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Research Article

Perceptions of physicians working in the Home Care Service regarding the promotion of palliative care in the Brazilian Unified Health System

Percepções de médicos atuantes no Serviço de Atenção Domiciliar sobre a promoção dos cuidados paliativos no Sistema Único de Saúde

Percepciones de los médicos que actúan en Servicios de Atención Domiciliaria sobre la promoción de los cuidados paliativos en el Sistema Único de Salud

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Abstract

Introduction: The Home Care Service represents a strategic setting for the provision of palliative care within Brazil's Unified Health System, facilitating discharge from the hospital and improving the quality of life of patients and their families. However, its implementation faces challenges related to network coordination and shortages of supplies and professionals. **Objective:** To analyze the practices and perceptions of physicians working in the Home Care Service of Blumenau, Santa Catarina, Brazil, regarding the implementation and delivery of palliative care. **Methods:** This exploratory, qualitative study was conducted with four physicians working in the service. Data were collected in September 2025 through semi-structured interviews and analyzed using thematic content analysis. **Results:** Findings indicate that the Home Care Service is perceived as fundamental to palliative care practice, enabling a unique understanding of family and social dynamics. Despite this potential, several significant barriers were identified, including limited resources and staffing; poor network coordination, marked by a lack of knowledge about the service's responsibilities; ongoing family demands; and the limitations of medical practice, which requires managing social issues for which traditional curative training provides insufficient preparation. The essential role of the multidisciplinary team and the complex balance between protocol standardization and individualized care were also highlighted. **Conclusions:** Although the Home Care Service is a valuable setting for palliative care, its effectiveness is constrained by gaps in medical training and by fragmentation within the healthcare network. Strengthening permanent education in palliative care and improving coordination across levels of care are essential to ensuring comprehensive home-based care.

Keywords: Palliative Care; Unified Health System; Medical Assistance; Home Care Services.

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Resumo

Introdução: O Serviço de Atenção Domiciliar representa um cenário estratégico para a oferta de cuidados paliativos no Sistema Único de Saúde, facilitando a desospitalização e proporcionando maior qualidade de vida aos pacientes e suas famílias. Contudo, sua implementação enfrenta desafios relacionados à articulação da rede e à escassez de insumos e profissionais. **Objetivo:** Analisar as práticas e as percepções dos médicos atuantes no Serviço de Atenção Domiciliar de Blumenau/SC sobre a implementação e a oferta dos cuidados paliativos. **Métodos:** Trata-se de uma pesquisa exploratória, de abordagem qualitativa, realizada com quatro médicos atuantes no serviço. A coleta de dados ocorreu em setembro de 2025 por meio de entrevistas semiestruturadas, e os dados foram submetidos à análise temática de conteúdo. **Resultados:** Os resultados indicam que o Serviço de Atenção Domiciliar é percebido como fundamental para a prática de cuidados paliativos, permitindo um entendimento singular da dinâmica familiar e social. Apesar desse potencial, foram identificadas barreiras significativas, como a limitação de recursos e profissionais; a desarticulação da rede, marcada pelo desconhecimento das atribuições do serviço; as demandas contínuas das famílias; e os limites da atuação médica, que exige uma gestão de problemas sociais para a qual a formação curativa não oferece preparo adequado. Destacam-se ainda a imprescindibilidade da equipe multidisciplinar e o complexo equilíbrio entre a padronização de protocolos e a individualização do cuidado. **Conclusões:** Embora o Serviço de Atenção Domiciliar seja um espaço potente para os cuidados paliativos, sua efetividade é limitada por lacunas na formação médica e pela fragmentação da rede de saúde. É necessário fortalecer a educação permanente em cuidados paliativos e aprimorar a articulação entre os níveis de atenção para garantir um cuidado domiciliar integral.

Palavras-chave: Cuidados Paliativos; Sistema Único de Saúde; Assistência Médica; Serviços de Assistência Domiciliar.

Resumen

Introducción: El Servicio de Atención Domiciliaria constituye un escenario estratégico para la oferta de Cuidados Paliativos en el Sistema Único de Salud, al facilitar la deshospitalización y promover una mayor calidad de vida para los pacientes y sus familias. Sin embargo, su implementación enfrenta desafíos relacionados con la articulación de la red y la escasez de insumos y profesionales. **Objetivo:** Analizar las prácticas y percepciones de los médicos del Servicio de Atención Domiciliaria de Blumenau/SC respecto a la implementación y práctica de los cuidados paliativos. **Métodos:** Investigación exploratoria, de enfoque cualitativo, realizada con cuatro médicos del servicio. La recolección de datos ocurrió en septiembre de 2025 mediante entrevistas semiestructuradas, y los datos fueron sometidos a análisis temático de contenido. **Resultados:** Los hallazgos indican que el Servicio de Atención Domiciliaria es percibido como fundamental para la práctica de cuidados paliativos, ya que permite una comprensión singular de la dinámica familiar y social. A pesar de este potencial, se identificaron barreras significativas: limitación de recursos y profesionales; desarticulación de la red, marcada por el desconocimiento de las atribuciones del servicio; demandas continuas de las familias; y límites de la actuación médica, que exige gestionar problemas sociales para los cuales la formación curativa no proporciona suficiente preparación. También se destaca la imprescindible labor del equipo multidisciplinario y el complejo equilibrio entre la estandarización de protocolos y la individualización del cuidado. **Conclusiones:** Aunque el Servicio de Atención Domiciliaria es un espacio potente para los cuidados paliativos, su efectividad se ve limitada por lagunas en la formación médica y por la fragmentación de la red de salud. Es necesario fortalecer la educación permanente en cuidados paliativos y mejorar la articulación entre los niveles de atención para garantizar un cuidado domiciliario integral.

Palabras clave: Cuidados Paliativos; Sistema Único de Salud; Asistencia Médica; Servicios de Atención de Salud a Domicilio.

INTRODUCTION

The definition of palliative care (PC) has been established as active, holistic care for people experiencing suffering due to serious illnesses that affect the physical, emotional, social, and spiritual dimensions, especially during the terminal phase.[1] This approach recognizes death as a natural process and can be applied throughout the entire course of the disease.[1]

Access to PC is essential to ensuring human dignity.[2] This care can be provided at different levels of care and in various care settings—ranging from home to specialized institutions—by professionals with basic or advanced training.[1]

The growing prevalence of noncommunicable diseases—the leading causes of global mortality—underscores the need to expand PC.[3] Although PC is often associated with cancer, more than 70% of the demand stems from other conditions, such as human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), dementia, cardiovascular and pulmonary diseases, tuberculosis, and cerebrovascular diseases.[3] The need for PC must encompass different stages of life and various contexts of illness.[4]

However, PC in Brazil remains concentrated in tertiary care due to the limited availability of services and a shortage of trained teams.[5] Studies show that integrating PC into Primary Health Care (PHC) improves symptom management, prevents hospitalizations, reduces costs, and increases satisfaction,[6] particularly by enabling the development of individualized and continuous care plans, thereby strengthening the bond between physicians, patients, and their families.[7]

In this context, Home Care Service (SAD; Serviço de Atenção Domiciliar) serves as a complementary and personalized strategy provided in the home, promoting a better quality of life.[8,9]

Despite these advances, PC in PHC is still rarely discussed and faces significant challenges.[10] Thus, it is necessary to strengthen strategies that broaden this dimension of care.[10]

In light of this, the following research question arises: how do physicians working in the SAD of Brazil's Unified Health System (SUS) perceive and practice palliative care? The general objective was to analyze the practices and perceptions of physicians in the SUS–SAD regarding the implementation of PC.

METHODS

This is an exploratory, qualitative study conducted at the SAD affiliated with the Municipal Health Promotion Department (SEMUS; Secretaria Municipal de Promoção da Saúde) in the municipality of Blumenau, Santa Catarina, Brazil, which provides complementary home care to SUS users—primarily following hospital discharge—offering clinical stabilization, rehabilitation, palliative care, facilitating discharge from the hospital, and support for families, since 2011.[11]

The four physicians working at the SAD were invited to participate in the study and formally agreed to participate by signing the Informed Consent Form. The inclusion criterion was defined as being a physician who had been working at the SAD for at least five months, and the exclusion criterion was being on vacation or leave during data collection, which took place in September 2025 through recorded interview supported by a semi-structured questionnaire.

For data analysis, the technique selected was Minayo's thematic analysis, comprising the phases of pre-analysis, exploration of the material, and interpretation of the results.[12,13]

This research was conducted in accordance with the guidelines of Resolution No. 466/2012 of the Brazilian National Health Council, ensuring the confidentiality of information and the anonymity of participants.[14] The project was submitted to the Research Ethics Committee for review and was approved under Opinion No. 7.687.428 (CAAE: 89073925.9.0000.5370). The study also received authorization from SEMUS, ensuring the institutional authorization required for its conduct.

RESULTS

Four physicians from the SAD in Blumenau participated in the study: one male and three females, aged 27, 45, 48, and 73. Three of the participants were married and had children, while one was single and childless. Regarding religion, two identified as Spiritists and two as non-practicing Catholics.

The time since graduation varied widely, from two to 48 years, as did the length of service at the SAD, which ranged from five months to 11 years, with specializations in Internal Medicine, Family Medicine, Palliative Care, Geriatrics, and Home Care.

The thematic analysis enabled the creation of four categories, namely:

- Palliative Care in Practice within the SAD;

- Challenges in Implementing Palliative Care;
- Clinical Protocols and Interdisciplinary Support; and
- Public Perception and Changes in Demand for the Service.

In the category "Palliative Care in Practice within the SAD," when asked about their own understanding and the effectiveness of PC in home-based care, all professionals reported viewing it as an effective and fundamental approach, aimed at promoting the patient's quality of life while minimizing their suffering and that of their family.

The physicians interviewed believe that closer contact—sometimes on a daily basis—allows for support that goes beyond the relief of physical pain and other symptoms and offers emotional support to the entire family. One professional emphasizes the importance of looking at the patient "beyond the diagnosis":

> *So, there's the issue of the patient's spirituality that is taken into account, their psychological well-being, and their social circumstances—whether financial vulnerabilities or care-related issues (M02). (our translation)*

From this same perspective, the interviews revealed an understanding that knowledge of family dynamics and the social context is a determining factor in the success of home care, and that care often extends beyond strictly clinical dimensions. On this point, one participant noted:

> *Since we're in the patient's home, the family issue is very important. Sometimes there's no support structure. [...] A large portion of our patients have social problems. There's no one to care for them, no one to provide the care. [...] We go into the home trying to guide them on what should be done—what's best, what's ideal (M01) (our translation)*

> *In the home, we can truly understand the family dynamics of that person, of that patient, what their vulnerabilities are, what their actual needs are, because not everything is a matter of diagnosis and treatment (M02). (our translation)*

Care management—whether due to the absence of a capable caregiver or the burden concentrated on a single family member—highlights not only a challenge but also the very structure of resources available to the patient, or the lack thereof. These resources include interpersonal relationships, which often remain invisible to the team in other care settings.

When addressing the limitations and difficulties of home care, accounts emerged that make up the category "Challenges in Implementing Palliative Care." Participants highlighted, among the main obstacles, the scarcity of resources and professionals available to meet care demands:

> *[...] we have a limited staff, so there should be more professionals, because there are so many patients [...], and greater availability of medication, which I still think is very limited (M02). (our translation)*

> *[...] our resources are very limited; although funding comes from the federal ministry for the SAD, it is not exclusively allocated to the SAD (M01). (our translation)*

Limited resources sometimes lead to reliance on hospitals to meet care needs, as one of the professionals notes:

> *Patients who are hospitalized, need to be discharged, and are on antibiotics, for example. The hospital provides the antibiotics, and we administer them at home [...] because if we had to rely on the service here, we wouldn't have any (M01). (our translation)*

Despite this limitation, doctors acknowledge the assistance provided by the public system and a certain degree of privilege in the local context:

> *We're privileged here in the SUS today, for example, in having access to morphine—something that's much harder to come by up North and in the Northeast. [...] Take fentanyl, for instance—it's simply not available in other places (M04). (our translation)*

The physicians report that the SAD itself is still, in many cases, not widely known within the healthcare network, which highlights the difficulty of effective communication regarding referrals, as well as weaknesses in integration and training across the different levels of care. These obstacles contrast with the service's crucial role in promoting patients' quality of life, as the participants emphasize:

> *And I still think that both the hospital that refers these patients and the health clinic are unable to refer them to us effectively […]. We depend on a regulation process in Blumenau; they come via SISREG [...] if the patient's needs aren't very clear, they often die before we can even reach their home. Or their clinical condition deteriorates significantly [...] There need to be other communication channels between these teams [...] (M02). (our translation)*

> *Just recently, I was at a training session held by the healthcare network—and there were only doctors there—and they told me that the SAD was only for changing catheters. So, even our own colleagues in the network don't understand it. So, we don't expect the general public to even know... what the SAD is and how it works, right? (M02). (our translation)*

> *Also, the lack of knowledge in primary care [...] we receive a lot of prescriptions, a lot of nonsense, especially regarding analgesia, wounds, and pressure injuries. I think that to improve our care, we'd have to provide training for primary care providers; I think that it would work better (M03). (our translation)*

However, another obstacle emerged from the interviews: the difficulty in managing expectations regarding the temporary nature of the service:

> *Sometimes we follow the patient for a few months and discharge them. And then they don't want to be discharged, right? [...] We even explain at admission that it's a temporary service, that it's for a short period (M01). (our translation)*

> *After some time in the SAD, the patient returns to their primary care facility. They aren't patients of the SAD; they're just under the SAD's care (M03). (our translation)*

Within the category "Clinical Protocols and Interdisciplinary Support," the responses highlighted perceptions related to the organization of care, care protocols, and the work of the multidisciplinary team. Participants emphasized that, in daily practice, care is often individualized and adjusted according to the demands that arise at the time, which means that clinical decisions rely primarily on accumulated clinical experience, making rigid approaches inappropriate in practice:

There's no way it could be rigid. Every patient is different (M01). (our translation)

So, when we're at the patient's home every week—or even more often—we know whether they're in pain or not; we end up identifying it, and sometimes we don't even need to use any kind of scale (M02). (our translation)

Although flexibility and continuous adaptation are indispensable in home-based PC (a reality that highlights the absence of formalized protocols), physicians simultaneously recognize the need for clear guidelines that enhance the safety and consistency of practices:

So, everyone kind of follows them, but they aren't documented (M02). (our translation)

We're trying to adjust the clinical protocols—especially now that we have a palliative care physician—to try to develop protocols so we can all speak the same language (M01). (our translation)

In addition, the importance of the multidisciplinary team's role was widely recognized, as it is considered essential for comprehensively addressing the patient's physical, emotional, and social dimensions:

You can't provide palliative care without a multidisciplinary team. A doctor alone won't be able to do it (M04). (our translation)

Concluding this analytical dimension, the category "Public Perception and Changes in Demand for the Service" emerges, in which participants point out that myths and taboos associated with PC still persist, factors that contribute to the initial resistance of family members and patients to accepting the therapeutic process.

There's still a lot of prejudice against palliative care [...] the taboo surrounding morphine and nutrition [...] palliative care is only for those who are dying! And that's not the reality (M04). (our translation)

The physicians highlighted the influence of the media and outreach strategies in transforming social perceptions and increasing demand for the service, fostering a more positive understanding of the importance of PC. One of the professionals emphasized that this change is a recent phenomenon:

The demand is much higher... it's becoming increasingly well-known and valued (M01). (our translation)

Oh, it's changed a lot, especially in the last two or three years, because of the media (M03). (our translation)

Another point mentioned concerns gaps in medical education and professional culture, linked to the lack of public policies and specific regulations. This scenario reinforces the notion that success in medical practice is exclusively linked to curing, rather than to the alleviation of suffering. Overall, the reports also indicate a gradual shift in cultural and institutional attitudes, in which PC is beginning to be recognized as a central aspect of health care, guided by the dignity and holistic well-being of the individual.

DISCUSSION

The effectiveness of the SAD as an essential setting for the practice of PC emerged as one of the main findings of this study. Physicians emphasized that home-based care enables a broader understanding of the patient's reality, including family dynamics, social conditions, and interpersonal relationships—aspects that are often overlooked at other levels of care. This unique aspect of home care is related to the nature of PHC, which maintains closer ties with individuals, families, and communities, differing from secondary and tertiary care levels, which are generally located outside the area where the patient lives.[15]

Continuous monitoring and the shared development of care plans serve as pillars of this practice, promoting integration among services and ensuring continuity of care. From this perspective, the transition of care emerges as a fundamental strategy for optimizing health resources and improving the quality of life of patients and their families,[16] while also contributing to the appropriate use of hospital beds, prioritizing them for acute or decompensated situations.

However, the findings of this study reveal a significant contradiction: although the SAD plays an essential role in the healthcare network, a lack of understanding regarding its responsibilities persists even among the system's own professionals. According to physicians' perceptions, misinformation and the absence of effective communication channels compromise the service's potential, leading to inappropriate referrals and prescriptions, which undermine continuity of care.

This disconnect is not an isolated phenomenon, but a challenge widely described in the literature on the PC transition. Communication failures among teams compromise patient safety, causing insecurity, confusion, and anxiety among patients and their families.[17] It is therefore necessary to strengthen communication flows and interprofessional collaboration to ensure continuity and comprehensiveness of care.[17]

A second significant barrier identified in this study concerns the discrepancy between families' perceptions—who expect continuous and permanent care—and the transitional nature of the SAD. This divergence stems from the very purpose of the service, which was conceived as a PHC strategy to reduce the burden on the hospital-centered system.[18]

The difficulty in understanding on the part of families, however, is directly related to another structural barrier mentioned by the interviewees: social fragility within the home. This interdependence is observed in cases of social vulnerability and care transitions. In these contexts, family caregivers are reported to face moderate-to-severe difficulties following hospital discharge, with the social domain being the most affected.[19]

Thus, resistance to discharge can be understood more comprehensively, going beyond an explanation centered solely on a lack of information about the nature of the service. This situation reflects a legitimate fear among families, who feel unprepared to provide comprehensive care after the disruption of their bond with their primary source of security.[19] This social vulnerability manifests itself in the fear of handling emergencies at home without adequate support or in the belief that the home care service lacks sufficient resources for critical situations.[19]

In this context, one of the most complex aspects of managing home-based PC becomes evident: the challenge of reconciling the logic of a transitional service, such as the SAD, with the philosophy of continuous care that underpins the principles of PC.[1]

Given this scenario, the recent Brazilian Ministry of Health Ordinance (GM/MS) No. 3,005/2024 recognizes the importance of comprehensive and continuous care by establishing the Home Care Modality 3 (AD3; Atenção Domiciliar tipo 3), aimed at patients whose clinical condition makes definitive discharge difficult.[20] Furthermore, the discussion regarding the fragmentation of the healthcare network and the complexity of discharge leads to another key finding: the SAD exposes the limitations of traditional medical practice.

This limitation is a direct reflection of the gap in training within a purely curative system—a challenge documented in the Brazilian context. Among the challenges faced by faculty responsible for teaching PC, there is a limited understanding of the topic's importance among clinical instructors and within the health system in general, emotional discomfort, and, above all, conflicting clinical perspectives that complicate the teaching process.[21]

This systemic culture of denial of death and the dying process—in which healthcare professionals are not prepared to understand finitude as a natural part of existence[22,7]—has direct repercussions on training and clinical practice. This context compromises the quality of the professional-patient relationship,[23] contributes to the perpetuation of reductionist views and creates barriers to the incorporation of PC into health services.[7]

In order to address these educational shortcomings, the Brazilian National Education Council (CNE; Conselho Nacional de Educação) recognized, in 2022, the need to include education and training in PC in medical undergraduate programs.[24]

However, even with advances in initial training, significant challenges remain when professionals enter clinical practice, where the complexity of care demands continuous professional development and institutional support.

Given this context, the identified challenge concerns striking a balance between the standardization of clinical protocols and the need for care centered on each patient's unique circumstances. The lack of formal, standardized materials in institutions leads to variations in the quality of guidance offered to family caregivers.[25] In this regard, individualized PC and symptom management plans, accompanied by written and accessible instructions, can promote autonomy, safety, and preparedness among patients and caregivers in the care process.[26]

Accordingly, to prevent standardization from resulting in rigid practices, a flexible approach is necessary—one grounded in communication, advance care plan, symptom control and relief, and team management.[27] This approach presupposes a profound cultural shift in medicine, shifting the focus from curing alone to improving quality of life.

In recent years, there has been steady progress, with significant growth in services since the 2000s.[28] In this context, the aging population and the increasing demand for continuous care underscore the need for structural changes. The approval of the Brazilian National Palliative Care Policy (PNCP; Política Nacional de Cuidados Paliativos) in 2024 marks a milestone by consolidating PC as an essential component of the SUS, integrating PC into the Health Care Network—from primary care to home-based care and the hospital setting.[29] With regard to human and structural resources, the shortage of trained professionals and the lack of implementation of public policies aimed at strengthening PHC in this field continue to hinder the expansion and institutionalization of PC throughout the country.[7]

Although Palliative Medicine was recognized as a field of practice in 2011,[30] it remains a subspecialty in the country, and the Brazilian National Academy of Palliative Care advocates for its consolidation as a medical specialty.[28]

Despite the weaknesses at the national level, the findings of this study highlight significant local advances, such as regular access to essential medications, which are often limited in other regions of the country. This distinction, perceived by physicians as a "privilege," demonstrates how the quality of care depends not only on national guidelines but also on the priorities and commitment of local management.

In summary, although the country is making progress in structuring the PNCP, the consolidation of effective practices within the PHC system still requires continuous investment in professional training, intersectoral integration, and management strengthening. Only through this coordinated effort will it be possible to transform isolated advances into a sustainable model of care centered on dignity, comprehensive care, and the quality of life of patients and their families.

A strength of this study is its ability to shed light, from the physicians' perspective, on the structural and organizational aspects that influence the provision of PC within the SAD, particularly in the context of PHC. A limitation acknowledged is that the study was conducted in a single service, which may restrict the range of professional experiences and limit the generalizability of the results to other settings within the SUS.

Even with these limitations, the findings offer relevant insights for practice and research. In the field of care, they highlight the need for continuous training of teams, the formalization of protocols that do not stifle care, and the strengthening of communication flows between points in the network. These elements are essential for ensuring safe transitions, expanding families' autonomy, and consolidating the role of primary health care (PHC) in coordinating care. From a scientific perspective, the results highlight the importance of studies investigating strategies for integration between SAD, hospital services, and specialized teams, as well as research evaluating the impact of recent policies, such as the PNCP and the AD3 model, on the local organization of services. Advancing in these areas is essential for transforming isolated experiences into sustainable models that promote dignity, comprehensive care, and quality of life.

CONCLUSION

The results reveal that SAD physicians recognize PC as an essential component of comprehensive care, associated with comfort, dignity, and quality of life. Their practices demonstrate a human-centered approach, active listening, and clinical management focused on alleviating suffering, reinforcing the role of the SAD in PHC. Despite structural and training challenges, the teams seek to integrate PC principles into their daily practices.

In conclusion, the incorporation of PC into the healthcare network strengthens the resolutiveness and humanized nature of the SUS. However, it is necessary to strengthen permanent education in PC and improve coordination among levels of care in order to ensure continuous and dignified home care.

CONFLICT OF INTEREST

Nothing to declare.

AUTHORS' CONTRIBUTIONS

DMS: Conceptualization, Formal Analysis, Methodology, Writing – Review & Editing. GRF: Data Curation, Formal Analysis, Writing – Original Draft, Writing – Review & Editing. JFR: Data Curation, Formal Analysis, Writing – Original Draft, Writing – Review & Editing.

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