

Palliative care education: experience of medical and nursing students

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The research remarks the importance of training professionals capable of handling the subjectivity required to palliative care. This is a qualitative study, with an exploratory and descriptive approach. It aims to explain and analyze the experience of undergraduate medical and nursing students in palliative care, identifying the challenges and understanding the formative requirements for this type of care. It was possible to identify five aspects that make up the experience: change in the perception about palliative care, identification with the patients and their family, rationalization and awareness process, palliative care education and practice learning and multidisciplinary work. The study shows the importance of practice activities in palliative care learning, the valorization of the multidisciplinary teams, the suffering involved in the process of self-identification with the end-of-life patient and the cycle of empathy and estrangement resulting in the emotional maturity needed in palliative care.

Keywords: Teaching. Medical Education. Nursing Education. Palliative care. Attitude towards death.

Introduction

Palliative Care (PC) was defined by the World Health Organization (WHO), in 2002, as an approach or treatment that improves the quality of life of patients and their families facing illnesses that threaten the continuity of life. PC must be supported by the skills of a multiprofessional team to help patients and their families adapt to the life changes that are imposed by the illness, as well as promote the necessary reflection so that they are able to face the irreversible condition and/or the possibility of death¹⁻⁴.

According to the WHO, the principles of PC are: provides relief from pain, asthenia, loss of appetite, dyspnea, among others; affirms life and death as natural processes; integrates psychological, social and spiritual aspects into the clinical aspect of patient care; intends neither to hasten nor postpone death; offers a support

system to help the family cope during the patient's illness and in their own bereavement; offers a support system to help patients live as actively as possible until death; uses an interdisciplinary approach to address patients' and families' clinical and psychosocial needs, including bereavement counseling and support⁴.

The recognition of life's final stage can be difficult, but it is extremely necessary in order to plan the care that will be provided and to prepare patient and family for losses and death. Even after the patient's death, the PC team must give attention to the family's bereavement process: how death occurred, the degree of comfort, and the impacts it has brought to the family and even to the interdisciplinary team. Post-death family assistance can and must be initiated through preventive interventions⁴.

In Brazil, PC emerged in the 1980s, at the end of the dictatorship period, when the healthcare system focused only on the cure of diseases. It was expanded in 1997, with the creation of *Associação Brasileira de Cuidados Paliativos* (ABCP - Brazilian Palliative Care Association)⁵. In 1998, *Instituto Nacional do Câncer* (INCA – National Cancer Institute) inaugurates *Hospital Unidade IV*, exclusively for PC⁶. In 2005, *Academia Nacional de Cuidados Paliativos* (ANCP - National Palliative Care Academy) is created, and a great advance is registered in 2011: *Conselho Federal de Medicina* (CFM – Federal Council of Medicine) recognizes PC as an area of medical action, through Resolution CFM 1973/2011⁷.

Some factors still influence PC practice, such as absence of a national PC policy, hindered access to opioids, absence of a specific discipline in the education of health professionals, and scarcity of services and programs specialized in PC. In addition, the aging of the Brazilian population and the increase in the incidence of cancer have transformed the patients who need PC into a problem of huge social impact⁵.

Palliative medicine and curative medicine complement each other to provide support for the patient during their illness and also during their process of dying; the latter is a natural part of living. Lack of training to face situations of communication and support for patients at the final stage of life causes a great loss in the health professional-patient relationship. The professional feels impotent because he has failed to fulfil the objective of curative medicine, and the patient feels helpless for not having the necessary support in a situation of great frailty⁸. Over time, the professionals who have not received any PC education tend to estrange themselves from the patient. Therefore, it is necessary to evaluate these professionals' knowledge of PC and respond to this through changes in their education^{8,9}.

Nowadays, PC has been receiving little attention in the undergraduate curriculum of health professionals. So that future professionals have a humanistic view of patients' needs beyond therapeutic possibilities of cure, the curriculum of undergraduate courses must be modified and specific PC contents must be prioritized¹⁰.

In light of what was presented so far, our questions are: How is the medicine and nursing students' experience of assisting patients in PC? What difficulties do they perceive? How does education contribute to this kind of assistance? The study is justified by the identification of subsidies that will guide the education and practice of health professionals in PC.

This study aims to investigate the experience of medicine and nursing students in the assistance provided for patients in PC, understanding the education that is required for this type of care.

Methodology

This is a descriptive study with qualitative approach that was carried out with medicine and nursing students who had participated, at least six months before, in an Extension Program called “*Bem Cuidar*” (Caring Well), developed at *Universidade Federal de São João del-Rei, Campus Centro-Oeste* (UFSJ/CCO). The “*Bem Cuidar*” Extension Program aims to qualify patients in PC and their caregivers for care and/or self-care by means of educational actions, favoring comfort during hospitalization and preparing them for hospital discharge. These activities occur in the oncological sector of a medium-sized hospital located in the central-west region of the state of Minas Gerais (southeastern Brazil), and are performed by undergraduate students from the Medicine and Nursing courses, as well as teachers, nurses, psychologists and social workers.

The project was approved by the Research Ethics Committee of the above-mentioned institution (CAAE 30487014.4.0000.5545). The students who accepted to participate in the research and signed an informed consent document were included in the study. Data were collected through ten semi-structured interviews conducted at a private space in UFSJ/CCO. The study was carried out with no predefined sampling, considering the concept of data saturation. Some of the questions that were asked during the interviews were: What difficulties do you face when you assist patients in PC? How has your PC education been? What do you think should be improved in your PC education?

The material was analyzed by means of Thematic Analysis. In the interviews that were collected, we searched for data related to the students’ PC experience and education. We attempted to find the meaning nuclei that compose a communication, whose presence or frequency means something to the targeted analytical objective. Operationally speaking, Thematic Analysis unfolds in three stages: Pre-analysis, Exploration of the material, and Treatment of results and interpretation¹¹. Pre-analysis consists of choosing the material to be analyzed, revisiting the study’s initial hypotheses and objectives to reformulate them in view of the collected material, and developing indicators that guide the final interpretation. Exploration of the material is the moment of coding, in which crude data are transformed in an organized way and aggregated into units, which enable to describe the characteristics that are pertinent to the content. To achieve this, the data were classified and aggregated, and the categories that commanded the specification of themes were chosen. The categorization allowed to gather more information by means of a schematization, correlating classes of events to organize them. Treatment of results and interpretation consists of the organization of crude data in order to constitute themes, which can be defined as units that naturally free themselves from the analyzed text.

Results

Ten students were interviewed, five from the Medicine course and five from the Nursing course. The students were aged between 21 and 30 years and were enrolled in the third through the ninth periods of the course. The acronyms IM and IN mean Interview with Medicine student and Interview with Nursing student, respectively, followed by the number of the order in which the interview was conducted. The themes that compose the students’ experience are presented below.

Change in the perception about PC

Many students reported, in the interviews, on the process of change in their perception of what PC is. The students said that, before they were prepared for having contact with patients, they had in mind that PC started when there was nothing else to do for that patient. After studying the matter in detail and performing the practical activities, they realized that this patient had a large demand for care and there was still a lot to be done.

“When I enrolled in the program, I realized that palliative care is totally different from what we learn in the undergraduate course. It’s not about dying; it’s about having quality of life during treatment even when there’s no possibility of cure”. IN1

According to some interviewees, the main agent of this change was in the space opened for patients and families, who expressed their intervention needs through their discourses. With each daily demand, the student gradually formed a range of solutions that were appropriate not only for that patient, but for all the others. Listening to patients and families is mentioned by the interviewees as the most important tool to improve quality of life.

“So, when I started letting them (patients and families) demand, I gradually understood what my role was. (...) while they talked, I thought: the patient needs to hear this, he needs us to approach this issue, the family needs us to talk about this”. IN6

According to the students, as they gained experience, they realized that, in addition to the technical part, targeted at treatment of physical pain, it is important that this care is integrated into others that aim to treat psychological, spiritual and social pain. They conclude that this amplified perception of the patient’s needs resulted in a more humanized assistance.

“A conversation to see what he’s thinking, what he’s feeling. And not, for example, he’s feeling pain in his leg, ok, then I’ll give him a medicine. No, we want to know what he’s really feeling, not only physical pain; other types of pain, too. I think that this matters to the patients”. IM4

Identification with patient and family

During the research, varied degrees of empathy among students, patients and caregivers were expressed. The majority of the interviewees reported that they were affected by the suffering of patients and their families, while only a few of them said that they were not very moved by it. The students that mentioned the occurrence of this countertransference reported the emergence of associations between their life history and the patients’ situation. Many reported that they identify with the families and deal with their suffering, imagining themselves in their situation. Empathy makes the interviewees imagine themselves in the position of the families when they lose their loved one and, in many interviews, we identified a preference and greater facility in dealing with patients rather than with their families.

“So, I think that one difficulty is when I think that he (patient) could be one of my relatives. Could my father or my mother be the patient lying there”? IN3

“I project myself on the caregiver, as if it were me taking care of my mother and father. I don't know how it would be”. IM4

Some students had family stories of death by cancer and had contact with the disease during some time in the family sphere. They said that, frequently, the patient's story brought recollections of their own story. At some moments, the patient was compared to the affected relative:

“My grandfather died of cancer recently, so I made this association many times. I witnessed his suffering. So, when I see a patient suffering, I remember him, and it's hard”. IN5

In other situations, factors like the patient's age, sex and physical characteristics led the student to an identification in which they ended up associating the patient with a relative, independently of any stories of cancer in their own family. This empathy generally leads to comparisons between the patient and the students' mother or father. They state that this identification mainly occurred when they saw themselves as the caregiver and imagined how it would be to take care of an ill father or mother.

“I have difficulties with female patients, for example, who are young, my mother's age”. IM4

“When I arrived at the room, the way in which the patient spoke reminded me of my grandfather. So, at first, it was difficult to get used to that”. IN8

Of all the identification reports, the most intense are those that derive from the students' identification with the patient – when they imagine they are in their place. The interviewees state that this occurs more frequently when the patients' ages are closer to theirs, which makes them imagine themselves in an end-of-life situation.

“The closer to my age, the harder it is for me to approach the patient”. IM2

“Young patients end up with a much deteriorated appearance and then you inevitably think about yourself. To think that I'm 22 and I could be like that”. IM4

Rationalization and sensitization process

PC practice strongly involves the patient's psychological state and, consequently, the caregiver's emotional state is influenced. Discourses about how these influences occur, the mechanisms created to handle them and their consequences permeated a large part of the interviews, revealing a cyclic process of rationalization and sensitization that was expressed by a large part of the students. Some of them said that they used to have a more neutral and distant attitude at the beginning of their practical activities, and as time went by, this attitude was gradually transformed, with an increase in sensitivity. Other interviewees mentioned the

opposite process: they started their assistance practices in a more sensitive and empathic state and, as time went by, they started to rationalize the impressions of the contact with these patients.

“In our profession, we hear that the professional can't display emotion. But in the program, we see that this isn't totally true. At some moments, you need to sit beside the patient, beside the family, and be there with them, sharing this emotion”. IN8

“I've been feeling very sad due to death. What I do is I don't think about it. But sometimes, when I'm more stressed and I see that the patient died, I get very sad”. IM4

According to the students, this rationalization process is characterized by an estrangement from the patient's situation, which prevents the emergence of empathy and limits emotional expression during the visits. They explained that this was a mechanism to protect themselves from the suffering that was perceived in the palliative situation. They cited mechanisms like not imagining themselves in the patient's situation, not imagining a relative in the patient's situation, trying to forget what occurred in the visits when they leave the hospital, and becoming emotionally cold. Some reported that, as time goes by, a process of banalization of death emerges, modifying the impressions that it used to create in them before.

“Sometimes, I'm a little cold like this. But this is the profession I've chosen and I've been improving, I visit the patients, I see the consequences and I can't get carried away by the emotional side”. IN3

“I think that we get used to it, to death. At the beginning, when I went there, it was worse. It's getting better. I think that, as time goes by, we get used to everything”. IN5

At another moment, this estrangement evolves to the perspective of sensitization, and empathy with the patient is created. The interviewees stated that empathy emerges when a sincere space is opened to listen to the patient. Others reported that they treat the patient as if they were a member of their family. According to the students, this change in attitude optimizes assistance, as they start to have a better understanding of the patient's needs and of how they can truly contribute to improve their quality of life.

“I approach the patients in the way I'd like my relatives to be treated.” IN3

“I think it's empathy, putting yourself in the other's shoes. What each one has already brought about their own life. The capacity each one has of listening, of getting interested.” IM7

Other interviewees added that it is important to have an empathic attitude instead of being impartial and insensitive; however, it is necessary to sustain a calm and balanced posture in order to be able to support the patient and the family, as they may feel shaken. They report that the PC provider must have control of their impulses and feelings, a skill that is well lapidated in daily practice.

“I was able to maintain an attitude that was neither too emotional nor impartial. (...) I tried to stay in front of the patient, mainly when he or the family started to cry, I tried to maintain a calm emotional state. Because

when the family breaks down, when people start to cry in front of us, we have to maintain some serenity". IN6

"So, when they're suffering, it's not that we must hide our emotions. We must take our emotions together with theirs, without letting this influence our work. This is one of the things I learned with the visits". IN8

Finally, many interviewees said that they felt sad when they experienced the patients' suffering situations, but that, even so, this interaction generated extracurricular learning that was truly a lesson for life. In addition, they mentioned that a more positive view of life emerges, as well as an attempt to take maximum advantage of each moment of interaction with patients who had a limited life expectation.

"We have to come here and really seize the moment, because you may fall into a situation in which you won't have the opportunity of doing this anymore. So, emotionally speaking, to me it was also extremely valid, extremely positive". IN6

Palliative care education

The interviewees were asked about the theme of PC education and talked about personal learning and also about contents provided by the curriculum of the Medicine and Nursing courses. All of them categorically stated that the curriculum approach to PC is insufficient, both in terms of content and in instigating the student to search for further knowledge about the matter. The student who does not get involved in extracurricular activities related to PC graduates without being prepared to support patients and families in these situations.

"The standard curriculum did not approach the issue of PC at any time". IM2

"I think that the student who's not much interested in this matter graduates with a very weak PC education". IN8

On the other hand, the extracurricular activities were identified as great providers of lessons, both in the theoretical and practical fields. The highlight was the optional discipline of PC, which is offered to the Medicine and Nursing courses. According to the interviewees, it provided tools for them to know more about the matter, and changed the concept of PC that they had. The *Bem Cuidar* Program was mentioned as a developer of practical knowledge precisely because of the direct contact with patients, the team and the hospital environment, not to mention the discussions that occurred in the meetings. Some students stated that this theoretical/practical dynamics is fundamental to PC education, and one does not work well without the other.

"Thinking about practice, there is no doubt about the importance of the Bem Cuidar program, but as for theory, I think that the optional discipline is better. It contributed a lot for you to begin with the basics and develop your knowledge. I think that the optional discipline was what helped most." IM7

When they were asked about what should be done to enrich the PC curriculum content, the majority stated that the matter should be approached more times in the clinical and psychosocial disciplines, further developing the theoretical side. In addition, they suggested the development of the palliative philosophy during the practical curricular activities - for example, in the internships.

“Well, I think that the course should certainly offer a curricular discipline that approaches PC in some classes.”

IM4

“It should be theoretical-practical. Take the student to the hospital, to visit the patient and talk to him, to show in practice how it is done”. IN6

Furthermore, the interviewed students reported that they learned a lot with their visits to patients in PC. According to them, this learning cannot be transmitted by means of theoretical classes; it is developed gradually with the performance of practical activities. These activities enable to enhance the diverse types of skills that are necessary to the health professional who works with patients in a situation that is so delicate like that of PC.

“Some things we only learn with practice. For example, how to deal with the patient. One thing is another person speaking about it, or even myself; a totally different thing is when you arrive at the hospital and the patient is there and needs you. It is very different in practice.” IN5

The participants described this situation as hard, causing a great impact, and variable according to each assisted patient and relative. To many of them, the first visits were the most difficult, as they were anxious because they wanted to have been more prepared for the moment. However, they state that it is due to this that practical learning is enriching. Dealing with this diversity of challenging situations makes them create their own mechanisms to provide comfort for patients and their families. They lose inhibition and fear and learn to listen, guide and teach whatever is necessary. Above all, they learn to support patients and families, which shows that they have truly learned to humanize assistance.

“Until you get used to it, practice a lot and is able to break the impact of entering into a room like this, it takes some time”. IM2

“Each assistance, each patient, each family is seen in a different way”. IN3

The students reported that they learn to deal with the person as a person, and not as a disease, shifting the focus of what is learned in the curricular disciplines, which are grounded on the biomedical model. This change becomes rewarding when they realize that the patients are happy to have someone who cares and who pays attention to them. The students were satisfied with this opportunity of learning to look at the human being as a structure that is larger than the purely biological aspect. Listening to the patient and to the family attentively is the main tool to change this way of looking and to develop action strategies.

"It complements what I learn in the university. I acquire a more humane character, and I think about the person as a person, not a disease, not a bed, not a room (...) I learn to see the person as a larger structure, not just the biological side". IM2

The interviewees state that this humanistic education makes them become better professionals and provides lessons that go beyond the sphere of work. They say that dealing with patients at the end of life provides an opportunity to reflect on the valorization of life, of its moments and of interpersonal relations as a whole.

"Due to the diseases we treat, we learn to value our life". IN3

"These patients teach us. I wonder if I'd be as strong as they are if this happened to me". IM2

Satisfaction with all these lessons is emphasized in many discourses. Satisfaction is related to the opportunity to help and do good to other people. Many students reported that, after the visits to the hospital, they go home feeling happier, rewarded and with more energy to continue assisting patients.

"When I go to the hospital, what I intend to do is help patients and their families. And when I leave the hospital I feel that I have accomplished my mission. I guided them, I taught them, I did a good deed to the families and patients." IN3

"I'm learning to deal with people who are at the end of their life, and it's very complicated to help them in this difficult moment. But when you see the patient's and the companion's response, you feel rewarded, with more energy to go to the hospital." EE5

Finally, the interviewees condensed all these pieces of information into discourses that show the need of a curricular reform that provides more space for PC in their education. They suggest further theoretical development about the theme, but with a transversal practical approach in the diverse curricular disciplines of the undergraduate course.

"I believe, without any doubt, that they could include this discipline with some classes to make people pay more attention to this area". IM4

Multidisciplinary teamwork

Generally speaking, the students conceptualized multidisciplinary as mutual help aiming at the patient's wellbeing. They concluded that providing care in a team facilitates to approach the patient and family and enables a greater capacity for offering comfort. According to them, the provision of guidance to the family and patient becomes more adequate, as there is always a second person to correct divergent information, to add relevant explanations, to ask other questions that would be important or to direct the conversation to another focus of interest. They stated that this corrects failures in the assistance.

“The person can remember something that you’ve forgotten, something that would be important to ask. Having one more person, I think that there are less failures in the issue of assistance to the patient and family.” IN8

Many interviewees mentioned that the difference of approach that exists between the Medicine and the Nursing courses is important. The students explained that these differences act in a complementary way for better assistance. Furthermore, they highlighted the great exchange of knowledge and experiences that derives from the interaction of people who have different views because they come from different courses and because they are at different periods in the undergraduate course.

“It helps because I have the view of a nurse and you have the view of a doctor, so it’s a differentiated way of assisting the patients”. IN3

“I don’t know something and she does, there’s no reason why I shouldn’t ask her. She can explain it to me, in the same way that I can teach something to her”. IN5

Discussion

The concept of health becomes complete only when its meaning is broadened beyond the biological issue and encompasses the entire biopsychosocial and spiritual sphere in which the individual is included and defined. This complexity should always be considered when healthcare is provided, no matter if it is curative or palliative. Due to this importance, the current trend of transformation of the curricular lines that form health professionals emerges, with the inclusion of nuances of humanization. Such transformation is reflected on the search for the expansion of PC teaching, and an important step is the recent regulation of Palliative Medicine^{7,12}. Thus, it is necessary to educate a professional who is capable of dealing with subjectivity. However, this change is a great challenge: How can we teach, in the classroom, the best way to provide words of comfort? To understand the patients’ true needs? To practice empathy?

In spite of the universality of this new conceptualization of health, the interviewees’ discourses show that, when the focus is on the sphere of PC, it becomes even more clear. When the students address the difficulties, lessons and rewards of the assistance they provided for patients at the end of life, they express the great importance of the humanized view. Dealing with these patients showed what is necessary to exercise palliative care, transposing this to their health practices in general, at the same time that it revealed the theoretical gaps in their education. Corroborating other studies, our data point to the incipience of PC-specific content in undergraduate curricula, which leads to lack of training to deal with end-of-life situations^{10,13,14}.

The students’ criticism against the curriculum because it lacks contents about the theme of PC indicates that the above-mentioned challenge has not been overcome yet. The teaching of PC in Brazil is still crawling through initiatives that have been successful but remain isolated – it is important to remember that a large number of people die without such care¹². The great difficulty is dealing with what cannot become technical – dealing with the subjectivity of the being. However, the students themselves believe that this curricular reformulation is possible. The interviewees realized, in an optional discipline about PC, that the matter is broad

and does not fit in the rare and superficial classes offered by the curriculum. These classes must be more complete and in a larger number. They must be presented in a longitudinal way during the whole education process, creating the notion that cure and PC walk together. In this way, the students would focus on these problems, and this would generate deep meanings in education and professional action¹⁴.

It has become clear that practical activities with patients in PC are a laboratory for the creation of individual and shared knowledge. Without these activities, it is not possible to achieve a consistent education for these students in PC¹⁵. This becomes obvious when we realize that education in any other area of health is based on a theoretical-practical approach. With PC, this would not be different. When the students put themselves in the situation of providers of comfort for the patient who is at the end of life, they are forced to transit through a complex of impressions, feelings and transferences that are impossible to simulate inside the classroom. It is precisely from learning how to deal with this complexity that the students extract the lessons that complete their theoretical education. This experience allows the exercise of attitudes like compassion, respect, dialog, and therapeutic practices like pain control¹⁰.

At this moment of dealing with practice, an important aspect of this study stands out: the great diversity of attitudes found among the students. Their discourses indicate that each one undergoes a unique process of search for their own path to achieve the best assistance. This process results from the interaction of various factors, such as family education, personal education, degree of sensitization, and knowledge about PC. Although heterogeneous, this process somehow culminates in the same level of humanization and communication, skills that are considered pillars of PC¹³. In practice, the subjectivity of the caregiver and that of the patient touch each other and generate personal responses to the end-of-life situation.

The antagonistic discourses of empathy and coldness in the assistance end up complementing each other in a cycle of transformation and learning. At one moment, the student gets close to the patient and shares their pain; at another moment, the student gets emotionally estranged to be able to continue providing care without affecting their emotional aspect negatively. After this period of rest, the student returns to empathy and begins a new cycle. Although this process is generalized among the interviewees, we must bear in mind that it does not occur identically in all of them. At this point, aspects of individuality must be considered. The time that each stage lasts, the degree of empathy, the level of emotional estrangement and the learning process are different to each student.

The result of this experimentation of relationships is the maturing process undergone by the professional, who gradually finds adequate attitudes to each moment of the assistance provided for patients who are at the end of their life. Some of the interviewed students were already in this stage and were aware that patients and families need a professional who maintains the necessary emotional control to be able to provide support but, at the same time, is empathic towards their end-of-life situations. This requires from the professional the capacity for understanding, facing and tolerating¹⁰. Those who were not in that stage yet were searching for the best way to deal with these patients, which only reflects the plurality of responses to this process.

Another notion that develops along this line is that the help of the professional colleague tends to provide a great contribution to the quality of the assistance and that the interaction with the other student generates learning in partnership. Here, differences in the approaches play the role of complementation, one making up for the other's failure. Thus, the students start to perceive the value of multidisciplinary, even if they

still do not know how to define the subtleties of each profession's approach. At this moment, the capacities that each one has developed are more valuable than the specific knowledge of each course to the search for a broad assistance in PC. Multiprofessional teamwork must be stimulated, with sharing of responsibilities, active listening among members, and joint decision-making¹³.

Finally, it is possible to notice that the path outlined by the student to overcome the challenges imposed by PC generates knowledge that can be transposed from the professional to the personal sphere. This education process transforms them into better human beings, capable of developing, in their relationships, spaces to welcome and express feelings like pain and suffering¹⁰. Closeness to death creates a relativization of time, as students start to value its passage and, consequently, the use they make of it. Each second with the patient in an end-of-life situation must be used in favor of their comfort and, when they achieve this, the omnipresent feeling is gratefulness for spending their own seconds of life doing good.

Conclusions

The students' experience of PC made them notice the several aspects of work within this specialty and their involvement in the amplified concept of health, which is completed by the process of dying with dignity and with minimum pain, no matter what type of pain it is. The development of the necessary skills to provide this type of care was possible only during the practical activities, the moment when the importance of multidisciplinary in palliative action was also perceived.

During this stage, a cycle of empathy and estrangement was started. This cycle enables students to develop an emotional balance that is necessary for PC. During this process, the students have reactions of self-identification or family identification with the situations in which the patients are, and these reactions have the potential for generating suffering in the students, which, in turn, is solved when the students reach the balance mentioned above. The lack of theoretical disciplines in the curriculum generates difficulties in PC learning. The creation of an optional discipline is an option to bridge this gap, but it fails to reach all the undergraduate students; therefore, it fails to raise the interest of all of them in the theme.

It is necessary to stimulate, more and more, the theoretical and practical teaching of PC in the curricula of undergraduate courses in the area of health and encourage research that aims to improve this education. This is the only way to guarantee to patients at the end of their life and their families that the process of dying will occur with all the comfort and dignity to which they are entitled.

Collaborators

Álvaro Percínio Costa participated in the conception and design of the study, data collection, data analysis and interpretation, and in the production and revision of the final version of the text; Kátia Poles participated in the conception and design of the study, data analysis and interpretation, and in the production and revision of the final version of the text; Alexandre Ernesto Silva participated in the conception of the study and in the revision of the final version of the text.

References

1. Pessini L. A filosofia dos cuidados paliativos: uma resposta diante da obstinação terapêutica. *Mundo Saude*. 2003; 27(1):15-34.

2. Academia Nacional de Cuidados Paliativos. Manual de cuidados paliativos. Rio de Janeiro: Diagraphic; 2009.
3. Boemer MR. Sobre cuidados paliativos. Rev Esc Enferm USP. 2009; 43(3):500-1.
4. Cuidados Paliativos [Internet]. Rio de Janeiro: Instituto Nacional do Câncer; 1996- 2015 [acesso 2015 Jul 29]. Disponível em: http://www1.inca.gov.br/conteudo_view.asp?ID=474
5. Associação Brasileira de Cuidados Paliativos [Internet]. São Paulo: Associação Brasileira de Cuidados Paliativos; 2011-15 [acesso 2015 Jul 29]. Disponível em: <http://www.cuidadospaliativos.com.br/site/inicio.php>
6. Pessini L, Bertachini L. Humanização e cuidados paliativos. São Paulo: Loyola; 2004.
7. Resolução CFM nº 1.973/2011. Dispõe sobre a nova redação do Anexo II da Resolução CFM nº 1.845/08, que celebra o convênio de reconhecimento de especialidades médicas firmado entre o Conselho Federal de Medicina (CFM), a Associação Médica Brasileira (AMB) e a Comissão Nacional de Residência Médica (CNRM). Diário Oficial da União. 1 Ago 2011. Seção I:144-7.
8. Figueiredo MT. Educação em cuidados paliativos: uma experiência brasileira. Mundo Saude. 2003; 27(1):165-70.
9. Pinheiro TRSP. Avaliação do grau de conhecimento sobre cuidados paliativos e dor dos estudantes de medicina do quinto e sexto anos. Mundo Saude. 2010; 34(3):320-6.
10. Duarte AC, Almeida DV, Popim RC. A morte no cotidiano da graduação: um olhar do aluno de medicina. Interface (Botucatu). 2015; 19(55):1207-19.
11. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2006.
12. Oliveira JR, Ferreira AC, Rezende NA. Ensino de bioética e cuidados paliativos nas escolas médicas do Brasil. Rev Bras Educ Med. 2013; 37(2):285-90.
13. Fonseca A, Geovanini F. Cuidados paliativos na formação do profissional da área de saúde. Rev Bras Educ Med. 2013; 37(1):120-5.
14. Toledo AP, Priolli DG. Cuidados no fim da vida: o ensino médico no Brasil. Rev Bras Educ Med. 2012; 36(1):109-17.
15. Feuz C, Rosewall T, Willis S. Radiation therapy students knowledge, attitudes, and beliefs about palliative and end-of-life care for cancer patients. J Med Imag Rad Sci. 2015; 46(3):271-9.

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