific purposes, signing the Informed Consent Form (ICF). In order to preserve interviewees' anonymity, they were identified according to their profession through the abbreviations "NUR" (nurses) and "PHY" (physicians), followed by an Arabic numeral, which corresponded to the order the interviews were conducted.

### Type of study

This research is a descriptive study, with a qualitative approach, carried out from September to November 2017. This research derives from the senior thesis submitted to the Interprofessional and Professional Health Residency Program of the *Universidade Federal de Santa Maria* (UFSM, RS - Federal University of Santa Maria). It is entitled "Assistance to people undergoing oncologic treatment in urgency situations in an emergency department".

## Methodological procedures

### Study scenario

The study was conducted in the emergency department of a university, public, general care, and teaching hospital of high complexity, located in the central region of Southern Brazil. It is a reference hospital for the care of 45 municipalities of two health departments. The emergency department assists through a medical regulation center, except for people undergoing cancer treatment, because the hospital has the UNACON qualification by the MS, taking responsibility for the integrated care of cancer treatments in all its phases and to people from a municipality in the region that does not offer medical service during the night.

In 2017, the year of data collection, 11,494 visits were performed to adult patients in this emergency department, 4,070 of whom required hospitalization in the sector itself. Concerning the work team, it comprises professionals from different areas. The nursing staff consists of 30 nurses, 55 nursing technicians, and one nursing assistant. The medical team is composed of physicians, oncologists, and hematologists, and about ten residents in internal medicine and oncology.

### Data source

For the selection of professionals, the following inclusion criteria were adopted: being a nurse, oncologist, a hematologist, and resident physician on these specialties, and working in the emergency department for at least six months. It is noteworthy that the performance of oncologists and hematologists and resident physicians on these specialties on duty in the emergency room is foreseen by the institution under study, respecting their service shifts. Professionals on medical leave or absent from work during the data collection period and those in administrative positions were excluded. The sample was not defined a priori, because this study is qualitative research. However, during the data collection, as there was a repetition of information and the objectives regarding the answers were achieved, the interviews finished when reaching 12 participants.

The professionals (physicians and nurses) were included in the study due to their attributions in the care of cancer patients who seek the emergency service, often debilitated, to be assisted by them. Also, because they conduct care in a supposedly individualized manner, and this scenario is important to the people undergoing treatment since it becomes the reference of care, support, and reception in the face of any complications of the disease.

### Data collection and organization

Data collection occurred through semi-structured interviews, which focused on professionals' performance and perceptions regarding the care of people undergoing cancer treatment in emergencies; and through the application of an instrument elaborated by the authors, containing data related to sociodemographic configuration. Before starting the interviews, the pilot test was applied to evaluate the interview script that proved appropriate.

The approach to the participants was performed in rooms of the institution according to their convenience and availability, and

prior scheduling, in order not to interfere in their work dynamics. The researchers (members of the residency program mentioned above) conducted the interview individually, recording them in audio equipment for later transcriptions, which interview lasted approximately 20 to 50 minutes.

### Data Analysis

For the systematization and analysis of the data, the minayo's operative proposal technique was used in two operational moments. The first included the essential determinations of the study, which were mapped in the exploratory phase of the investigation. The interpretative phase, which constitutes the second moment, was subdivided into two stages: (1) the ordering, which comprised the transcription, rereading and organization of the material; and (2) the classification of the data, which included a horizontal and exhaustive reading of the texts, cross-sectional reading, final analysis and the construction of the report with the presentation of the results<sup>(10)</sup>.

In the classification of the data, there was a thorough and repeated reading of the collected material in order to resume the possibilities and initial objectives of the research. After these classifications, the material underwent a reduction process, highlighting the most relevant themes, which were aggregated and regrouped into central categories<sup>(10)</sup>. The final analysis was based on the interpretation of the sequences of relevance aligned with the meaning of the participants' speech in the context studied<sup>(10)</sup>. Once the in-depth immersion on the empirical material was achieved, and the stages of organization and classification of the data were completed, the final analysis was performed. It consisted of the rereading of the units of meaning, integrating them with the theoretical assumptions, and with the informants' context.

Based on data analysis, three categories emerged: 1) The person with cancer from nurses and physicians' perspective; 2) Comprehensive care of people with cancer or deconfiguration in the emergency department?; and 3) The context of the emergency department and the repercussions on the care of people with cancer.

## RESULTS

Six nurses and six physicians participated in the study, seven women and five men, aged between 24 and 39 years old. Regarding the physicians, five were residents (four in oncology and one in hematology) and one oncologist. Considering the length of training in higher education, the professionals reported 3 to 17 years. About the length of work experience in the emergency unit, it ranged from 6 months to 14 years.

We will discuss below the categories that emerged from the data analysis

### The person with cancer from nurses and physicians' perspective

The participants' reports show that people with cancer who are assisted in the emergency unit receive differentiated care because it is a process of illness considered difficult and unpredictable, which requires specific treatment, often associated with the

end-stage. These characteristics, according to the professionals, require special attention from the team.

*When a hemato-oncology patient enters, you can be too careful, that's what I believe. We need to carefully handle these patients with great care. It's complicated; it's a ticking time bomb. (NUR 1)*

*This patient is debilitated, tired, sometimes exhausted from chemotherapy, radiotherapy, and in the end-stage. (PHY 6)*

The statements, especially from nurses, reveal that people with cancer hospitalized and remaining in the emergency department have an unfavorable prognosis due to the disease or palliative care. They also report that these people have difficulties in obtaining beds in an inpatient unit.

*We have patients who have been down here for 30 days, who stay for 24, 48 hours, and not a single bed for the patient turns up. That's an enormous difficulty we face here. We don't understand why is that [sic] for certain patients it is so easy to find a bed on the upper floor and other cool their heels here, are discharged, or die and don't get a bed. The rotation of hemato-oncology is very selective. (NUR 11)*

Furthermore, other reports point out that the person with cancer seeks the emergency department for the most varied reasons; the main ones are fever and signs resulting from treatment or progression of the disease.

*Febrile neutropenia, I think it's common, pleural effusion, disease progression. Sometimes intestinal obstruction, intense uncontrolled pain. Sometimes somatic, due to central nervous system progression, neurological worsening. (PHY 12)*

Given these mentioned specificities, nurses and physicians reported experiencing difficulties in providing care. Even those who are doing specialization courses have stated that theoretical training is deficient.

*We don't have a very good theoretical background [...]. (PHY 8)*

On the other hand, one of the physicians working in oncology refers to the whole staff being able to work in oncological emergencies not necessarily needing deep knowledge of oncology to provide this type of care:

*You wouldn't necessarily need to know oncology to treat clinical complications. Internal to oncology, because sometimes patients who have had chemotherapy develop complications, but outside, in other services, not necessarily just the oncologist can treat them. The internist himself would be quite able to give treatment. These are things that should be fundamental to all of us. (PHY 10)*

Perceptions related to how professionals see people with cancer in the emergency department converge for specific care assistance, either due to complications from treatment with chemotherapy, radiotherapy, or due to disease progression, palliative care, and the end of life. Besides, some professionals report that they have difficulties in attending, and others understand that all those with proper clinical training can provide qualified assistance to people with clinical complications.

## Comprehensive care for people with cancer or deconfiguration of the emergency department?

The professionals state that there is an institutional orientation that the emergency department becomes the reference of care for people undergoing cancer treatment at the institution. From this perspective, they expressed their perceptions about orientation, considering the functional capacity of the unit.

*If he comes in spontaneous demand, he will get screened and assisted. There is the hospital's policy to serve hemato-oncologic patients. It is good because some patients should come here, as they are in post-chemotherapy, but there are the smart ones, who have been finished treatment for years and take advantage of it to have access to the hospital. (PHY 3)*

The service is not configured from the professionals' point of view, as they do not realize or understand that the patient must also be attended in this unit and not only those who can receive active treatment. Also, they believe this also occurs due to the complexity of the care of people with different levels of severity.

*I have three ideas about the hemato-oncologic patient: the one that goes just because, who could solve a minor problem in the health center; he broke his finger because he has cancer; he has this right. Another: he has a fever; the staff on duty does not know what to do because it is cancer, they do not know what medicine to use. And when the patient at the end-stage comes - the emergency room should be for something urgent, just because it's a reference unit, we have to see this patient, I think it's a little complicated, the unit is an emergency room. We became overwhelmed. (NUR 2)*

*The emergency room is not configured; its objective is not having people hospitalized and staying here at the end of life, letting the patient decease here. (NUR 4)*

We highlight that some professionals reflect on the responsibility of other levels of care for assisting people with hemato-oncological diseases as a means of meeting demands, which could be met independently at the tertiary level. In view of the fact that this does not occur, the emergency service is not configured, contributing to overcrowding.

*The emergency room ends up taking up a lot, and, many times, these patients wouldn't even need to come to the emergency room; they wouldn't need a tertiary service to be attended. They could go to smaller hospitals or in their city and would do the same thing as here, and the patient would get more comfortable. (PHY 9)*

On the other hand, the participants consider that not denying care in the emergency department is a potential from the perspective of integrality and access, but they assume that this overloads the public service.

*Although with the regulation system, whoever gets here, we will assist, we do not need to charge anything, ask: "do you have an insure?" That's great in the public system; you're going to treat everyone the same way. (NUR 4)*

Nurses and physicians emphasized three questions regarding the access for people with cancer to the emergency department:

seeking care for reasons not configured as urgent and necessary at the tertiary level; Assistance from other levels of care; and free and comprehensive care. Based on this view, they mentioned a possible deconfiguration of the emergency department because of the integrality of access.

### **The context of the emergency department and the repercussions on the care of people with cancer**

The statements concerning the emergency department scenario emphasized that the professionals attend overcapacity, which is a result of the great demand for care. Some participants reported that the unit does not have adequate nursing staffing for the number of people attended. This work overload may result in the (dis)qualification of the care provided.

*We have a high patient load per professionals, both technicians and nurses, it causes a lack of longer time to listen to the patient, conversation, dialogue, exchange of information, not done, we are always running after time, to give priority for the most serious patients. The hemato-oncology patient is a bit left out; there is awaiting attention. (NUR 5)*

In this sense, professionals also perceive the need for adequate accommodation as a requirement to provide qualified care, since many people are hospitalized and stay in the corridors using stretchers and wheelchairs for accommodation.

*It bothers me a lot, accommodating the patient who is on an ambulance stretcher, with a bad mattress, no pyramid foam or pneumatic mattress, sometimes no support to infusion bags. We've already glued infusion bags to the walls. In terms of accommodations, I find our unit precarious. I feel the need to improve that. (NUR 5)*

There are also statements that expose the performance of professionals in the emergency department, which reveal feelings such as guilt. That is because they are not able to provide care as they should, and there is concern regarding the risks of punishment and legal processes, which sometimes interfere with the engaged conduct.

*I don't care; I would attend on the floor. If it goes to justice, I'll be the one on the line. The judge doesn't care if there was a bed or not. They think we have the power to solve everything. The guy called, there is no bed? The administrative guy will say: look, we don't have a bed, that's it! He works at the administration, can not be charged, legally, with non-assistance, because he is not in the health area. But, the physician, the nurse, if you knew and said no, it's your fault. (PHY 3)*

Faced with the risk of punishment and conflicts with the administrative sector, professionals listed the work, union, and training of the team as strategies that enhance the overcoming of adversities in this scenario of action, thus contributing to handling the situations and meeting the demands of the service.

*We have hardworking, committed, responsible professionals, and it's great. We have good technologies in the hospital, good treatments, good teams, good people. (NUR 5)*

*We find solutions, make the diagnosis, and give the treatment. This really happens, even if it takes time, that frustrates the patient*

*because it takes longer than necessary, but in fact, it happens, there is nothing to complain about. (PHY 7)*

The professionals' statements point out to service of the emergency department, configured as overcrowded, having an inadequate infrastructure and insufficient human resources, reflects in the care of people with cancer, and causes professionals to be insecure and afraid. However, the scenario can overcome these difficulties, such as teamwork and meeting demands, based on qualified infrastructure and human resources.

### **DISCUSSION**

The study revealed the perceptions regarding how people with cancer have access to the emergency department, which is easy in comparison to others, as the service does not require regulation. Professionals characterize the need for careful and sensitive care of a person with unpredictable and unfavorable clinical conditions.

Cancer causes physical, psychological, and social changes for those who experience it, causing internal conflicts and substantial impacts on their clinical condition due to the disease<sup>(11)</sup>. In a review addressing anticipatory grief, the most prevalent disease related to the subject was cancer. This fact illustrates the construction of the social view that this disease is associated with death, even before it happens<sup>(12)</sup>. The participant's statements in this study corroborate this conception.

In the participants' view, the person with cancer has an unfavorable prognosis, which is associated with this socially shared perspective, and those who seek care and are hospitalized are in palliative treatment or the end-stage. Due to this condition, these people have difficulties in finding beds in inpatient units, so they remain there indefinitely - often until they die.

In a study on the difficulties faced during the assistance to hospitalized patients in the context of palliative care at a CACON in the state of Rio de Janeiro (RJ), nurses identified the absence of different beds for this patient profile. They also reported that the current configuration of beds in clinical wards, as a general hospital, has contributed to the difficulty in establishing priorities in care, as well as in organizing the time of care at the bedside, a fact also related to the deficit of human resources in nursing<sup>(13)</sup>.

The results obtained in the mentioned study are similar to the reality investigated regarding the difficulties of palliative actions in the emergency department scenario and the use of this care only in the end-stage. This fact may be related to the recent palliative practice in Brazil, which dates from the late 1990s<sup>(14)</sup>. Since this issue still cannot be fully discussed and reflected in the professional practice of these services, planning care to patients who are under palliative care has to be postponed in favor of others who have an unfavorable acute clinical condition.

Regarding the reasons why patients sought the service studied, the participants reported that it occurred for several reasons. An international multicenter prospective cohort research found that the main reasons cancer patients seek care in emergency units were similar to that described by the participants in this investigation: pain, nausea, and vomiting, fever, in addition to chest pain and dyspnoea, as suggestive symptoms of pleural effusion<sup>(6)</sup>.

Regarding the professionals' feeling of being prepared for attending such cases, reported by the participants, we observe a lack of knowledge in the oncology area. Regarding the qualification of care of this patient, a specific department was created to attend the oncology emergencies in the state of Ohio, in the United States, where the assistance is provided by professionals trained for this purpose. As a result of this action, it was noticed that the more complex needs of cancer patients were better addressed<sup>(15)</sup>. However, composing sectors of this magnitude is not conventional in the Brazilian scenario and even worldwide, as it implies a set of institutional and legal changes.

People with cancer seeking care in emergency unities arouses the study participants' perceptions concerning the possible deconfiguration of the emergency unit due to comprehensive care and guarantee of constitutional rights. In this sense, it is noteworthy that health is a constitutional right, and the access for the person with cancer is ensured by the National Oncology Care Policy, which determines that the health institution offer emergency support when necessary<sup>(4)</sup>.

Cancer patients' need for hospitalization is noticeable in the participants' statements. A North American study also observed this data, which showed that cancer patients seeking emergency care resulted in hospitalizations more frequently (59.7%) compared to those who did not have complaints related to cancer (16.3%)<sup>(16)</sup>.

Also, the scarcity of beds in wards for hospitalized cancer patients, resulting in a longer stay in the emergency department, as reported by professionals, is a problem - shown in different Brazilian states - that leads to unit overcrowding<sup>(17)</sup>. This situation can cause losses to the care of such patients due to the characteristics of emergency services, such as the excessive number of patients; the diversity of clinical severity, with critical patients alongside those who are more stable; the scarcity of resources; the overload of the nursing team; the insufficient number of physicians; and the discontinuity of care<sup>(18)</sup>.

Besides, participants also listed issues concerning the responsibility of the Care Network towards assisting people with cancer. They question the possibility of providing the first assistance or responding to demands since it could occur in small hospitals in the region or Primary Care units<sup>(18)</sup>.

In this sense, we emphasize that effectuating care systems integration is a challenge for SUS, especially in the emergency context. The resoluteness of the Primary Care is associated with meeting spontaneous care demands and providing the first assistance in emergencies, thus absorbing a demand that is found today at the hospital entrance doors, when they should be destined to attend more serious emergencies<sup>(18)</sup>. In this regard, another study reports the lack of training and knowledge about cancer and its consequences, which causes insecurity in primary care professionals about approaching and assisting oncological issues<sup>(19)</sup>.

Regarding the deconfiguration of the emergency unit for applying the principle of integrality, it is important to highlight that this discussion must take place in the daily practice of health professionals. Based on this concept, managers and professionals must understand the needs expressed to be later able to respond to the demands of people and the population<sup>(20)</sup>. This conception is quite broad, as it reflects the configuration of health professionals' role in emergency care, how the health care networks are

organized to meet people with cancer's needs, and whether health institutions have been considering the Brazilian epidemiological scenario to respond to such demands adequately.

Thus, entering the service scenario, questions arose regarding the considered excessive demand for services. This condition reflects an inadequate infrastructure and an insufficient number of professionals. Inadequate infrastructure is a negative aspect of teamwork because it influences assistance due to the lack of resources, space, and adequate conditions. Activities overload, on the other hand, is a complicating factor in exercising humanization. This is due to limiting professionals concerning time and attention dedicated to people, forcing them to make choices regarding the demands presented, which impacts not addressing people's needs and expectations<sup>(21)</sup>.

Given the real complexity in this context, it is necessary to reflect on the activities developed by health professionals in the hospital environment. In a study carried out in a French university hospital emergency unit, professionals reported a lack of time to perform their tasks, work overload, and fear of making mistakes, conditions that resulted in occupational stress. The same study also highlights that these difficulties faced by professionals can affect patient safety, especially in this work environment, considered to be of high risk<sup>(22)</sup>.

Such situations, linked to insecurity about the risk of punishment and legal processes for not having the conditions to offer dignified care to patients in the emergency unit, can also provoke moral distress since the workers recognize the ethically appropriate action, but they feel prevented from acting according to their reasoning, due to fear or circumstances beyond his competence, which can compromise their moral values and identities<sup>(23)</sup>.

Considering this specific situation, the participants listed work potentials as strategies to overcome the obstacles experienced in daily professional life: responsibility, commitment and the training of professionals; the work and union of the nursing team; the resolution of cases; and the institution's prestige as a reference for health promotion in the served region. A study on methods used to promote teamwork in an emergency unit identified four strategies to achieve it: articulating professional actions, establishing cooperative relationships; building close bonds with conflict management; and maintaining these bonds<sup>(24)</sup>. The current study perceived these actions in participants' speeches, which become essential as they improve the work process and help to face the presented challenges.

### Study Limitations

We considered as limitations of this study: the impossibility of making generalizations about the findings and the characteristics of the selected methodological design; not including other professionals from the multiprofessional team; including oncologists or hematologists and physicians residing in this area as study participants, instead of general practitioners, since the specialists have more knowledge to deal with an oncological emergency; and conducting the study at only one point of the health care network. We suggest that new studies include other professionals so that they can also discuss how they perceive care of cancer patients in the emergency department context and explore other care scenarios that provide care to this population.

## Contributions to the nursing field

The study enabled pondering on the care provided to cancer patients, how workers should prepare, the high demand for care, the structure of the unit, and the healthiness of this environment, both for the professional and the patient. It is necessary to explore, recognize, and complement this care dynamic to make advances in this context. It is essential to consider the resources of each territory and the strengthening of the health network and provide a follow-up that fulfills the needs of the population constructively so we can guarantee the integrality of care.

## FINAL CONSIDERATIONS

The study revealed that nurses and physicians' perceptions of care of people with cancer in the emergency department are that it is different from the care of the general population, due to the characteristics of the illness process that requires specific, qualified, humanized and personalized, care as well as because of the how this assistance occurs, as these patients do not need to go through the hospital's central regulation. Still, in this context, we identified that, among the various reasons for hospitalization in the emergency department, there are demands related to palliative or end-stage care. Brazil still has a few units of palliative care, which allows us to reflect on the importance of this assistance in the emergency department.

Another relevant aspect identified in the study refers to the deconfiguration of the emergency department, due to the demand

for needs arising from the care of cancer patients. This view was also endorsed by the responsibility of the care network and the sharing of responsibility for caring for these people. There was also a reflection on the integrality of access for people with cancer, as this transcends the guarantee of care and enables pondering on care provided to them.

## ERRATUM

Article "Nurses and physicians' perception of the care of oncology patients in the emergency department", with number of DOI: <https://doi.org/10.1590/0034-7167-2019-0677>, published in the journal *Revista Brasileira de Enfermagem*, 73(Suppl 6):e20190677, in Portuguese title:

Where to read:

**Percepção de enfermeiros e médicos sobre a assistência aos pacientes da oncologia no pronto-socorro**

Read:

**Percepção de enfermeiros e médicos sobre a assistência aos pacientes da oncologia no pronto-socorro**

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