

ONCOLOGICAL PAIN OF HOSPITALIZED PATIENTS IN PALLIATIVE CARE: AN INVESTIGATION OF THE OCCUPATIONAL THERAPY PRACTICE

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Highlights: (1) Important gaps were found in terms of pain assessment. (2) There are similarities in the *modus operandi*, however, systematic patterns were not verified in occupational therapy interventions. (3) The professional narratives showed generalist practices.

PRE-PROOF

(as accepted)

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ABSTRACT

This study aimed at investigating the occupational therapy practices in relation to the oncological pain of hospitalized patients in palliative care. It is a descriptive study which used a qualitative approach, and counted with the participation of 10 occupational therapists acting in hospitals, specifically in infirmaries who treated oncological patients in palliative care, with

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minimum experience of 3 months. Procedurally, the snowball method was used and the data collection was performed via Google Meet interviews. The content was transcribed and systematized through thematic analysis. Averagely, the age of participants was 31,3 years-old, acting for 5,1 years and working with palliative care for 4,4 years. From the content gathered in the interviews, three thematic categories emerged and culminated in the systematization of seven subcategories. In this article, the focus is on the *Modus operandi* of the occupational therapists treating oncological pain category, which is divided into four subcategories (Work schedule, Knowledge and use of tools in pain assessment, Resources and techniques used for pain management, Documentation in medical records). Frailties were identified in the *modus operandi*, especially regarding the assessment process. Nonetheless, the acting characteristics presented by the occupational therapists showed associations of pain with the occupations, a relevant aspect in favor of defending the specificities of this profession.

Keywords: pain; palliative care; occupational therapy.

INTRODUCTION

The palliative care (PC) is constituted by holistic practices which focus on people who suffer from limiting and life-threatening illness. The actions are extended to the family unit which supports the care, considering prevention and suffering relief in benefit of quality of life (1).

Although PC configures a human right, global indicators show that more than 60 million people display severe suffering from life-threatening illnesses, a factor that could be prevented through PC. In these statistics, there is a diverse range of illnesses in which oncological diseases take up a share of 28,2% (1).

Cancer is one of the main causes of death in the world as well as the main public health issue. It also corresponds to one out of four main premature deaths in most countries around the globe (2).

The symptoms and multidimensional concerns which people with cancer and other conditions experience impact significantly in their quality of life. The prevention and suffering relief are the center of palliative interventions, which must be held by a multiprofessional team through interdisciplinary actions.

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Through article 8, section I, from ordinance GM/MS nº 3.681, since May 7th 2024, which institutes the *Política Nacional de Cuidados Paliativos - PNCP* (National Palliative Care Policy) as part of *Sistema Único de Saúde - SUS* (Brazilian Unified Health System) it is stated, among the assistencial team's attributions, the necessity of holding broad assessments which aim to promote pain relief and other symptoms, considering physical, psychological, emotional, spiritual and social needs of the ill person.

Regarding the pain, specifically, the symptom is defined as a “sensitive and emotionally unpleasant experience that is associated, or similarly associated, to a real or potential tissue injury.” (4) Considered the fifth vital sign, the pain comprises several physiological, emotional and cognitive processes, and its main function in the body is to activate protective responses, as an alert which aims to reduce possible tissue damage (5).

An interview and physical exam is required for the pain assessment, as to identify the type of pain and comprehend its impact on the person regarding their biopsychosocial and spiritual states. During the interview, it is imperative that the information related to quality (pain sensation), location, factors which trigger improvement or worsening of the symptom, the intensity and frequency of the pain, impact on daily-life activities, functionality, sleep quality and repercussions in the quality of life (6). Additionally, a physical evaluation must be performed in order to identify the presence of alterations in sensory and motor function.

The pain impact on the patient's ability to engage in meaningful occupations and their biopsychosocial are aspects which outline the importance of occupational therapists as essential members of the multidisciplinary team, which is focused on pain management (7). Occupational therapists must be qualified in order to conduct a complete evaluation as to not only identify performance deficits but also preserved and potential skills, aiming to develop a specific and unique treatment plan so patients are able to return to their priority occupations (8).

Relying on evidence-based practices, the occupational therapists, through a holistic and broad manner, must thoroughly evaluate the structural, physiological, psychological, environmental and personal factors that influence the pain experience. Through this assessment, self-management strategies, functional activities, practical techniques and specific

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exercises for function and participation improvement might be applied, according to the therapeutic goals established collaboratively between the patient and the therapist. (8)

From this perspective, the focus of occupational therapists in palliative care is to contribute to patient empowerment through activity management. This includes activity analysis, skill development, activity adaptation, problem-solving, prioritization, planning and pacing, as well as the use of ergonomics, communication skills training, coping strategies, relaxation, stress management, and environmental modification (9). Overall, occupational therapists are responsible for assisting patients in identifying and incorporating self-management strategies into their daily routines in order to reduce pain and promote participation in meaningful occupations, with the aim of improving quality of life (10).

Given the information above and considering evidence from the literature regarding the role of occupational therapists in pain assessment and management, as well as the fact that pain is one of the most prevalent symptoms among patients receiving palliative care (especially those with advanced cancer [1]), it is evident that there is a lack of studies investigating how these principles have been operationalized in clinical practice. Therefore, this study was guided by the following research questions: What are the characteristics of occupational therapists' practice in oncological pain care for hospitalized patients receiving palliative care? Has this interventional process been carried out in a systematic manner? Consequently, the main objective of this study was to investigate the practice of occupational therapists in oncological pain care for hospitalized patients receiving palliative care.

METHOD

This is a descriptive study with a qualitative approach. As for inclusion criteria, the study considered occupational therapists working in hospital settings, specifically in infirmaries who treated oncological patients in palliative care, with minimum experience of 3 months.

Occupational therapists who had hospital experience in oncological palliative care but were not active during the data collection process, graduate students in training, professionals

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acting in oncological palliative care for pediatric patients and occupational therapists who were working in the hospital administration area were not considered for this study.

For data collection, a characterization form and an interview guide were developed by the researchers. These instruments were assembled based on a review of the relevant literature and were submitted to three expert judges with experience in hospital-based occupational therapy and/or palliative care. The judges assessed aspects such as clarity, coherence, language, question sequencing, and alignment with the study goals. This analytical process resulted in suggestions for the inclusion of additional questions in the interview guide, which were incorporated by the researchers. Moreover, a pilot study was conducted, leading to the need to revise the order of the interview questions, as well as to rephrase one of the questions to improve comprehension and better achieve the study goals.

Taking these processes into account, the final version of the characterization form included information on the participants' professional profile, such as name, age, time since graduation, length of experience in hospital settings, length of experience in oncology, length of experience in palliative care, city/state of practice, type of hospital, and postgraduate training. The interview guide, therefore, aimed to understand the characteristics of occupational therapists' practice in palliative care, including exploration of care dynamics, professional knowledge about pain, and difficulties experienced in this area.

Data collection was conducted through the snowball method, which is a non-probabilistic sampling technique based on chains of referral. In this method, sampling begins with key informants, referred to as seeds, who identify other potential participants, who indicate further participants, resulting in a referral chain of study participants (11).

Five occupational therapists were selected as seeds for this study and they belonged to leading oncological hospitals, one from each region in Brazil (North, Northeast, Midwest, Southeast and South), according to the inclusion and exclusion criteria mentioned above.

The participants were contacted via e-mail through an invitation message, which contained all the information about the research goals and means of participation, as well as the contact of the researcher for questions and further information if necessary. Upon acceptance, the participant would receive the access link to the informed consent for reading and agreement. After filling out the informed consent, the interview appointment was set according

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to availability. Then, the link to the virtual call was sent 24 hours prior to the appointment along with the interview script.

This methodological process included 27 invitations to participate in the research in total, resulting in the participation of 10 occupational therapists, as shown in Figure 1.

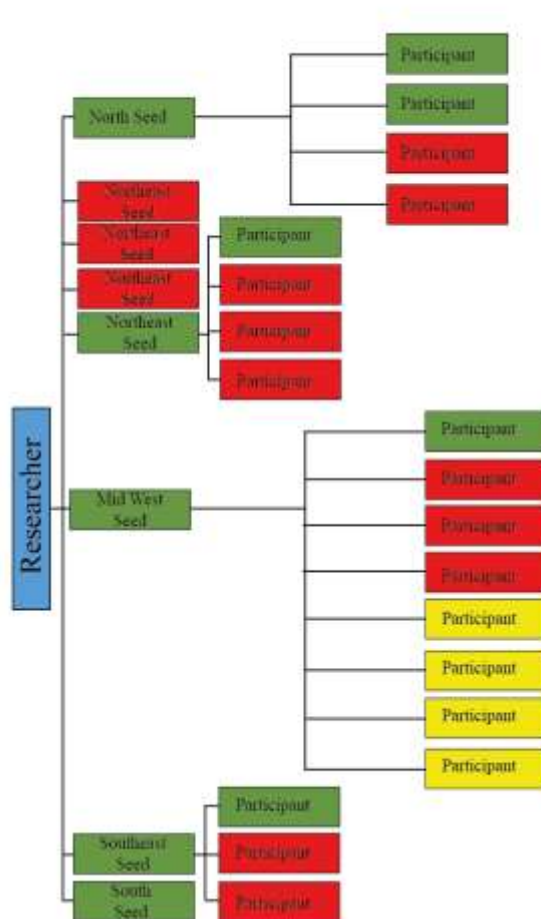


Chart legend:

- Participated in the research;
- Seeds and indications that did not respond;
- The nominations were answered, however, they did not meet the criteria.

Figure 1- Data collection flow using the snowball method.

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The interviews were conducted virtually through the *Google Meet*® platform, lasting 40 minutes on average, in accordance with the recommendations issued by the Ministry of Health regarding research procedures involving any stage carried out in a virtual environment (12).

By the end of each interview, the recording generated by Google Meet® was downloaded and stored on a local device without internet access, in order to ensure data security. The audio recordings were fully transcribed by the researcher for thematic analysis (13). Data obtained from the characterization form were summarized using simple descriptive statistics.

The study followed the principles set forth in Resolution No. 466/2012 of the National Health Council (CNS) and was submitted to the Research Ethics Committee of the Federal University of São Carlos, receiving approval under opinion No. 5.923.631.

RESULTS

Participants profile

Considering the participation of 10 occupational therapists, the respondents' characteristics showed a predominance of women (n = 9), with ages from 24 to 45 years and a mean age of 31.3 years.

Geographically, three participants practiced in the Northern region, two in the Northeastern region, two in the Southeastern region, two in the Midwestern region, and one in the Southern region of the country.

Regarding professional experience in hospitals, a length of practice ranging from six months to 12 years was verified, with a mean duration of 5.1 years. Concerning experience in palliative care, the average length of practice was approximately 4.4 years, with a minimum of six months and a maximum of 12 years.

With respect to acting location, most of the interviewees work in public hospitals (n=9), as only one participant acted in a private hospital. Regarding the weekly workload dedicated to hospital care and palliative care, half of the participants (n = 5) reported working 30 hours

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per week, while three participants reported a workload of 60 hours per week due to holding positions as resident occupational therapists. Moreover, one participant reported dedicating 25 hours per week exclusively to PC, while another reported dedicating 12 hours per week.

Thematic categories

Based on the information gathered from the interviews, three categories were established: 1) Challenges concerning oncological pain management, 2) Repercussion of the oncological pain in occupations and 3) *Modus operandi* of occupational therapists' practice regarding oncological pain. Those originated subcategories, according to the systematization on the chart below:

Chart 1. Thematic analysis systematization

CATEGORIES	SUBCATEGORIES
Challenges concerning oncological pain management	Fragilities in the interdisciplinary work and restrictions in the medicine prescription for analgesics Professional knowledge restrictions and short professional experience
Repercussion of the oncological pain in occupations	Activities of daily living
<i>Modus operandi</i> of occupational therapists' practice regarding oncological pain	Work routine Knowledge and use of pain assessment tools Resources and techniques used for oncological pain management Medical form documentation

Source: Author (2025)

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In this article, the *modus operandi* theme and its subcategories will be presented, considering the scope designed for this work and the need to address the research questions and objectives initially presented.

***Modus operandi* of occupational therapists' practice regarding oncological pain**

The hospital care provided by occupational therapists was described by participants through information about their daily work routines, the assessment process with oncological patients receiving palliative care and experiencing pain, and the interventions implemented with these participants. The convergence of this information allowed for a closer understanding of the *modus operandi* of this practice.

Subcategory: Work routine

In the narratives related to work processes, it was verified that, within occupational therapists' routines, professionals run an assessment of care demands at the beginning of their shifts. This process is carried out through both active case identification and referrals from the healthcare team, as well as through bedside visits, which are mainly conducted multiprofessionally.

We do active search, but we also provide care upon request from other professionals, from the medical team to the rest of the multiprofessional team.(Participant 5).

I do active search, and also my colleagues already know about occupational therapy in this area and thank God in palliative care it is pretty well known. (...). Sometimes I arrive at the unit and there are some patients that the teams requires my attention. (Participant 8).

When we get to the infirmary, we start by screening the patients who are in the clinic. Most of the time, since it is not only me, other people and I share the work... (Participant 1).

I usually do the visit, check all the demands, [...] during the visit I assess them and, for the patients who are already being seen, I check what is the demand for the day so I can follow up, or in case there is a new demand, or whether anything changed in the clinical status, but this is the process I usually like to go through. (Participant 3).

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Nowadays we are structured in a multiprofessional manner, so we do a multiprofessional visit. We do the visit early in the morning with most part of the team, and we end up screening the patients who need our attention more immediately, (...) then we do the screening visit, then according to the screening we direct our care for those patients who we know we can work best with (Participant 6).

Based on the screening process, it was possible to observe that occupational therapists adopt eligibility criteria for patient care as a means of establishing priorities. These criteria are founded on aspects such as the severity of the clinical condition, functional status, whether the patient is already under follow-up, and institutionally established urgencies.

I am responsible for 25 beds, let's say, although it sometimes varies. So I look at which patients are there, I see those I already know or who have returned, I assess KPS, and then I always try to select those with a somewhat better KPS. I also take age into account. I pay close attention to age and some diagnostic factors (Participant 4).

Priority is given to patients we see every day, so we classify patients who require daily care as a priority (...) these are priority 1 patients for daily care. Priority 2 patients are those we need to see two to three times a week, usually just twice. Patients who are already ambulating, who are independent, who have a caregiver that is aware, and whom we can guide so they can carry out our semi-independence guidelines regarding activities of daily living (...) Priority 3 patients are those who are stable, functionally independent, with preserved motor and cognitive functions, but whom we still make sure to see (Participant 7).

Eu dou prioridade para aqueles que eu já estou acompanhando. Então como é pouco tempo para uma quantidade grande de pacientes então a gente dá prioridade para aqueles que têm maior demanda, que a gente pode ter mais trabalho funcional com eles (Participante 10). I give priority to the ones I am already following. Since there is little time for a large number of patients, we prioritize those with greater demands, with whom we can do more functional work (Participant 10).

[...] consultations in the hospital are categorized as urgency, emergency, relative urgency, and admission (Participant 2).

The evaluation process of oncological patients experiencing pain is operationalized through the gathering of targeted information, as well as through the assessment of the impact of this symptom on occupational performance.

We verify the issue of patient mobilization, whether they will experience pain when mobilizing, pain when holding a spoon, pain when getting up, going to the bathroom,

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doing their basic needs, or bathing (...) we assess through occupations (Participant 1).

Yes, I assess the patient. I do the interview, as I explained to you, with the family and with the patient when they have a certain level of awareness. Then I try to understand what this patient's limits are, what the patient is currently able to tolerate doing (Participant 2).

I try as much as possible to identify what causes the pain, for example, during the shower, to see whether I need to think about some type of adaptation. So I work based on discomfort, I try to approach it from that angle, because sometimes even bed bathing becomes uncomfortable and painful (Participant 4).

I observe whether this pain is interfering with performance, especially in activities that the patient identifies as something they would like to be doing but are not being able to. I always return to these questions. For example, if the patient says 'I can't sit,' and we see that the pain is not severe enough, we try positioning the patient in sitting and evaluate whether it is a postural issue that can be adjusted with cushions or other supports (...) We then perform these kinds of tests, range of motion, positioning, but mainly focused on activity performance itself. So if the patient says, 'I can't feed myself, I have a lot of pain in my cervical region,' and if it is related to oncological pain, I ask whether movement causes pain, whether they can show me how far the pain goes. We perform these tests based on performance, mobility, and observation according to what the patient reports (Participant 6).

So, I make my own evaluation script, but it is already internalized here. (Participant 8).

The use of standardized assessment protocols was not mentioned by occupational therapists. The narratives revealed an assessment approach centered on information gathering and observation of the relationship between pain and occupational performance. Nonetheless, there was evidence of limited analytical differentiation regarding pain typology, as well as a lack of systematic physical examination procedures.

As observed, participants' stories did not provide details regarding the assessment process. In light of the assessment information described in the previous paragraphs, occupational therapists also broadly reported the interventional practices implemented following the evaluation. On this matter, it was evident that participants primarily intervened through training in activities of daily living (ADLs), using adaptive strategies and resources aimed at promoting independence during functional mobility, bathing, and feeding, while considering the influence of pain in the process.

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We do a lot of gait training, a lot of mobilization, daily activities practice, (...) (Participant 1).

(...) we try to think of adaptation strategies, to make that moment possible, whether that makes sense to the patient, you know? Then, we adapt it in the bed. I have made some adaptations (...) And then, this is the way we have been working so that it is possible for the patient to perform the activity. Most of the time, even when the patient is in pain (...) we train a little bit every day and check the pain issue, if the pain starts to improve, we are able to move forward in that practice. We do it every day, so we do this practice with them step by step considering that the issue always comes from the pain (Participant 2).

Then, after the assessment, I start the prescription of energy conservation measures and task adaptations aimed at conserving energy. I identify what the patient's demand is at that moment in relation to maintaining independence and functionality. (Participant 8).

In adaptation, for instance, we work on the patient trying to sit up, walk to the wheelchair, eat, their ADLs. We make adaptations that will not force a movement that might cause them pain - this is a work we do a lot (Participant 10).

In participants' reports, references were made to clinical situations in which patients were experiencing aggravation of pain. In this context, different professional approaches to managing this clinical situation were observed, ranging from the decision not to implement interventions to the adoption of interventions involving activities drawn from the occupational repertoire and relaxation strategies.

Accounts associated with the absence of interventions in situations of acute pain reflected an understanding that such cases require initial pharmacological investments, and by such means limiting the role of the occupational therapist in this scenario.

A patient who is having acute pain, managing this patient was initially very difficult for the team. This is a patient who cannot tolerate sitting. When we attempt to change their position in bed, they experience significant pain. In this case, there is really nothing that can be done (Participant 2).

If the physical pain is not in control, I cannot act regarding the other pain demands (...) so I will not be able to do it if the physical pain is not controlled (Participant 3).

The more acute pains were the cases in which the doctor had already intervened with medication (...) so I was not able to work directly when the patient had acute pain (Participant 10).

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On the other hand, there were participants who implemented interventions in situations of acute pain exacerbation, using meaningful activities and relaxation techniques to support pain management.

Então utilizo alguma atividade significativa para aquele paciente com dor aguda, para que ele possa ocupar a mente dele e possa se sentir melhor a utilização da música, a utilização de pintura, a utilização de recursos significativos para ele (Participante 1).

(...) acredito que técnicas de relaxamento seriam uma das estratégias que seriam positivas nesse momento (Participante 10).

In addition, it is important to state that one of the participants mentioned during the acute and chronic pain interview that the same intervention protocol is applied for both situations.

I basically follow the same protocol (Participant 8).

Subcategory: Knowledge and use of pain assessment tools

It was observed that the instruments most regularly reported were intended to identify pain intensity levels, and that the participants' knowledge regarding pain assessment instruments showed use of and familiarity with those most commonly employed in routine clinical practice.

We have another standard in the hospital which is the pain scale: zero means no pain and 10 means total pain. (Participant 1).

(...) with palliative patients we work in a different way, I included the PPS, the VAS scale (Participant 2).

(...) We have it in our clinic, we mainly use two assessment scales. One is the PPS for performance, and the other is the ESAS, which includes a specific item for pain, rated from 0 to 10, and in case the patient is unable to provide a numerical

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rating, we then resort to a visual analog scale. In this way, they can indicate their pain level using hand or finger movements within the visual analog scale (Participant 3).

We end up asking by the visuals, like the “moderate pain,” “from zero to ten,” “highest pain/lowest pain”(Participant 4).

We usually only use the VAS scale. It is too subjective, right? If we think about it, the pain is subjective because each person will feel it in a different waye (Participant 5).

We have adopted either ESAS or VAS as a standard. We use those in bedside situations or that pain scale, the one we ask the patient and they answer from 1 to 10 (Participant 6).

In our practice we use the visual scales, the number scale, VAS, NRS and so forth, so we can have a parameter and then we will be able to evaluate and reevaluate on the very same day(Participant 7).

I use that pain scale, the classic one, right? I use the VAS results for classification. (Participant 8).

In that case I use PPS, KPS and VAS (Participant 9).

(...) the analogical scale, from 0 to 10, then I will do the visual analogue assessment. I ask the patient how strong their pain is from 0 to 10, where they are feeling it, the sort of pain... The sort of pain has a high impact, whether the pain is constant or it has a peak, because that will affect the patient’s quality of life (Participant 10).

Based on the information above, it was verified that only one participating professional reported exploring aspects beyond pain intensity, such as the location, type, and frequency of the pain symptom. It was also noted that the most frequently cited instruments were focused on measuring pain intensity, including the Visual Analog Scale (VAS), the Edmonton Symptom Assessment System (ESAS), and the Numeric Rating Scale (NRS). Notably, although the question specifically addressed pain assessment, Participants 2, 3, and 9 mentioned the use of the PPS (Palliative Performance Scale) and the KPS (Karnofsky Performance Scale), which are instruments aimed to assess functional performance in patients receiving palliative care rather than pain itself.

Regarding knowledge of pain assessment instruments beyond those routinely used in clinical services and the participating occupational therapists’ own practices, variability was observed. This ranged from a lack of knowledge, to expressions of partial knowledge without accurate identification of instruments, to more comprehensive and expanded knowledge of pain assessment tools.

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Part of the participants stated that they do not possess any knowledge about instruments other than the ones which were operationalized in their service:

Only the ones we use in the clinic. I cannot recall it by name exactly. For specific pain evaluation, no (Participant 2).

I am not familiar (Participant 5).

VAS and PPS, I have no knowledge about any others (Participant 9).

On the other hand, part of the participants affirmed having knowledge about other instruments and/or initiatives to seek further familiarity with them. During the interview, however, they were not able to specify which instruments those would be.

We have knowledge of other instruments. By the way, in the current ANCP (National Academy of Palliative Care) manual, there are a few pain scales which are nice, but we do not use them (Participant 6).

We have been doing research, really. I will be very honest, now I cannot remember because in the past week I was searching for some online and I found some interesting information, but I have not read it yet (Participant 8).

I know some, but to be honest, I have not applied them (...) I know some other ones but I forgot their names (Participant 10).

Only one participant was able to precisely mention instruments about which they possess no knowledge, but those are not recurrently used in their routine:

The Faces scale, VAS, the Behavioural Pain Scale, which is used in the ICU. We also have another one that is very interesting: I recently became familiar with the PAINAD scale for dementia, which we used with two of our patients who had cognitive decline, and it was very interesting to use (Participant 7).

Considering practical aspects of pain assessment instruments, the participants reported aspects related to the frequency of reapplication of assessment instruments throughout the care process. On that matter, only one participant mentioned not conducting reassessments through the reapplication of pain measurement instruments.

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I do not conduct reapplications. Because sometimes there is not enough time, because this is our reality, unfortunately, and I do not know what it is like in other clinics: when patients come in for palliative care hospitalization, they come in too late. Unfortunately, those are patients who we cannot treat for too long or discharge them. We have not been able to establish this in our routine because of how late they arrive for treatment (Participant 8).

For the remaining participants, the reapplication of pain assessment instruments is part of their routine. However, variations regarding the frequency of reapplications were observed.

At least once a week. While that patient is with us in the clinic, they have not been discharged or have not passed, we keep reapplying the test at least once a week (Participant 1).

I reapply it daily (Participant 2).

Usually, during the visit, we apply a pain assessment basically every day (Participant 3).

(...) I only reapply it if the patient gets rehospitalized or if I notice any changes, in case the profile or demands have changed. But it is mostly under these criteria: rehospitalization, hospitalization or change in clinical picture (Participant 4).

I like to ask the patient, in the beginning and in the end of my service, so I know in case there is any alteration (Participant 5).

Sometimes we reapply right after the activity in order to check whether it has caused any effect (Participant 6).

(...) So, it turns out that we evaluate and re-evaluate our patients almost every day. I don't have a fixed schedule to tell you, like, 'we will reassess and formally reapply the instrument.' That doesn't really work for us in practice, you know? It works much more in the daily routine. As I mentioned, there are patients who are in one condition in the morning, and by the afternoon I already need to record that their pain has become worse, and that is already a reapplication. (Participant 7).

Let's say weekly, for instance, but that is for a patient who is stable, something that is not acute and that speaks more to disease progression, to the process of finitude, so we tend not to rely as much on these instruments. (Participant 9).

Every time I go to the bedside, whether it is to make an intervention or for a visit, I make those re-evaluations (Participant 10).

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It was identified that the frequency of reapplication of pain assessment instruments varied, with reports indicating daily, weekly, during the intervention itself, or depending on clinical circumstances and hospital dynamics.

Subcategory: Resources and techniques used for oncological pain management

. It was observed that participants reported using several resources in their practices. There were remarks made regarding the use of techniques and resources related to positioning and movement facilitation, which seem to reflect strategies aimed at improving pain associated with musculoskeletal components.

(...) Decompression orthoses are what we use most frequently in the clinic; they are usually what makes up most of our routine (Participant 3).

(...) Positioning, use of cushions, especially for patients who are highly bedridden and have pain related to immobility itself, decompression orthoses (Participant 6).

(...) Positioning in bed to decompress the bone areas (Participant 8).

Adaptation, for example, we work with the patient when they are trying to sit, trying to move to a wheelchair, while eating, ADLs, that sort of thing. We make adaptations that avoid movements that cause pain. This is also a work that we do a lot (Participant 10).

(...) I am used to always working with assistive technology. For example: when a patient has a strong desire to feed themselves, we have adaptive devices available in the clinic, and I personally make some of them (Participant 1).

(...) I can work on adaptations too, it varies a lot (Participant 4).

We create strategies through adaptations as we go, so that we perform an activity in a different way, you know? (Participant 2).

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Another resource that emerged from participants' accounts involved recommendations for the use of self-regulation techniques, such as relaxation and breathing techniques.

Relaxation techniques (Participant 1).

Breathing techniques for the patient, we conduct the breathing techniques for them (Participant 3).

Massaging, breathing, I use a lot of Yoga methods with them (Participant 8).

The guided breathing technique is the pinnacle of resources available in occupational therapy (Participant 9).

The meaningful and patients' interests activities were also mentioned as non-pharmacological measures employed in pain control by the participants.

For pain management I usually use (...) meaningful activities for the patient (Participant 2).

We end up using the patient's interest activities (...) (Participant 6).

I think that what I use most often is a meaningful activity (Participant 9).

Three participants mentioned employing energy conservation techniques among the resources used. However, they did not clarify how the use of these techniques related to pain management.

(...) The energy conservation technique (Participant 1).

I see that energy conservation techniques can reduce pain significantly (Participant 4).

(...) The energy conservation measure (Participant 8).

An absence was noted in participants' reports regarding other non-pharmacological strategies which are scientifically recommended, such as pain education, sleep hygiene, and integrative practices.

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Subcategory: Medical form documentation

In regard to the information about the *modus operandi* of occupational therapy practice, participants reported that, among the procedures performed, they prepare medical record entries in order to document their conduct and facilitate communication among healthcare professionals.

In the hospital we have an electronic medical record (...) We are able to compare and document information through it. We then print it and place it in the physical medical record as well. But everything remains recorded in the system, and the entire team has access to it (Participant 2).

The hospital has an electronic medical record, so every time we provide care, we document it. At least in occupational therapy, particularly in the clinical oncology ward, we tend to describe our conduct (Participant 5).

We have operationalized this daily care control, which is from occupational therapy, from oncology, for instance (...), we have an electronic medical record (Participant 6).

I usually write it in a descriptive way on the medical record what has transpired during the service (Participant 7).

I add the material I use in the electronic medical record (...) not specific or in detail. We include, for instance: resignify the hospital context, we include exactly what was done (Participant 10).

In relation to pain data in the composition of medical record documentation, only two participants mentioned including detailed descriptions of the symptom in their written records.

I include in my medical record the relevance of that pain, what the patient has mentioned, according to the pain scale. I also add the activities I proposed to that patient and I include how he felt towards those procedures (Participant 1).

We usually add to a checklist what symptoms and pain the patient presented, then I describe the resource I used with that patient for their pain. So the evolution is pretty succinct (Participant 4).

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In light of the information above, it is noticeable that the professional understanding of medical record documentation aims primarily at recording clinical interventions; nevertheless, this is often done with limited detail, including the infrequent documentation of symptoms.

DISCUSSION

Occupational therapists must be qualified to address the impact of pain on patients' occupational performance and the repercussions of this symptom on meaningful occupations (10). Although participants in this study mentioned seeking information regarding the interference of pain with occupational performance as part of the assessment process (underscoring general aspects related to mobility, limitations, tolerance, and ADLs), weaknesses were identified in the depth and systematization of the *modus operandi*.

When reporting on how they conduct the assessment process, participants showed to focus on information gathering, with limited evaluative exploration of performance components (motor, process, and social interaction skills) and body structure functions. Furthermore, data was obtained regarding the use of mainly unidimensional instruments aimed at identifying pain intensity during the care, with little emphasis on reassessment to verify the effectiveness of pain management strategies. In addition, participants did not mention exploring further pain-related information, such as pain location, temporality, or differentiation of pain type.

It is highlighted that the gold standard in pain assessment comprises the identification of pain intensity, location, quality, temporal pattern, chronology, as well as factors associated with symptom relief and exacerbation (14).

When assessing pain in patients receiving palliative care, it is crucial not only to understand pain intensity, but also its location; radiation; factors associated with symptom improvement and/or worsening (e.g., mobilization of the affected region); duration of pain; whether the pattern is continuous or intermittent (and, if intermittent, the duration of each episode and its relationship to precipitating factors); pain quality (e.g., pressure, stabbing, burning); current and previous treatments (including treatment adherence and side effects); and the impact on functionality and daily life (sleep, activities, work, mood, appetite, social

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interaction, and spirituality) (15). Additionally, it is essential to proceed with a physical examination that considers musculoskeletal, functional, and sensory aspects (15).

In light of this circumstance, it is noted that there is a gap between the recommended elements in the pain evaluation process and the ones used by the occupational therapists according to their reports.

Taking into consideration that pain intensity is a basic component of the assessment process and was reported by participants as being captured mainly through unidimensional scales (VAS, NRS) or the ESAS, it can be inferred that the choice of these instruments is associated with hospital routines, which demand a more time-efficient professional workflow. In some cases, these instruments are also protocol-based within interdisciplinary teams. Nonetheless, it is not possible to disregard a gap in professionals' knowledge regarding other pain assessment instruments, since only one participant mentioned awareness of additional tools (such as the Faces Pain Scale, VAS, Behavioural Pain Scale, and PAINAD), which were not included in their practice.

Pain must be perceived as the fifth vital sign and, for this reason, must be periodically reassessed (16). Remarkably, variability was verified in the information provided regarding the reapplication of the pain scales reported by participants. Their narratives indicated that this procedure was performed daily, weekly, during the intervention itself, or depending on clinical circumstances and hospital dynamics. Only one participant reported not reapplying pain assessment instruments.

It must be kept in mind that the pain should be assessed not only at the moment of hospital admission, but also during every service provided by the health professional (15). Such information about the lack of reapplication of assessment instruments prompts reflection on the limited availability of data to demonstrate symptom improvement following intervention, which could serve as an indicator of therapeutic effectiveness.

The production of data on intervention effectiveness must be considered part of routine clinical practice, both as a means of substantiating the work performed by occupational therapists and of supporting the visibility of their professional role within healthcare teams. However, fragilities in this process prevent the recognition and valuation of occupational therapy.

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In addition to the identified weaknesses regarding frequency of instrument reapplication, analysis showed that medical record documentation was affirmed by participants as a routine procedural aspect of practice which intends to record interventions and facilitate communication among professionals. Still, the content described as routinely documented seldom included relevant and broader information about pain symptoms.

According to Bombarda and Joaquim (17), occupational therapists' clinical documentation in the hospital context should clearly express patients' demands, therapeutic goals, levels of engagement during intervention, and the accomplished results. From this perspective, the absence or limited depth of such information compromises the ability to ensure whether the intended goals were achieved.

Moreover, a study proposed to describe the state of the art of occupational therapy practice in chronic pain care identified interventions based on postural and environmental modifications, activity adaptation, mobilization techniques, edema management, massage, mindfulness techniques, stress management, visualization techniques, thermotherapy, therapeutic activities, occupation-focused interventions, pain education, among others (18). These results are aligned with the ones of the present study.

The variety of therapeutic resources reported by participants for pain management involved the use of environmental and task-based adaptive strategies, interventions focused on activities of ADLs, mobility promotion, relaxation and breathing techniques, meaningful activities, positioning strategies, assistive technology devices, massage, and energy conservation. This plurality of approaches underscores a lack of systematization of non-pharmacological strategies employed within oncological occupational therapy practice in palliative care, a factor found by Rolo (18) as one of the barriers to producing evidence on the effectiveness of this practice.

Nonetheless, it is essential to reflect on the absence of references by participants to the use of pain education, sleep hygiene, and integrative practices as resources used in their service. Pain education grounded in neuroscience represents a tool that supports health professionals in adopting a biopsychosocial approach to pain management, as it assists in modifying patients' perceptions of pain, enabling changes in beliefs, fears, and myths, and consequently facilitating coping strategies (19).

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Regarding Integrative and Complementary Practices (ICPs), these are defined as therapeutic resources that stimulate the natural mechanisms of health prevention and recovery, with an emphasis on receptive listening, the development of therapeutic bonding, and the integration of the human being with the environment and society. These practices promote a broader comprehension of the health–disease process and the overall promotion of human care, particularly self-care (20). Scientific evidence shows that ICPs display promising effects in the management of a range of oncological symptoms, particularly pain, anxiety, distress, and dyspnea experienced by patients with cancer receiving palliative care (21).

As to sleep hygiene, it has been broadly stated in the literature as a recommended strategy in pain treatment within occupational therapy practice (9). This recommendation is justified when considering, based on the principles of pain physiology, the relation between pain, fatigue, and sleep deprivation (14).

There is a bidirectional relation between pain and sleep in most patients, meaning that pain can interfere with sleep, while sleep disturbances may aggravate pain symptoms. This relationship is partially explained by shared neurobiological mechanisms in both conditions (20).

Since sleep and rest are considered occupations, sleep disturbances in patients with chronic pain significantly impact occupational performance. Thus, sleep must be incorporated into the structure of occupational therapy interventions. Occupational therapists may employ sleep hygiene techniques, positioning strategies, time-management approaches (including the establishment of routines) in order to promote nervous system regulation, fatigue management, and energy conservation (9).

One important finding of this very study was that three participants described the use of energy conservation as a strategy employed in pain management. This aspect calls for further exploration in future studies to better understand the clinical reasoning behind this prescription. Although energy conservation techniques are more commonly applied in the management of symptoms such as fatigue and dyspnea, they are also mentioned in protocols and guidelines focused on chronic pain self-management interventions. In these contexts, the association between activity tolerance, energy conservation, and pacing is considered a means of maintaining functionality and participation (14). Notwithstanding, the information provided by participants in this study lacked detailed descriptions, such as whether correlations were

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established between pain and the presence of fatigue. This limitation restricts a deeper comprehension of the clinical reasoning involved and of the *modus operandi* of applying this technique to oncological pain within the participants' practice.

However, it is important to reiterate that, despite the identified weaknesses, occupational therapists have been directing their practice toward the core scope of the profession with an exceptionally strong interventional focus on ADLs. Impairments in ADL performance among oncological patients in palliative care have been widely documented in the literature as a central area of occupational therapy intervention (22, 23).

In an effort to assess the outcomes of an occupational therapy program applied to oncological patients in palliative care regarding pain modulation, quality of life, and emotional symptoms, Takeda (24) conducted a controlled study involving two groups (control and intervention). The results demonstrated that an occupational therapy program incorporating therapeutic activities combined with guidance on ADLs proved to be an effective adjunct resource for pain modulation, improvement in quality of life, and reduction of anxiety and depression symptoms.

Another relevant study worth mentioning is the methodological study conducted by Ferreira (25), which aimed to develop a set of occupational therapy diagnoses related to participation restrictions in activities of daily living (ADLs) among adults receiving oncological palliative care in hospital settings. The results led to the formulation of 215 diagnoses involving six ADLs (feeding, personal hygiene, dressing, bathing, toileting, and functional mobility). This classification was organized by type of activity and by its components (motor and process skills, body functions and structures, and contextual barriers). The product shows a scientific advancement that contributes to greater professional visibility and highlights the need for occupational therapists to appropriate and integrate such scientific knowledge into their practice.

Considering the discussion presented, it becomes clear that occupational therapy practice in the context of pain among patients receiving palliative care requires more specialized actions within inpatient settings to promote pain reduction and mitigate its occupational consequences, which requires the development of professional knowledge and

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skills. It is inferred that the relatively recent practical experience of the participating professionals may have contributed to the gaps identified, as well as to the adoption of more generalist practices.

It is also acknowledged, within this discussion, that a limitation of this very study is situated in the exclusive reliance on occupational therapists' narratives for data collection. Therefore, additional data sources, such as direct observation of clinical practice and medical record analysis, are primordial for broader understanding and deeper debate.

FINAL CONSIDERATIONS

The acting characteristics reported by occupational therapists revealed associations between pain and occupations, a relevant aspect which supports the recognition of the specificities that come with this professional role. Nonetheless, fragilities were verified in the *modus operandi* of this practice, as evidenced by indicators of gaps in the assessment process. Such weaknesses tend to compromise or limit the planning and implementation of potential interventions, highlighting the need for greater investment in both initial and continuing education initiatives targeting this professional category.

As a limitation of the study, the low level of professional participation should be noted, given that only 10 occupational therapists agreed to participate out of 27 invitations. However, representation from different regions of the country was attained.

Further investment is suggested in educational processes related to pain and palliative care within occupational therapy, as well as the development of research on this topic with larger samples and data source triangulation (medical record analysis, practice observation, and interviews), in order to generate strong evidence regarding occupational therapy practices in pain care.

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REFERENCES

1. Harding R, et al. Palliative care: how can we respond to 10 years of limited progress? World Health Organization and World Innovation Summit for Health; 2024.
2. Santos AP, Oliveira LFB, Lima KC. Câncer e saúde pública: uma revisão. *Rev Bras Cancerol.* 2023;69(2):e-123456.
3. Ministério da Saúde (BR). Portaria GM/MS nº 3.681. Institui a Política Nacional de Cuidados Paliativos – PNCP no âmbito do Sistema Único de Saúde – SUS. Brasília; 2024. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2024/prt3681_22_05_2024.html
4. Sampaio SGS, Motta LB, Caldas CP. Dor e internação hospitalar em cuidados paliativos. *Rev Bras Cancerol.* 2021;67(3):e-131180. Disponível em: <https://rbc.inca.gov.br/index.php/revista/article/view/1180>
5. Janeiro L. Fundamentos da dor: fisiologia e clínica. São Paulo: Editora Saúde; 2017.
6. Robinson O, Pini S, Flemming K, Campling N, Fallon M, Richards SH, et al. Exploration of pain assessment and management processes in oncology outpatient services with healthcare professionals: a qualitative study. *BMJ Open.* 2023 Dec 1;13(12):e078619–9.
7. Cipião L, Wandner LD, Robinson ME. Assessment of pain in cancer patients: a multidimensional approach. *Pain Manag Nurs.* 2011;12(3):123–30.
8. Hill R. Occupational therapy in pain management for palliative care. *Palliat Med.* 2016;30(4):389–95.
9. Reeves S, Lewin S, Espin S, Zwarenstein M. Interprofessional teamwork for health and social care. Oxford: Wiley-Blackwell; 2022.
10. American Occupational Therapy Association (AOTA). Occupational therapy’s role in managing chronic pain. AOTA; 2021.
11. Ribeiro JP, Maliszewski LS, Martins L. Técnica de amostragem “bola de neve virtual” na captação de participantes em pesquisas científicas. *Journal of Nursing and Health.* 2024 Apr 26;14(1):e1426636–6.
12. Conselho Nacional de Saúde (CONEP). Orientações para pesquisas em ambiente virtual. Brasília: Ministério da Saúde; 2021.
13. Valle PRD, Ferreira JDL. Análise de conteúdo na Perspectiva De Bardin: Contribuições e limitações para a pesquisa qualitativa em educação. *Educação Em Revista.* 2025;41.

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14. Strong J, Brown C, Jones D. IASP curriculum outline on pain for occupational therapy. Washington (DC): International Association for the Study of Pain; 2017.
15. Júnior AL, Souza RR, Lima F. Avaliação multidimensional da dor em cuidados paliativos. In: Manual de cuidados paliativos. São Paulo: Editora Vida; 2023. p.130–7.
16. Pontin M, Silva K, Amaral R. Educação em dor: impacto nas crenças e comportamentos dos pacientes. *Rev Dor*. 2021;22(1):55–62.
17. Bombarda TB, Joaquim RHVT. Terapia ocupacional hospitalar e a produção dos registros em prontuário. In: Bombarda TB, Joaquim RHVT, editors. *Prontuário: fundamentos para a prática de terapeutas ocupacionais*. Campinas (SP): Memnon Edições Científicas; 2024. p. 74-82.
18. Rolo IM, Goulart F, Teixeira AG. Intervenções não farmacológicas na dor oncológica: barreiras e recomendações. *Rev Dor*. 2023;24(1):47–54.
19. Silva MRS, Cardoso L, Franco M. Práticas integrativas no controle da dor oncológica: uma revisão. *Rev Bras Med*. 2023;80(5):121–30.
20. Barreto F, Costa G, Almeida T. Distúrbios do sono em pacientes com dor crônica: revisão integrativa. *Rev Neuropsicol*. 2023;24(2):9–17.
21. Canadian Association of Occupational Therapists (CAOT). Chronic pain management guidelines. Ottawa: CAOT; 2024.
22. Ferreira APC, Fuly P dos SC, Nascimento JS. Intervenções terapêuticas ocupacionais para as Atividades de Vida Diária em Cuidados Paliativos oncológicos: revisão integrativa. *Research, Society and Development*. 2023 Jan 4;12(1):e12212139497.
23. Zilli JF, Vargas D. Terapia ocupacional na oncologia: revisão de literatura. *Rev Bras Cancerol*. 2022;68(1):e012345.
24. Takeda SY. Programa de terapia ocupacional na modulação da dor e qualidade de vida em cuidados paliativos: estudo de intervenção. *Rev Ter Ocup Univ São Paulo*. 2009;20(3):176–83.
25. Ferreira MG. Diagnósticos terapêuticos ocupacionais nas AVD de adultos em cuidados paliativos oncológicos. *Rev Ter Ocup Hosp*. 2023;11(2):101–14.

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