PAIN, KNOWLEDGE, AND SUPPORT: THE EXPERIENCE OF A MULTIDISCIPLINARY TEAM IN AN ONCOLOGY OUTPATIENT CLINIC IN BRAZIL

Dor, conhecimento e acolhimento: experiência de uma equipe multidisciplinar em um ambulatório oncológico no Brasil

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ABSTRACT

Pain is one of the most feared symptoms by adult cancer patients. However, it is also one of the most frequent. In the healthcare field, meanings influence teamwork and patient adherence to treatments. This issue highlights the importance of research investigating meanings related to complex human phenomena, such as pain. The main objective of this study was to understand the meanings attributed to pain in adult cancer patients by professionals from a specialized outpatient cancer clinic. Developed following the principles of the clinical-qualitative method, this study interviewed 20 professionals from an outpatient clinic specializing in health care for adult cancer patients. The number of participants was defined by using the inductive thematic saturation criterion. The instrument used was a semi-structured interview. Data collection was performed individually and recorded in audio. The corpus of this study was composed of literal and complete transcripts of the audio recordings of the semi-structured interviews and was subjected to clinical-qualitative content analysis. Field notes provided additional input for this purpose. The validity of the categories resulting from the clinical-qualitative content analysis was confirmed through a meeting with other researchers from the research group, predominantly postgraduate students. The results were organized around reports that highlight the importance, for the participants, of specialized professionals, who must be both welcoming and supported, favoring the care of adult cancer patients with pain. These findings can be used in different initiatives to improve health care offered in specialized outpatient clinics.

Keywords: Pain, Perception, Patient Care Team, Qualitative Research.

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INTRODUCTION

The concept of "total pain" is used to capture the multifaceted pathophysiology of pain experienced by cancer patients, emphasizing that adequate pain relief requires addressing its physical, psychological, social, and spiritual dimensions[1]. Caring for these patients should involve a holistic approach, ideally delivered by an interdisciplinary team. Such a team brings together diverse areas of expertise, aiming to broaden the scope of care to encompass not only patients but also their peers and the healthcare team as a whole[2].

The International Association for the Study of Pain (IASP) defines pain as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage"[3]. This definition, endorsed by the World Health Organization (WHO), is widely accepted among healthcare providers and researchers focused on pain.

Cancer, a chronic degenerative disease, is responsible for approximately 12% of deaths globally and accounts for around 15 million new cases each year, causing a significant public health impact that ultimately influences public policies. Therefore, these statistics highlight the need for policies that encourage scientific research and economic investment in developing alternative strategies for patient support, monitoring, treatment, and care[4].

Clinical expertise is now recognized as equally essential as values, attitudes, and behaviors in healthcare[5], especially in cancer care. Humanized care integrates a scientific understanding of the health-illness-treatment process with an individualized view of each patient[6]. This approach should be a central consideration in the educational curriculum and training of healthcare professionals[7,8].

Finally, it is essential to mention that, in healthcare, the work team itself can be a significant source of professional satisfaction, particularly when each member contributes with unique knowledge and individual experience to benefit patients[6]. Similarly, a willingness to collaborate is highly valued and fosters a positive, supportive environment.

In this context, this study aimed to explore the meanings that professionals in a specialized outpatient clinic attribute to pain in adult cancer patients and to examine how these insights relate to applying skills gained through their clinical experiences.

METHODS

Methodologically, this study employs a qualitative research design. Such type of research focuses not on phenomena per se but rather on the meanings these phenomena hold for individuals or groups[9]. Thus, regardless of the specific objective, qualitative research seeks to describe and understand human experiences in their most subjective aspects, prioritizing the perspectives of participants[10].

Participants in this study were healthcare professionals over 18 years old who had been working in the same healthcare service for at least one month at the time of data collection. To ensure anonymity, participants were given pseudonyms inspired by the names of galaxies and constellations, while any patients they mentioned were assigned pseudonyms based on comets.

The study setting was an outpatient clinic specializing in adult cancer care within a public hospital in a medium-sized city in southeastern Brazil[11]. This hospital exclusively serves patients through the Unified Health System (*Sistema Único de Saúde* - SUS) and is a regional reference center for approximately 500,000 people, providing a range of clinical and surgical services. Additionally, it is certified as a High Complexity Oncology Care Unit (*Unidade de Assistência de Alta Complexidade em Oncologia* - Unacon) by the Brazilian Ministry of Health, being equipped with the human and technological resources necessary for the diagnosis and treatment of various types of cancer.

The hospital provides inpatient beds and emergency, urgent, and outpatient care to meet the diverse needs of adult cancer patients, specifically in Breast Surgery, Gynecology, Urology, and Coloproctology. The outpatient clinic operates Monday through Friday from 7 am to 7 pm, excluding holidays, and is staffed by a multidisciplinary team of 41 professionals. This team includes 12 doctors (three oncologists, two urologists, two general surgeons specializing in the digestive system, an anesthesiologist, a cardiologist, a breast cancer specialist, a gynecologist, and a palliative care specialist), five nurses, two nursing technicians, one nursing assistant, two pharmacists, two pharmacy technicians, a psychologist, a social worker, a nutritionist, a clinical laboratory technician, three receptionists, two cleaning assistants, a pantry and kitchen assistant, and seven security guards.

The primary data collection tool for this study was a semi-structured interview. This method, well-suited for clinical-qualitative research, allows participants to freely express their personal perspectives and meanings regarding the topic defined by the researcher[12].

The thematic guide for this study included the following questions: (1) What does pain mean to you? How does it manifest in adult cancer patients? (2) In your opinion, is pain in adult cancer patients different from pain in other patients? If so, in what ways?; (3) In your opinion, what factors improve or worsen the pain of adult cancer patients?; (4) In your opinion, how should pain in adult cancer patients be assessed in terms of cause and intensity?; (5) In your opinion, what should the goals of care be for adult cancer patients experiencing pain?; (6) What is it like for you to care for adult cancer patients with pain complaints? Do you see positive and negative aspects? If so, which ones?; (7) Has your perspective on this topic changed over time? If so, how?; (8) In your opinion, what could be done to improve the care of adult cancer patients with pain?; (9) Do you have any notable examples from your professional experience involving caring for adult cancer patients in pain?

Of the 41 professionals at the outpatient clinic, 27 were invited to participate in this study, with no refusals or withdrawals. However, two participants were unavailable due to health-related work absences. Not all eligible professionals were contacted because the sample size was determined using the saturation criterion rather than the exhaustion criterion. This approach was selected as it is widely accepted for scientific validity in qualitative research[13]. Specifically, the inductive thematic saturation criterion was used, as the number of participants was defined once the themes identified in the initial data analysis were deemed sufficient to address the research objective[14].

The corpus of this study consisted of complete, verbatim transcriptions of the audio recordings from the semi-structured interviews, which were then analyzed using clinical-qualitative content analysis, following the methodological framework developed by Faria-Schützer *et al.*[15]. This approach builds on Bardin's[16] original content analysis method. Therefore, the first step is to perform a preliminary immersive reading of the material (or a "floating reading" if literally translated from the term lecture flottante used by Bardin in her original work in French). This step aims to connect the reader with latent meanings and construct units of analysis related to the research focus, a recommended practice in clinical-qualitative content analysis in the health field that is useful to interpret underlying meanings within individual interviews[15]. The validity of the analytic categories — ensuring they were mutually exclusive, thematically cohesive, and aligned with research objectives — was confirmed in a second meeting involving additional researchers from the group, primarily postgraduate students.

This study received approval from an Ethics Committee and followed ethical standards outlined in Brazilian legislation. All participants signed an informed consent form before data collection, formally explaining the study's objectives and procedures. It was clearly stated that all eligible participants were free to decline involvement without consequence and could withdraw their consent at any time, even after data collection was complete. The researcher's commitment to maintaining participant confidentiality was also formalized within this document.

RESULTS

The study involved 20 professionals from diverse roles within an outpatient clinic specializing in adult cancer care, including doctors, nursing staff, pharmacists, psychologists, social workers, nutritionists, receptionists, security personnel, and environmental services/cleaning staff, as detailed in **Table 1**.

Twelve participants emphasized that caring for adult cancer patients requires specialized technical knowledge, linking this need to their understanding that pain tends to be more intense in this population. Seven participants mentioned they had studied or sought additional information on the topic since beginning their work at the Oncology Outpatient Clinic. Antila's account illustrates this sentiment:

> *“If you don't have a prepared team, with knowledge, they won't be able to understand what they [the patients] are saying [...]. Perhaps a trained professional will understand it perfectly. They will be able to see them [the patients] in their entirety within their [the professional's] knowledge. Something that I think other professionals will have this difficulty with”.*

Seyfert highlighted the importance of ongoing education for healthcare providers:

> *“The palliative [care] course, these courses that we have been doing [...], really opened my mind. [...] I think that people [professionals] should have more knowledge, you know? More closely, about the oncology patient. About the phases of their treatment, the phase of life that they are in. Because I only had this vision when I got closer, when I started working with this. So I see that, I think that many people do not have this knowledge and treat them as a normal patient who is there, who is hospitalized, the same treatment for everyone. So I think that is lacking”.*

Half of the participants emphasized the importance of understanding each patient's unique needs and offering a welcoming attitude, often through simple gestures, aligning with the view of pain as a subjective experience, which is central to the second category. Seyfert shared an example from a consultation to illustrate this approach:

> *Met “I think that what makes [pain] better is when you understand them [patients]. Listen to what they want to say; sometimes, if they are upset, understand that moment and respect it. So much so that I respect it a lot. Just today, a patient's daughter said: ‘Oh, I want her to eat fish.’ A daughter told her mother, who was there in a wheelchair: ‘I want her to eat fish because fish is good. Because someone at the other hospital sees the nutritionist, and she eats a lot of fish, and my mother has to eat fish.’ So I said: ‘Look, but if she doesn't like fish, we have to respect her, she can eat other things.’ Then the lady made such a happy face, like: ‘Someone understands me.’ You know? ‘Phew! I won't have to eat fish.’ So I felt that she was relieved. Because, in addition to all the pressure of the treatment, the pain she is feeling, the surgery she had, she also had a daughter pressuring her to eat the fish she doesn't like [laughs]. So I feel that just by the fact that the patient is respected, they already feel more relieved”.*

Pegasus similarly highlighted the importance of building trust with patients:

TABLE 1 - Distribution of Participants by Sex and Position within the Multidisciplinary Team

PARTICIPANT	POSITION	SEX
Cartwheel	Nursing Technician	Female
Antila	Registered Nurse	Female
Lacerta	Psychologist	Female
Redshift	Front Desk Staff	Female
Hoag	Registered Nurse	Masculino
Columba	Pharmacy Technician	Female
Hydra	Cleaning/Environmental Services Associate	Female
Mice	Oncologist	Female
Magalhães	Security Guard	Masculino
Messier	Registered Nurse	Female
Andromeda	Front Desk Staff	Female
Lyra	Social Worker	Female
Seyfert	Nutricionist	Female
Phoenix	Front Desk Staff	Female
Aquila	Pharmacist	Female
Pegasus	Registered Nurse	Female
Centaurus	Pharmacy Technician	Female
Sagitta	Nursing Technician	Female
Cassiopeia	Pharmacist	Female
Markarian	Registered Nurse	Female

* To preserve their anonymity, participants were identified by pseudonyms, referring to the nomenclature of galaxies and constellations.

> *"I think that, in addition to the physical exam, an anamnesis of everything that has happened [is necessary]. You must have the means, and the person must have the confidence to tell you. Because many times they don't trust you and they don't tell you everything that has happened. And we try as if it were building blocks, like this, to put it together, to be able to understand. So, I think that's it, you have the trust of the person, you can get them to tell you everything. [...] What has been happening to them over the course of these days".*

Cartwheel shared a story that illustrates the impact of a welcoming approach in easing pain-related symptoms:

> *"We have a patient here, an old one, not a new one. She was terrified of the Portocath®. When the Portocath® was implanted, she felt sick, very sick. She vomited, and when it was time to get it, you know, to put the little needle in there, she felt pain. The smell of chlorhexidine [...]. What did I do one day? I put makeup on her. I said: 'Look, let's do this?' I said to Antila: 'Antila, swap the chlorhexidine for alcohol,' and she went there and swapped it [winking one eye as if to imply that we were just pretending]. Then I started putting makeup on her. I said: 'We're going to put makeup on you and you're not going to look. Let's agree on this? You're not going to look?' I started putting makeup on her, and playing around, and putting makeup on her. So Antila punctured her, the medications started to run, she didn't feel it, she didn't feel sick. Do you understand? She didn't even feel the prick".*

Cassiopeia, on the other hand, recalls the importance of complementary therapies:

> *"Using complementary therapy techniques, which we talk about, integrative medicine. Maybe a massage, acupuncture, aromatherapy, right? Complementary therapies that also take the patient out of the cold environment of the hospital. [...] The goal would be not only to improve the pain itself, but to treat it, which I repeat because, from my experience, I see that sometimes it is a palliative, a word. The goal would be not only to focus on the pain, but on the patient's quality of life as a whole. This will directly influence them. Their perception of pain".*

Antila, conversely, emphasized the importance of promptness in care delivery, resonating with the theme of prioritizing cancer patients experiencing pain, as discussed in the second category:

> *"If everything happens quickly, I think it gets better, right [...]. And then, sometimes, what makes it worse is the delay, right? I think that makes it worse. It increases their pain. And then it gets better when we see them, and we do it faster. We feel it, that it improves. The delay in seeing them, the delay in medicating them [...]. Because we see, for example, when they [the patients] arrive here, we welcome them, we put them [in the bed]. It's not that they are not in pain, they are, but then, the speed at which we address their discomfort, we prepare the medication and follow the prescription to alleviate it; I believe it improves. When they are in pain and they haven't even managed to get a bed or be seen, I think it gets much worse".*

Cartwheel seems to agree with this position:

> *"The patient shouldn't feel pain in the hospital. [If] the patient is in pain, I think you have to put them first, see them first, medicate them [...]. You can't feel pain in a hospital. I think that's the end, in my opinion. You can't understand that. You see the person in pain and waiting there, right? I think you have to see them first".*

Hoag further discussed possible side effects of medication and stressed the importance of non-pharmacological approaches to pain management:

> *"We still have the false impression that medication solves everything. If you are in pain, you will take painkillers, you will take, I don't know, sedatives, and you will solve the pain, right?[...] We forget about care that can also reduce pain. [...] There are several factors that improve pain before you have to overload an organism with medications when it is already overloaded with other things. [...]. That is why I say that pain is unique, each patient is unique. Each patient is unique. And there is no one-size-fits-all recipe, so we need to work as a team. And learn a lot about this problem of pain, right? [...] Every day we are learning new ways of dealing with pain [...]"*

Hoag also highlighted the importance of a supportive, multidisciplinary approach to pain management:

> *"I think we need a cohesive team, right? That's what we call a multidisciplinary team. So we have the nutritional part, with the nutritionist, who can use foods that do not interfere so much in the body's cycle, in order to reduce the potential for pain. The psychologist, who works a lot with this acceptance phase. Nursing, in the aspect of dealing with the other person's pain and respecting the other person's pain limit. The medical team, right? Preparing this patient for a very difficult issue, which is palliative 'supportive', right? So, pain doctors are extremely important professionals because they are the reference, not only to prescribe the painkiller but also to guide the patient on how all of this will work. [...] The oncology patient wants very little from you. From the moment you open your ears to hear what they have to say and so on, look the person in the eye like that, you are already giving the first medication".*

Cassiopeia proposed expanding the care environment to better accommodate oncology patients:

> *"Here at the hospital we don't have a [specific] oncology inpatient ward. And I think that mixing patients with those from general internal medicine is very wrong. Because there are patients with many types of pathologies, viruses and bacteria, etc. And the oncology patient already has an extremely depressed immune system. The treatment is difficult, right? And exposing the patient, putting the patient in, carrying the patient upstairs, doing all that, that transportation, is what I think you end up contaminating everything. And staying there, together with the other patients, without having an exclusive place? I think that's what's needed".*

Messier, meanwhile, linked quality of life with the dignity of death when asked about ways to improve care for patients experiencing pain.

> *"I believe that these are palliative care beds. There are no vacancies for the people*

> *we deal with. Not to mention that when cancer patients become terminally ill, they can stay at home with their families, but no one is prepared for that. So what is the other option? Unfortunately [admission to a hospital]. But if they have access to a multidisciplinary palliative care team, explaining to the family what their role is... And [explaining] that the patient will be receiving care there. I think they would have a good quality of death. I think one could say with dignity. Because they will be speaking the same language there."*

The need to acknowledge the emotional burden on the multidisciplinary team was highlighted, although subtly, by several participants, including Markarian:

> *Sometimes you don't see many results. The patient has chronic pain, and sometimes you don't see much improvement, right? I think this also brings discomfort as a team. For example: 'Oh, what could we do?' Sometimes we've tried everything, and this patient doesn't get better. There's all this. I think this is frustrating for us [professionals] too, often."*

Similar reflections can be seen in the following report by Hoag:

> *"The loss of a patient in oncology is very painful for the team. We also need to deal with this, and also accept the loss of our patient, right? [...] So I had to talk to a lot of people to learn that the people we care for also pass away, right? [...]. And each patient will have a different impact on our lives too. Because they are human beings who lived with us for six months, a year, ten years, whatever. So when they stop being in the service, it is remarkable in some way, right? [...] And we need to deal with it".*

Although essential to achieve the goals of care for patients and family members, the role of public policy and political investment in establishing a national palliative care program was mentioned by only two participants, including Antila:

> *"How are we going to treat pain if we see that the national palliative care policy is also not implemented within the hospitals? So, they [the patients] arrive, but there is no national palliative care policy on where these patients will be cared for. Where they will be admitted to? There is not even [...] sometimes there is not even a bed for them. That is what we see, right? It may not be just like this in Brazil in general. Maybe in other hospitals it may be different. But I see it as a general problem, because of the service regulations, so all of this makes things difficult for them [patients]. So we watch them die".*

Magellan echoed these concerns, stressing the importance of political commitment to address these challenges:

> *"We see the government out there, they say they do it, do it, do it, but they are very negligent, they do not provide the assistance they should [...]. Whether you like it or not, it is a disease that has a death sentence, right? Many are cured, but most are not. What we can do, in the case of you guys, health professionals, is to alleviate the pain, most of the time. [...] So it has to start at the top. They [politicians] must see the situation of these patients and must really invest, invest heavily in it. Because there may not be a cure, but if there is survival, right? They say: 'Look, you will live another ten years'. Then the patient will [get better]. But that has to be a heavy [government] investment."*

DISCUSSION

Most participants emphasized the importance of technical knowledge for adequately managing patients with chronic, difficult-to-control cancer pain. Some healthcare professionals expressed frustration stemming from insufficient specialized training in chronic pain management, a sentiment documented in prior research[17,18]. In many cases, this frustration is internalized as guilt when treatments for complex cases are unsuccessful, with certain professionals even describing feelings of fear and stress upon recognizing the names of these patients on their clinic schedules[19,20].

However, the humanistic complexity inherent in caring for patients with cancer-related pain highlights the limitations of a purely technical approach. Consequently, the curricular guidelines for healthcare training should emphasize developing a critically reflective, humanistic skillset to address health promotion, prevention, recovery, and rehabilitation from a comprehensive perspective on the health-disease continuum[21]. This dimension of affective-social care aligns with institutional and governmental policies that advocate for humanization in healthcare, aiming to foster meaningful, empathetic relationships between patients and professionals[22].

To cultivate such humanistic skills in training, educators must recognize the depth and complexity of the concept of humanization. The formation of values, attitudes, and behaviors during professional training must be an intentional process facilitated through thoughtful planning and discussion in immersive teaching and learning environments. This approach requires implementing both formal and informal curricular strategies to nurture sensitivity, commitment, and respect for each patient's unique identity and humanity[23].

Participants in this study reported that comorbidities frequently accompany pain, including depression, anxiety disorders, loss of appetite, edema, and wounds, all of which negatively impact quality of life. The involvement of non-medical professionals—such as psychologists, nutritionists, nurses, and physiotherapists—is invaluable in providing holistic care that incorporates diverse coping strategies to support health. It is evident that an expanded, patient-centered approach, which transcends a purely disease-focused perspective, is the most effective way to achieve patient satisfaction[24].

Many participants also emphasized the importance of legitimizing patients' pain, even when it is not visibly apparent. Recognizing and validating a patient's pain relies on the strength of the bond between the professional and the patient with chronic pain, which is essential for a supportive approach and promoting health and well-being. When this professional-patient relationship is well-established, it often yields benefits beyond the accuracy of diagnosis[25].

Nonverbal communication is as significant as spoken words in the professional-patient relationship. Actions such as making eye contact, sitting at the patient's level, creating a welcoming environment, ensuring the patient and their family understand the information provided, allowing the patient to ask questions, repeating the patient's words as a form of validation, and minimizing external interruptions are all crucial elements in building trust and rapport, as noted by the study's participants[26].

Establishing a strong professional-patient relationship enables a deeper understanding of pain—a symptom as frequent as it is complex—and its profound impact on a patient's quality of life[27]. As the professionals interviewed described, this nuanced perception is essential to enhancing the quality of this interaction and recognizing certain behaviors repeatedly employed by the healthcare team.

Multiprofessional care fosters adaptive, contemporary healthcare systems that reflect the specific realities of each service, as highlighted by Hoag. This welcoming approach to care nurtures trust and commitment in the relationships between patients and professionals, facilitating advancements in health solutions and strengthening connections between teams and services in implementing public policies that support the SUS. This requires an ethical-political stance grounded in recognizing and valuing diversity, fostering collective agency, and ensuring living conditions that promote health[28].

The National Humanization Policy (*Política Nacional de Humanização* - PNH) advocates for structural changes in the management of health services through expanded democratic spaces for discussion, listening, exchanges, and collective decision-making. This approach includes not only welcoming patients and their families but also supporting the professionals who make up the multidisciplinary team. This support is essential, as it allows for a shared evaluation of the challenges in meeting the needs of the population—challenges reported by many professionals in the field[29].

PNH also outlines various approaches to creating a welcoming environment, including adapting physical spaces so that healthcare services align with care demands, reorganizing workflows, managing local teams to prioritize compassionate care, fostering humanized work relationships, restructuring management practices in healthcare units, building therapeutic bonds, and encouraging interdisciplinary practices[28]. These recommendations were echoed by participants in this study when asked about possible strategies for enhancing care for cancer patients with pain.

Complementary treatments, recognized in Ordinance Nº. 1,083 of the Brazilian Ministry of Health from October 2nd, 2012[30], were also widely recommended by participants as beneficial supplements to traditional pharmacological pain treatments, including for cancer pain[31]. Such approaches offer supportive options that can work alongside conventional treatments.

As the study's participants emphasized, the potential for pharmacological pain management side effects should be anticipated, prevented, and effectively managed. Nonetheless, adverse symptoms associated with analgesic medications remain common, often dose-dependent, and influenced by factors such as individual biological variations, the presence of comorbidities, and concurrent treatments—factors that are especially relevant in cancer patients[32].

Caution in pharmacological treatment is essential to avoid prescribing medications that contradict treatment objectives. One common misunderstanding, as highlighted by a participant, involves the misuse of hypnotic and sedative drugs for their assumed analgesic effects—a misconception prevalent among the lay population. Sedatives and hypnotics primarily affect the level and content of consciousness rather than addressing the underlying mechanisms of physical pain. Yet, some healthcare professionals may still misuse them, aiming to achieve pain relief through sedation. Adhering to the ethical principle of "do no harm"[33] requires recognizing that administering consciousness-depressing medications to patients in physical pain can lead to an unpleasant, unrelieved sleep state, leaving patients unable to adjust their position or perform self-care to ease their discomfort that remains unaddressed. Therefore, consciousness and analgesia, while interrelated, are distinct processes and should be treated with medications from different pharmacological classes as appropriate.

Participant Pegasus emphasized the importance of accurately interpreting patients' expressions to tailor care effectively. Her remarks highlight a commitment to understanding each patient's unique perspective within their social and personal context. This approach respects the values attributed to the patient's choices and the responsibilities that accompany them, enhancing the likelihood of successful treatment outcomes. Such a patient-centered approach is well-supported in scientific literature and has proven effective[34].

Pain is one of the primary reasons for suffering and seeking healthcare, with substantial economic implications for public health and wide-ranging biopsychosocial effects, as highlighted in this study. Timely, effective, and appropriate pain management directly affects both the perceived intensity of pain and overall quality of life[35]—a point well-recognized by the participants in this study.

In the state of São Paulo, Brazil, State Law Nº. 17,832, enacted on November 1st, 2023[36], recently guaranteed the prioritization of care for cancer patients. Nationally, Bill Nº. 4,890, introduced in 2020, which seeks to ensure preferential care for cancer patients in public services, is still under review in the Brazilian Chamber of Deputies[37].

Participant Cartwheel expressed a moral concern regarding the suffering of patients in pain within a hospital environment, considering such occurrences unacceptable. As a nursing professional in the Oncology Outpatient Clinic, Cartwheel's concerns are supported by scientific literature: numerous triage tools are available for the emergency setting, enabling nurses to prioritize immediate care based on severity[38]. Given that pain is widely recognized as the fifth vital sign[39], it should not be neglected.

Further concerns were raised about whether the multidisciplinary team at the Oncology Outpatient Clinic is sufficiently staffed to meet the needs of adult oncology patients experiencing pain, as well as about the organization of workflows. Ideally, this team would include clinical and surgical oncologists, palliative care and pain specialists, psychologists, nutritionists, physiotherapists, pharmacists, dentists, nursing staff, social workers, and chaplains, along with essential administrative personnel (such as receptionists, security, cleaning staff, kitchen and pantry staff, warehouse workers, human resources personnel, and lab/imaging technicians). The number of professionals should be sufficient to accommodate the rising demand of patients diagnosed with cancer, aligning with the Brazilian Constitution, which asserts that health is a universal right and a State obligation[40,41]. Moreover, although there is no set limit on the number of patients each professional should see per shift, staffing levels should always ensure quality and safety in patient care, as underscored in healthcare policies and guidelines[29].

Concerns about the adequacy of staffing in the multidisciplinary team at the Oncology Outpatient Clinic are closely linked to burnout among healthcare professionals. The scientific literature shows that burnout cases have risen significantly in recent years, primarily driven by work overload. In sectors like Oncology, this is compounded by a heightened self-demand among healthcare providers, stemming from the emotional strain of recognizing that curative outcomes may be unachievable in treating chronic diseases[42,43]. This theme emerged in several participant accounts, including those of Markarian and Hoag.

In cancer patients, community or hospital-acquired infections have a high risk of progressing into severe clinical forms, often leading to poorer prognoses and elevated morbidity and mortality rates. This vulnerability is influenced by factors such as cancer staging, length of hospitalization, febrile neutropenia, use of invasive devices, age, comorbidities, and microbial resistance[44]. Participant Cassiopeia highlighted this perspective, stressing the importance of a dedicated hospitalization environment for cancer patients, separate from units housing patients with other diagnoses.

Participants like Cartwheel voiced concerns about adapting physical spaces to align the supply of healthcare services to demand and shared ideas for enhancing service quality. She expressed a desire to create a game room to encourage patient socialization and plans to present this project to her supervisor. Cartwheel's focus on effective use of space, fostering humanized work relationships, and creating therapeutic bonds aligns closely with the principles outlined in the PNH[28].

Another critical consideration raised by participants, with clear applicability to clinical practice, is the need to view pain as a complex, multidimensional phenomenon. This approach aligns with the previously discussed need for comprehensive education and training across healthcare specialties that recognizes that pain arises from an interplay of biological, psychological, spiritual, and social factors. Fully addressing this perspective still requires expansive efforts in public policy and civic initiatives, updated institutional guidelines, and effective regulations from the Brazilian Ministry of Education to enhance both basic and professional training standards. Additionally, an empathetic commitment from caregivers and all those involved in health promotion is essential.

A limitation of this study is that the participants represent a wide variety of professions, encompassing different technical levels and specialties, as shown in **Table 1**. However, this diversity also brings valuable different perspectives. In this regard, the multidisciplinary team should work cohesively, collaborating with patients and their families and extending their knowledge to the community to improve the quality of life of health system users. Interdisciplinary health education and continuing education initiatives—particularly those focused on teamwork—foster shared responsibilities, helping to ease the burden associated with the expectation to meet the various needs of patients with life-threatening illnesses and their caregivers, whether formal or informal.

Another limitation is that this study was conducted in a single healthcare institution, with all participants working at the same location, which may restrict the generalizability of the findings. Environmental triangulation across multiple healthcare settings would be beneficial to enhance the validation of these observations.

CONCLUSION

The organization of both outpatient and hospital care for patients with cancer pain is crucial in promoting health and quality of life. Beyond professional considerations, the institutions' characteristics—including their management models, whether private or public, municipal, state, national, or even international—also play a foundational role. Additionally, cultural and social perceptions of these services influence care outcomes.

This article compiled the perspectives of professionals from a specialized outpatient clinic on the meanings attributed to pain in adult cancer patients, revealing a range of different insights. While participants shared their subjective views, many converged on key themes, including the importance of humanistic training for healthcare professionals, the need to legitimize patient-reported pain, and the value of an empathetic, welcoming, and compassionate approach in caring for patients with cancer pain. Multidisciplinary care was also highlighted as essential. Technical aspects of pain management, such as the sometimes inappropriate use of hypnotics, as well as concerns about the high incidence of burnout in this field, were noted. Other concerns included the need to achieve more effective pain control in healthcare services. These reports illustrate that public policies and cultural and institutional ideologies significantly shape healthcare professionals' experiences, ultimately influencing patient care and management.

CONFLICT OF INTEREST

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