ARTIGO ORIGINAL

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Nurses' Feelings About Caring for People with Neoplastic Wounds

Sentimentos de Enfermeiras no Cuidado de Pessoas com Feridas Neoplásicas

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Abstract

The aim is to understand the nurses' feelings in the care of people with neoplastic wounds during the dressing. This is an exploratory qualitative study carried out with 20 nursing assistants from a philanthropic hospital in Paraíba that provides care to patients with advanced cancer disease. The data were collected from April to June 2016, through interviews guided by a semi-structured script, after approval of the Research Ethics Committee of the Alcides Carneiro University Hospital under opinion No. 1,320,367 and analyzed by means of the Technique of Bardin Content Analysis. The speeches pointed to positive and negative feelings, perceived during the dressings accomplishment, where the sad feeling obtained the highest percentage of responses. It was evidenced that the nurses develop empathic abilities in the face of the patient's suffering, promoting solicitude actions with a view to the physical and psychic comfort of the same.

Keywords: Oncology; Oncological Nursing; Cutaneous Neoplasms.

Resumo

O objetivo é compreender os sentimentos de enfermeiras no cuidado de pessoas com feridas neoplásicas durante a realização do curativo. Trata-se de um estudo exploratório, de natureza qualitativa, realizado com 20 enfermeiras assistenciais de um hospital filantrópico da Paraíba que presta cuidados a pacientes com doença oncológica avançada. Os dados foram coletados no período de abril a junho de 2016, por meio de entrevistas norteadas por um roteiro semiestruturado, após aprovação do Comitê de Ética em Pesquisa do Hospital Universitário Alcides Carneiro sob parecer n.º 1.320.367 e analisadas por meio da Técnica de Análise do Conteúdo de Bardin. Os discursos apontaram sentimentos positivos e negativos, percebidos durante a realização dos curativos, onde o sentimento tristeza obteve o maior percentual de respostas. Evidenciou-se que as enfermeiras desenvolvem habilidades empáticas diante do sofrimento do paciente, promovendo ações de solicitude com vistas ao conforto físico e psíquico do mesmo.

Palavras-chave: Oncologia; Enfermagem Oncológica; Neoplasias Cutâneas.

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Introduction

The cancer incidence has been increasing in the last decades and, currently, the disease is characterized as an important public health problem in Brazil and in the world, constituting the second death cause in Brazil with 190 thousand deaths per year[1].

In Brazil, the estimate for the 2016/2017 biennium indicates the occurrence of approximately 600 thousand new cancer cases, including non-melanoma skin ones, which reinforces the cancer problem magnitude in the country. Regarding the new cases' number of cancer per state, non-melanoma skin cancer (182,000 new cases) will be the most incident in the Brazilian population, followed by prostate (61,000), female breast (57,000), colon and rectum (34 thousand), trachea, bronchus and lung (28 thousand), stomach (20 thousand), cervix (16 thousand), oral cavity (15 thousand), among others. For these same years, in the Northeast region, it is estimated that 47,520 neoplasm new cases occur in men and 51,540 in women[1].

Neoplastic wounds are formed by the malignant tumor cells infiltration into the skin structures, which consequently lead to the breakdown of its integrity, with the subsequent formation of an evolutionarily exophytic wound resulting from the uncontrolled cell proliferation that the oncogenesis process causes. They are also called neoplastic, oncological, malignant, tumor or fungus lesions, when they appear as a mushroom or cauliflower; and its prevalence, regardless of anatomical location, is not well documented, but it is estimated from international studies that 5 to 10% of people with cancer develop them[2-3].

The neoplastic wounds that affect the skin are another problem in the life of the person with cancer, because, progressively, they disfigure the body and become friable, painful, exudative and release a foul smell. The corporal deformity caused by these wounds, can cause in the patient a self-image disturbance and psychological wear, feeling of helplessness, humiliation and social isolation[3-4-5].

The treatment and care of these lesions is a complex subject because it requires evaluation of the oncological etiology, the wounds characteristics, the physical and emotional patient state and the wound staging. It is in this context that the nurse offers the most genuine care that transcends beyond basic needs, where the nurse is able to access emotional and subjective aspects to achieve transpersonality through communication and empathy and, develop and maintain the harmony and necessary confidence for this process and, in addition to developing skills and abilities that allow them to implement specific actions to the identified needs[6].

In view of this, it is necessary to understand the care process between nurse and patient with neoplastic wounds, since the nurse is the professional member of the multi and interdisciplinary team that is in greater contact with the patient. Accordingly, were searched the indexed databases using the descriptors "oncological wounds", "tumor wounds", "neoplastic wounds", "malignant wounds", "experiences", "feelings", "care" nurses "with the Boolean operators "OR "and" AND" and there was a published articles shortage that looked at the subject in scientifically reliable databases.

In this perspective and in the intention to deepen the knowledge about this subject, the following guiding question of the research emerged: What are the nurses' feelings in front of patients with neoplastic wounds?

Thus, the purpose of this study is to understand the feelings of nurses in the care of people with neoplastic wounds during the dressing.

Method

This is an exploratory research with a qualitative nature. The investigation scenario were hospitalization units of a philanthropic hospital, located in the city of Campina Grande (PB), considered a reference in the Paraíba state.

The research institution's locus presents a quantitative of 26 nurses in their totality; of these, 23 are women and three are men. However, only women accepted to participate in the research, so the researchers decided to standardize the title. The research participants were 20 care nurses of the institution, who provide care directed to the patient with cancer disease that presents

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neoplastic wound, selected according to the following criteria: that the professional worked for at least one year in the unit, was in work activity during the data collection period and availability and interest in participating in the research, confirming their agreement with the signing of the Free and Informed Consent Term (FICT). Those who were away were excluded (vacations, licenses, training).

The empirical material collection occurred during the period from April to June 2016 and was only started after the approval of the research project by the Research Ethics Committee of the Alcides Carneiro University Hospital of the Federal University of Campina Grande (HUAC/UFCG), under CAAE 50354215.9.0000.5182. Thus, it should be noted that the study was carried out considering the ethical observances contemplated in Resolution No. 466/2012 of the National Health Council, regarding the norms and guidelines regulating research with human beings.

To obtain the empirical material, a script was used with questions pertinent to the proposed objective. The interviews were carried out in a specific hospital place, without interruptions, recorded with authorization and lasted approximately thirty minutes each. It should be mentioned that, to maintain the nurses' anonymity in the study, the statements from this form were identified by the abbreviation "RN", Followed by numbers from one to twenty. Example: the first nurse interviewed was coded as follows: "RN1"; the second professional, "RN" and so on.

Shortly after the end of the interviews, the speeches were transcribed in full and were submitted in accordance with the Bardin Content Analysis Technique[7]. The empirical data analysis and interpretation were divided in three stages: the first one was composed by the pre-analysis, which consisted in the floating reading of the information set, in the corpus constitution and in the hypotheses and objectives' formulation; the second stage consisted in the material exploration, when the researchers organized the data from the categories, reducing the text to the significant expressions and the third stage involved the treatment of the obtained results and the interpretation, in which they made inferences and interpretations, correlating with relevant literature.

Results

Twenty nurses, aged between 24 and 60 years-old, 14 married, 5 single and 1 widow participated in this study. The research participants' characteristics that operated at the research institution showed a diversity of 1 to 39 years in relation to the training time, from 6 months to 28 years in professional experience terms and 2 months to 10 years in the which is related to the experienced time in the Oncology area.

To understand the nurses' feelings during the care provided to the patient with neoplastic wounds during the dressing, they were asked to answer the following question: "Tell me about the feelings you experienced during the dressing performance". The speeches are shown below, in Chart 1.

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Chart 1. Distribution of nurses' categories, frequencies and speeches regarding the question "Tell me about the feelings you experienced during the dressing performance." Campina Grande, PB, Brazil, 2016.

Categories	F(n=20)	Speeches
Sadness	07	*There are times when you hold your breath [...] sometimes, the patient we have been taking care of for a long time goes to death. We have to be very strong (RN1).* *I really feel a sadness in knowing to what extent the human being gets the neoplastic wound (RN2).* *I am very sad, worried, but I try to do my best, do a well done job, provide the patient's well-being (RN7).* *About sadness [...] they suffer greatly, depending on the extent, depth of the injury. Therefore, I take care with zeal, attention, not to feel pain (RN9).* *I have sensitivity. I get sad (RN14).* *Sad feeling because the patient feels fear of death and also has the smell of the wound (RN15).* *Painful feelings (RN18).*
Empathy	05	*We have to be very ethical, first of all, with the patient with neoplastic wound [...] most patients have odors, right? So, we give priority to not pass this on to the patient ... that we're feeling that odor [...] (RN1).* *We feel because, whether we like it or not, we see ourselves there in that sense, at that moment ... It is a wound that requires a lot of care. Because the person already comes with a negative diagnosis and still a wound caused by the disease itself, by the tumor itself, this is very sad, right? (RN2).* *During the treatment of the patient, I have the feeling of putting myself in the patient's place, of seeing how this illness is affecting him (RN3).* *Caring for a patient with a neoplastic wound is a bit tricky, because in addition to his suffering, there is also our sense of sadness (RN12).* *Respect for the patient and empathy, that is, you have to take his place. It has the issue of humanization too, which is very important, that you have to feel humanized and humanize this moment to perform a dressing (RN17).*
Compassion	04	*he feeling would be of compassion [...] that moves me to treat you in the best way (RN4).*

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		We feel sorry for the patient in that situation. (RN5). *Mercy feeling, because it is an absolutely painful injury (RN8).* *Feeling sorry. But I try to restrain myself, not to show the patient. If I could solve the situation he is, I would solve it (RN13).*
Gratification	04	*I feel gratified to be able to help, to offer at least comfort in such a delicate situation (RN5).* *During the dressing performance, I feel accomplishment and pleasure in being able to take care of (RN16).* *I think that caregivers have a sense of duty, of being able to offer their best to seek a better quality of life for the patient (RN19).* *During the dressing performance I feel affection, respect and ethics towards the patient (RN20).*
Seizure	01	*At the beginning, the main feeling that marked when I went to perform the first dressings was the fear, because we see that a lot of the patients come with greater suffering, because it's been a while since they already have that wound, so we're afraid of hurt. Fear of touching that wound and it bleeds and the patient gets nervous, right? (RN12).*
Indolence	01	*We have to be human with them, but if we get too involved, we will not do our job successfully. Because then the emotional will disturb, and then we cannot do the dressing (RN1).*

Source: survey data.

The category that obtained the highest percentage of responses, according to Chart 1 was "Sadness", followed by the categories "Empathy", "Gratification", "Compassion", "Apprehension" and "Indolence".

Discussion

Performing a healing is a reflexive task that cannot be considered only as a technical action, since it involves a relationship between two people: the one who cares and the one who is cared for. However, it is important to emphasize that it is extremely important for the professional to be scientifically grounded, with knowledge about the skin physiology, products on the market, indications according to the type of injury and knowledge about the products that are standardized in the hospital[8].

The Nursing team in cancer care, when performing the dressing, permanently deals with a diversity of feelings that are exacerbated by the demand characteristics and work environment, in which the professional demands a donation act, not only to the patient, but also your relative/caregiver[9].

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Therefore, for nursing care with cancer patients to be effective, the nurse also needs to be able to deal with the feelings of others and with their own emotions towards the patient without cure therapeutic possibilities, and especially with a wound that does not heal[9].

In the "Sadness" category, it is possible to perceive that the sadness feeling highlighted by the nurses participating in the research is related to the limiting situations for which the patient with neoplastic wound passes, among them: disease with no cure possibilities, disfiguring nature of the wound and a foul odor exhaled by it and the nearness of death.

A qualitative study[10] revealed that the physical appearance of neoplastic wounds represents a significant impact on nurses, who consider these lesions to be the major patient suffering cause, since they are disfiguring, invasive, incurable and painful. In addition, the study emphasized that fetid odor was the greatest challenge faced by nurses when performing a dressing, however, they did not show aversion signs during the procedure, thus avoiding embarrassment before the patient.

It is emphasized that the more intimate the professional relationship with those he cares for, the more likely he is to experience anguish feelings, since the suffering of the other is capable of mobilizing sadness, compassion, piety and closer nursing with people whose health/illness situation is accompanied by repulsive characteristics[9] .

Health professionals in caring for cancer patients, especially those with extensive lesions, become more fragile and vulnerable, for by recognizing and understanding the pain, suffering, and finitude of the other, they recognize their own pain and finitude. And it is from this human identification with the patient that nursing recognizes itself as a being open to suffering, capable of all the possibilities that life presents, with death being the most concrete possibility[11].

Given this context, caring for a person supposes a complex work, as it implies the will to help overcome suffering, thus necessitating human presence and intimate contact[12]. At this juncture, the nurses participating in the research were willing to take care of the patient with a neoplastic wound, revealing authentic attitudes, such as solidarity and solicitude.

From the psychological point of view, the art of caring requires the empathy development. Empathy and sympathy or compassion share the same etymological root, namely the term pathos, yet differ in the suffix. In this sense, the participating nurses revealed "Empathy" and "Compassion" as experienced feelings in the care of patients with neoplastic wounds. For a better understanding of these terms, the researchers decided to define the concept first, and then to draw discussions[13].

Compassion or sympathy is defined as an affective response consisting in feeling sadness or concern for the afflicted or needy; involves characteristic provisions for action, specifically help. Empathy is defined as a feeling of brotherhood, that is, understanding what a person feels, regardless of what he feels. Empathy is neither altruistic nor crude, but properly exemplifies the implicit solidarity of the human race. Compassion or sympathy is therefore clearly an emotion in the sense that it is a distinct emotion, perhaps dependent on the emotions of others, only in so far as it is an answer to them, but in no sense an imitation or reproduction of them. It is essentially, feeling bad because the other feels bad, in combination with a feeling of reaching him[13].

Both empathy and compassion/sympathy are affective and cognitive responses; that is, they involve concepts and ways of building the world and are of great importance to understanding people's emotional lives, it is part of man's natural ability to tune in to the emotions of others and to feel the urge to react without the need to a lot of thought[13].

In the screen study, nurses RN4 and RN13 really experience the compassion feeling, since this feeling directs the nurses to act, as they themselves expressed "in the best possible way" and "if I could situation that it is, it would solve. " While the others remain in the empathy dimension, that is, adopting positions of solidarity and solicitude. However, it should be noted that, empathy is a fundamental factor for the effective exercise of the profession, especially in the palliative care field.

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Empathy is the ability to interpret the feelings of the other in a particular context, requiring the human being's availability and ability to put himself in the other's place, to see the world as the other person sees, and then can genuinely feel the way the other feels in a given situation. It contributes to the creation of an interpersonal trust climate, a basic element in the health care relationship, and a necessary condition for this relationship to be effective, since trust and security cannot be imposed, but built[13].

Within this context, it is possible to perceive that one of the research nurses uses their maximum level of availability and empathy with the patient with neoplastic wound, when she mentions that she disguises to feel the putrid lesion smell, so that the patient does not perceive and feel excluded.

A qualitative study[10] revealed that nurses describe neoplastic wounds as devastating and that bad odor causes nausea and sickness when they come into contact with the patient. They also noted that after dressing, removing gloves and washing hands, they could still feel the odor in their hands and clothes. The nurses revealed that they try to hide these feelings when they come in contact with the patients, since they believe that it is a relevant and positive factor in the care of these patients.

Category four reveals the nurses' feelings of "Gratification" in relation to the care of people with neoplastic wounds, especially when they provide care, comfort, and maximization of the life quality through an effective dressing.

A qualitative study[10] pointed out that nurses emphasized gratification feelings, especially when they reach comfort and pain relief during dressing performance. In addition, they mention that respecting the person in the face of an incurable injury, promoting dignity and life quality during the death process are attitudes that give meaning to the profession practice.

To build something requires a certain optimistic temperament, a certain capacity for building. A human relationship can be characterized as uplifting when it positively transforms both professional and patient. A human activity is uplifting when the subject who develops it perfects through it, and constructs itself. The caring action is, in this sense, an edifying action, not only in the corporeal sense of the term, but fundamentally in the inner sense. To build up the sick and suffering person is to try to rebuild their inner self, to raise their personal identity again, to rebuild themselves after the fall and frustration of the becoming ill process[12].

Therefore, caring for someone, accompanying a vulnerable person is to exercise ethical responsibility, is to worry about the other and to take that concern as a moral duty and not solely as a feeling of closeness to the person. Precisely because the action of accompanying or caring implies responsibility, it has an ethical, as well as anthropological, psychological, social and spiritual character. The caring process and following goes beyond the technique limits and contains ethical elements. Caring presupposes technique, skill, but it is not reduced to technique[12].

Category five emphasizes the "Seizure" of one of the nurses when dealing with patients with neoplastic wound at the dressing performance time. This fear in performing the dressing is common in all professionals who deal with extensive, friable and, above all, painful wounds. Thus, nurses need to know what to do it, how to obtain and use the products properly, to minimize episodes of severe pain and profuse bleeding.

One study[10] pointed out that nurses describe the clinical management of malignant wounds as extremely difficult, which led to feelings of guilt or inadequacy of the profession, since they were not able to manage wound care in what they considered to be proper.

Given the complexity and devastating nature of neoplastic wounds, it is recommended that these lesions be treated by a multiprofessional team within an approach to the palliative care philosophy. This will facilitate the care provision in an individualized way, which is of vital importance in maximizing the patient's life quality. In addition, nurses need to recognize the existence of problems in all domains of patient existence, rather than just emphasizing the physical domain, which has been the contemporary literature focus[8].

Category six expresses a feeling of "Indolence" referred by a nurse in the sense of

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using that feeling as a guiding force for effective praxis. Indolence is a kind of feeling that emerges as a coping mechanism of the hospital situation experienced, characterized as the means found by the professionals to support the suffering they feel, and from there, to carry out the work in the best possible way[14].

The overcoming of spatial distance and ethical distance is fundamental in the caring action. You cannot take care of someone at a distance. To care for a sick person, one must approach it and thus overcome physical distance. In this sense, it is necessary for the professional to be emotionally involved with the patient, however, it is essential that he/she has emotional control over adverse situations during the care process. Emotional involvement is one of the vital aspects in the nurse-patient therapeutic relationship, since it helps both to be resistant to the limitations that this pathology imposes[15].

In this perspective, a possible and adequate path for humanization is, above all, the professional solidarity presence, reflected in the understanding and the sensitive eye, a look that awakens feelings of security and trust in the human being. This solidary presence gives life a chance to live, the warmth of simple things, even in the face of the tensions and risks of mutant moments, unpredictable and full of meanings[16].

To make and be the differential in care relationships in the hospital environment, it is required that the health professional act with humanity, solidarity, sensitivity, besides having correct posture and dignity of character, since human sensitivity is the ability to feel empathy, to allow oneself to be touched by the lives, sufferings and joys, hopes and desires of others who have their particularities and who transcend the rational capacity[16].

Caring for patients with neoplastic wounds can be an inexorable experience for nurses, since these lesions are disfiguring, bleeding, exudative, exuding an unpleasant odor, non-healing, and mutilating. Within this context, the nurses needs who care for these patients should be considered[3-4-5]. Thus, it is suggested that nurses who perform dressings in these patients share their professional experiences in support groups, allowing them to reflect and understand the emotional process they are going through.

Conclusion

At the end of this study, it was concluded that the discourses indicated positive and negative feelings perceived during the dressing. Recognizing that sadness was mentioned as the feeling that permeated caregiving, since nurses developed empathic abilities in the face of the pain and suffering of the patient.

It is hoped that this study may contribute to the knowledge construction and specially to hold the managers and professionals' attention on the need for permanent education, as well as a space for discussion of psychological and spiritual aspects, aimed at the health team, especially to nurses, since it is the professionals who are closest to patients and who usually perform the dressings to qualify the care provided.

The study limitations are related to the participants' number and to the study site, a single hospital, which prevents the findings generalization, however, these are considered valid, since they reflect similar conditions verified in larger surveys, standing out the need for complementary studies that involve the theme. There is still a lack of studies on the practice of specific care for the person with neoplastic wound, as well as the attitudes, behaviors and nurses' practices facing this limiting condition in which the person with advanced cancer disease is located in the hospital institutions, as well as in the home environment, which prevented further discussions.

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