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TELEMONITORING IN PALLIATIVE ONCOLOGY CARE: PERSPECTIVES OF PATIENTS AND CAREGIVERS

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ABSTRACT

Over the years, care in the cancer patient's journey has shown benefits for physical, social, psychic and spiritual well-being. Palliative Care (PC) is offered to everyone diagnosed with life-threatening illnesses, regardless of curative interventions. The focus is on the person, for whom there is always something to offer, even with an active disease and limited life span. Telecare has shown positive results by employing electronic technology in patients in palliative care and with advanced cancer, improving symptom control and reducing the use of emergencies and hospitalizations, being a promising approach for maintaining quality of life.

Keywords: Telemonitoring. Palliative care. Oncology. Perspectives of Patients and Caregivers.

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INTRODUCTION

Over the years, care in the cancer patient's journey has shown benefits for physical, social, psychic and spiritual well-being. Palliative Care (PC) is offered to everyone diagnosed with life-threatening illnesses, regardless of curative interventions. The focus is on the person, for whom there is always something to offer, even with an active disease and limited life span.[1]

Telecare has shown positive results by employing electronic technology in patients in palliative care and with advanced cancer, improving symptom control and reducing the use of emergencies and hospitalizations, being a promising approach for maintaining quality of life. [2]

The exchange of information in an agile and efficient way, mediated by technology, favors faster decision-making and aligned with the individual needs of each patient. In addition, teleassistance enables continuous emotional and psychological support, which is fundamental in care. Understanding the challenges and potentialities of interpersonal relationships can make the care plan more assertive and empathetic [3].

Castro et al3 observed potentialities and challenges in remote care for patients in palliative oncology care after reports from professionals, such as: importance of reflections in the team, better communication and interprofessional trust, mutual trust with patients and caregivers. As for the challenges, these include the need for regular training, increased workload, and the need to deal with messages and calls from family members on any day/time3.

Speech therapy is the science that studies human communication and this in a new work process must be analyzed in view of the benefits and difficulties that may arise. Understanding the experience of those involved with telecare offers insights into the impact on society and, based on these perspectives, can provide valuable data for management and new care policies. In this sense, qualitative research in the broad area of health can contribute to the understanding of this experience of patients and caregivers, observing the perspectives of service users through the interpretation of excerpts from the interviews5. What themes and inferences can emerge from the experience of caregivers and patients in oncological palliative care?

OBJECTIVE

GENERAL OBJECTIVES

Analyze the experience of caregivers and cancer patients in palliative care with the use of telemonitoring

SPECIFIC OBJECTIVES

a. First, the objective was to identify which themes are present in the perspectives of cancer patients in palliative care and caregivers in relation to the use of telehealth.
b. Next, it was necessary to correlate the themes resulting from the categorization process with sociodemographic data, diagnosis, and the number of remote consultations. To finally establish relationships between the themes with bibliographic reference.

METHODOLOGY

To analyze the use of remote care, the experience was chosen as the object of study because it represents the experience with this new work process of the palliative care center team of a university hospital located in Rio de Janeiro, after the implementation of Telehealth in the service.

A qualitative exploratory study with content analysis was carried out. Participants were selected for having used telemonitoring between March 2020 and July 2022. The study included patients and caregivers in oncological palliative care without cognitive alterations, with at least three remote consultations. Those with less than three teleconsultations were excluded.

The present study was approved by the Institution's Research Ethics Committee under CAAE number: 36687420.7.0000.5259 and the patients were instructed and informed about the research both in the telephone contact prior to scheduling the interview, and during the recording of the videoconferences, and their consent was recorded. In addition to the Free and Informed Consent Form (ICF) by sending a link containing a form, and filling out and resending it is considered as authorization.

14 in-depth interviews were conducted (six patients, eight caregivers) between May and September 2022, as shown in table 1, by videoconferences via WhatsApp, recorded on the Lenovo ideapadS145 using the Movavi software. Complementary data included

information from medical records (age, gender, diagnosis, and education). The scheduling ended when data saturation was reached and the information was repetitive.

The interviews were conducted by the speech therapist from the Palliative Care Center, who was also committed to the implementation of this telecare modality as a new work process seeking to ensure communication between patients, care and the front team.

By July 2022, there had been 653 telemonitoring with 311 patients treated in this way. The patients/caregivers were grouped by group according to the number of telemonitors: group A (six to nine), group B (three to five), group C (one to two). The interviews were designated as EPAC (patients) and ECUI (caregivers) and had an average of 20.56 minutes with the patients and 27.49 minutes with the caregivers. To avoid influencing the answers, the caregivers who live with the patients were interviewed separately.

Regarding gender, patients and caregivers were classified as male and female, and none of the interviewees named themselves as transgender. Regarding age, the EPACs were organized into three age groups: Range 1 (50-59 years), Range 2 (60-69 years) and Range 3 (70-79 years). The ECUI were divided into: Track 1 (30-39 years), Track 2 (40-49 years), Track 3 (50-59 years) and Track 4 (60-69 years). Regarding education, the level of education varied between incomplete elementary school, complete elementary school, high school and higher education.

Table 1. Information about the interviewees.

Interviewee	Age	Gender	Sickness	Education level	Number of telemonitors performed
EPAC 1	70	M	Prostate neoplasm	Incomplete elementary school	5 (GB)
EPAC2	71	M	Malignant neoplasm of the esophagus	Incomplete elementary school	5 (GB)
EPAC 3	71	F	Lung Neoplasm	Complete Elementary School	8 (GA)
EPAC 4	50	M	Thymus Neoplasm	Incomplete elementary school	5 (GB)
EPAC 5	65	M	Prostate neoplasm	Complete Elementary School	4 (GB)
EPAC 6	64	F	Tonsil Neoplasm	Incomplete high school	6 (GA)
ECUI 1	50	F	Pharyngeal neoplasm	Complete Elementary School	5 (GB)

ECUI 2	61	M	Prostate Neoplasm	Complete higher education	5 (GB)
ECUI 3	48	F	Lung Neoplasm	Complete Higher Education	9 (GA)
ECUI 4	58	F	Parotid gland neoplasm	Complete Elementary School	7 (GB)
ECUI 5	67	F	Prostate neoplasm	Incomplete Elementary School	5 (GA)
ECUI 6	40	F	Colon and bowel neoplasm	Superior	8 (GA)
ECUI 7	33	F	Prostate neoplasm	Superior	4 (GB)
ECUI 8	43	F	Tonsil Neoplasm	Superior	6 (GA)

(Abbreviations: EPAC: patients interviewed; ECUI: caregivers interviewed; GA: group A; GB: group B; M: male gender, F: female gender.
Source: Prepared by the author (2023).

After the interviews, the speeches were transcribed and read, with excerpts highlighted and coded using the Atlas.ti software for this organization. 30 inductive codes were listed, with some in common for both groups. The caregivers presented 28 codes, and the patients, 21. The codes were enumerated by the frequency of appearance.

The experience of patients and caregivers was categorized by similarity. 10 sub-themes emerged, later grouped into 5 themes. This process resulted in our theme tree. Each inductive code was assigned to a specific dimension in care.Table 2.

Table 2. Categorization of inductive codes.

Code	Subcategories or subthemes	Categories or themes
○ Patient-caregiver relationship	Relationship in integrated care	Empathy
○ Caregiver support		
○ Availability of caregivers		
○ Caregiver history		
○ Bond with the team		
○ Self-care	Impact on care management	
○ Severity of illness		
○ Expectation		
○ Awareness of the disease		
○ Spirituality	Comfort	
○ Time	Convenience in remote service	Contribution to the well-being of users
○ Perception of remote service		
○ Training	Communication	
○ Guidelines		
○ Communication		
○ Medicine		

○ Perception of face-to-face service	Applicability of face-to-face service	Organizational challenges
○ Travel to the outpatient clinic		
○ Physical contact		
○ Trajectory during the pandemic	Challenges in using telemonitoring over time	
○ Technology		
○ Connectivity		
○ "Emergency" online support	Possibility of quick responses	Responsiveness
○ Possibility of quick responses		
○ Hybrid model	Workflow change	
○ Comparison between remote and face-to-face service		
○ New working process		
○ Trust in the team	Relationships of trust, security and intimacy	Safety
○ Security in remote service		
○ Welcoming		

Source: Prepared by the author (2023).

Table 2 shows our thematic tree and how the themes emerged. After categorization, the author chose to create a table with the concepts for each theme based on the meaning of the word, the bibliography, consultation and coding. The following are the concepts in Chart 1:

Table 1. Concept of categories/themes.

Category/Theme	Concept
Empathy	Empathy involves understanding the emotional states of others. In our study, these are factors that contribute to a comprehensive care plan and care management, including the relationship between patients, caregivers, and the team, support, comfort, awareness, and disease severity.
Contributions to the well-being of users	In our interpretation, these factors contribute to promoting well-being, which involves meeting needs and satisfaction with life. We define health as a state of complete physical, mental, and social well-being. We observed situations involving the convenience of remote service, guidance, training and communication between those involved.
Organizational challenges	This term, inspired by the work of Oelschlägel et al.6, refers to the challenges faced by patients during care, including the applicability of face-to-face care (displacement, lack of physical contact, prescriptions) and issues in remote care (connectivity, use of technology).
Responsiveness	We allocated the information that favored the fast online support, the hybrid service model, the change in workflow and the new work process as a quick response to the pandemic.
Safety	Security is the effect of holding, indicating trust. In the scenario of telecare between patients/caregivers and the team, relationships of trust convey security. Welcoming is also a safety factor. We encompass safety in the use of technology and the feeling of interpersonal security with the team.

Source: Prepared by the author (2023).

DEVELOPMENT

In our study, five categories emerged from the interpretation of the excerpts from the statements of patients and caregivers that constituted our thematic tree. Namely: (1) empathy, (2) contributions to the well-being of users, (3) challenges, (4) responsiveness and (5) safety. The understanding of these themes within the context of telehealth and palliative care is the result of content analysis.

CATEGORY: EMPATHY

The theme empathy was the theme with the highest number of citations. We observed that in order to maintain a relationship between patient and family members aiming at integrated care, sometimes the caregiver needs to be available, physically fit and healthy. Thus, issues such as the availability of caregivers and the patient-caregiver relationship are fundamental to the care plan.

In the ECUI profile, we observe as degree of kinship the children, spouses and siblings. Most are children who work and the patients are cared for by their spouses who are also elderly and who, in order to carry out the telemonitoring, were waiting for the presence of their children to connect. In this way, these caregivers also need support and their history must be taken into account.

Another point that deserves to be highlighted is that many caregivers need to postpone personal and professional plans to contribute to the care of patients and throughout this care process, it is necessary to support them. Note the ECUI 7 report:

> Yes [postponing personal issues] I was in a matter of leaving home, but I was not able to go out, to leave my father sick, an elderly woman taking care of him. [...]So, it is a very important work.

As for the age of the interviewees, we can infer that regardless of age, empathy is necessary. Observe the ECUI 8 report (48 years old) "So, with the pandemic, I had to put all this together [personal life and care for the mother], and my mother recovering. So, it really was a race."

Caregivers of patients with head and neck cancer need integrated and multidisciplinary care, considering availability, history, and bond with the team. Challenges include feeding, communication, and apparent lesions on the face, emphasizing person-centered care and caregiver support. Emphasis on the bond with the team and the patient-caregiver relationship in empathy and diagnosis.

Considering the number of telemonitoring of the EPAC and ECUI, empathy does not depend on the volume of care, as group B of both established a bond with the team. The ECUI had more reports on empathy, as many faced distress in the responsibility of care, feeling supported by the team. Excerpt from ECUI 2 – group B: "She [psychologist] saw that my mother [caregiver] needed it and stayed a long time longer than my father [patient], so she realized that my mother would need follow-up [...] If she wanted to talk, she would be available."

A relevant point is about spirituality, which according to reports, brings a feeling of comfort to patients. In this category, this inductive code was the most cited. Note the excerpt quoted by ECUI 3: "I think that this time she is having was to prepare to be welcomed in heaven. Because if she left the way she was before, she wouldn't be well received and not now, now she's prepared.*"*

Notice this other excerpt from EPAC 5:

> (...) when I arrived there [Palliative Care Center] in 2019, I simply wasn't confident that I would stay alive, and they put me on my feet, under God, [...] I thank them very much, because that's where I managed to have a little peace, escape a little from the disease, forget that I have it, But I know I do, but it made it a lot easier for me.

CATEGORY: RESPONSIVENESS

Responsiveness was the theme that stood out the most in the EPAC group. To exemplify responsiveness, we can observe how the possibilities of rapid response are fundamental for patients. As in the following excerpt from EPAC 6: "So care was taken beyond the calls, beyond the calls. Several times I sent a message by WhatsApp and it was promptly answered"

Considering the theme of responsiveness and EPAC schooling, we observed that the comparison between face-to-face and remote care, and the change in workflow were points to be considered. We observed that issues regarding the ease of not having to wake up too early, because for face-to-face service, they need to leave hours before the service; Even in the issues of disease control, in which the patient reports that it is possible to maintain telemonitoring and move to face-to-face only in more severe cases, they brought reports of improvement in quality of life. Observe the excerpt from EPAC 2 – incomplete elementary schooling: "For example, if I have a problem, then there would be the difference of using the phone or going there because I should be there [in person] because there is a prescription [...] But not for control, everything is normal. It makes no difference."

Caregivers with higher education had more reports of responsiveness, showing concern with rapid responses due to the severity of the life-threatening disease. Most work and need to balance family care and professional/personal life. The most relevant codes are "emergency online support" and "new work process". I observe ECUI 6 – higher education*:*

> Because in the "palliatives" we arrived in despair, right, and I couldn't pass my despair on to my mother, right, so I sent the message of what was happening, even with the appointment already scheduled, and sometimes I called more than once in the same week.

In patients diagnosed with lung cancer, responsiveness was crucial, given the constant need for care. Rapid monitoring of symptoms is essential to avoid impairments in quality of life and comfort. Observe the excerpt from EPAC 3 – dependent on oxygen therapy: "my daughter, if I got sick, she would call the doctor. Did you understand? My daughter who had more contact like this [...]I talked to my daughter when I felt something, I told her, then she called the doctor"

Regarding the diagnosis and ECUI, a caregiver of a patient diagnosed with an advanced stage of disease reported the constant need for contact for guidance, demonstrating how these caregivers of patients with advanced cancer need online support and quick answers to their anguish and complications. ECUI 6 – Advanced disease in its excerpt makes clear the relevance of using online care as a complete face-to-face one.

> I always went on WhatsApp when something happened to her [...] It was very rich [telemonitoring] to have someone with easy access, they didn't take long to respond and that helped a lot, [...] The face-to-face is important, of course, but having the online would be you having an extra help, and that helps a lot.

EPAC in groups A and B reported satisfaction with remote care, resolving issues without the need for face-to-face care. The rapid implementation of the new work process during the pandemic minimized patient symptoms with the option of remote care. See the excerpt from EPAC 6 – group A*:* "So, care was taken beyond the calls, beyond the calls. Several times she sent a message by WhatsApp and was promptly answered. So, the care she took during the pandemic and to this day is wonderful for us, for the whole family."

When comparing remote and face-to-face care, the preference was for the latter. However, all highlighted the importance of the opportunity of distance care in combination with face-to-face. Notice the following quotes: EPAC 1 – Group B: "The face-to-face gives a type like this it is 80% in the online it is very far away, no, the video is an average of 60%"*;* ECUI 8 – group A*:* "Sorry, but that's the word, it was surprising, because we didn't expect it from the public network, we're very honest with you, okay? An accompaniment in excellence, as it was, as it is yours."

Here is the speech of EPAC 4 – group B:

> Face-to-face is better, isn't it? [...] So, by phone, we just talk more about the services. It was all very good, right? [...], because I'm feeling like I'm in front of you, you at your table, me sitting there in the chair, and you're talking to me, ... For me it's great.

We can also observe the speech of ECUI 3:

> I prefer everything in person, right? I think the contact, right? [...] I think it's better now [...] everything is adaptable... The patient who needs it and cannot be in person goes online [...] There's not that difference, right? There is the physical difference [...] and the effect is the same, it is very gratifying.

CATEGORY: CONTRIBUTIONS TO WELL-BEING

In the male group of caregivers, convenience in remote care was relevant. For women, empathy and bonding with the team were the most discussed topics. See the excerpt from ECUI 2 - male gender: "[I received calls from the team] Trying to find out how my father was, how he was feeling, not just medication care and all these issues. So they always look for it."

When we cross-referenced information on this theme with schooling, we were able to observe the importance for EPAC with incomplete primary schooling: the code "guidelines" was mentioned only for patients at this level of schooling, which justifies the real need for them to always be oriented about their care plans.

See the excerpt from EPAC 1 – incomplete elementary school: "I spent a period eating poorly. After [the team's guidance] I improved again. And it was a period of constipation (...) I was able to convey to them what was happening." The EPAC 2 – incomplete elementary school said: "I always try to take care of myself, everything within what, like your guidance, I always try to keep it".

For the ECUI group with complete or incomplete primary education, we observed a considerable flow. The importance of guidance and training for this group is fundamental. In this way, we understand the constant need for guidance and the availability of the team to carry out training for the use of videos in remote service. See the excerpts:

ECUI 4:

> They taught me how to do the dressing at home. Because it can't be just any bandage because their skin is very sensitive. [...] or. That tumor was growing a lot. [...] every 2 days I was dressing it, I changed it [...] it smelled bad.

Here is the speech of ECUI 5 – incomplete elementary school: "If it weren't for the team, I wouldn't have been able to know what I was going to do, I would have had to take an appointment. So at the other doctor, because that's all, right? If I didn't have you there at the time for me to guide."

As for training, note the excerpt from ECUI 5 – incomplete elementary school: "Okay, it was even good for me that I learned a lot more by moving, something that I didn't know how to use in the video, my daughter and my grandson guiding me. I think there's a learning experience, it was very good, okay?"

CATEGORY: ORGANIZATIONAL CHALLENGES

Organizational challenges are greater for older patients (Range 3: 70-79 years), such as commuting to the outpatient clinic. TM helped avoid contact with others in the pandemic and reduced the long commute between the patient's home and the hospital unit.

Considering the organizational challenges, issues related to physical contact and prescription of controlled drugs were highlighted for this group (Range 3: 70 –79 years) as well. Next, we have an excerpt that exemplifies this issue: EPAC2 – 71 years old: ″it is because I avoided a lot of contact with people that I left here in Caxias [Municipality] and there to the hospital [located in the municipality of Rio de Janeiro]. Wow, you have to take two drives and the second one that takes you there, it's very crowded".

Here is the speech of the 71-year-old EPAC 3:

> We get like this because the doctor didn't see it, he doesn't see how this lump was, right? She knew about this lump, but not to the extent that it is." [...]" Because when she applies the medicine, she leaves the prescription ready [...]My daughter stops by, get it.

Regarding the diagnosis of lung cancer in EPAC, organizational challenges include the occasional need for face-to-face support and the maintenance of TM over time. Issues of travel, physical contact, and medication prescriptions are also relevant. Note EPAC 3:

> So I'm talking to you, isn't it? Then you're not examining. And we are talking. And the same thing would be the doctor will talk, but will not know anything [...] But online, I'm going to say it like this, it's not seeing me, it's not examining me, it's touching me.

One point that deserves to be discussed is in relation to patients diagnosed with prostate cancer. In all themes, the flow of these was close to what shows the need for integrated care in all care spheres. See the excerpts EPAC 1: "The difference to face-to-face we go through everyone at once, right? And at a distance we go eh, it's usually one person and separate".

Here is an excerpt from EPAC 5:

> Look, [...]I'm going to sit on the fence, because both things [face-to-face and remote] made it a lot easier for me and face-to-face it was good, because I could be close to the person I know is taking care of me. And by phone, it's a little far, right? So we pretend that we are like this next to each other. Both are good.

In the theme related to diagnosis, the prolonged use of MD and the applicability of face-to-face care, the commute to the NCP unit is a relevant point, as the disease requires face-to-face care. Maintaining TM over time faces challenges. In the view of the ECUI 3 caregiver (lung cancer patient), face-to-face care was preferred, but challenges such as the need for oxygen therapy and travel logistics were barriers to depending only on this type of care. Observe the excerpt below from ECUI 3 – Caregiver of a patient using oxygen therapy:

> [...] It's like I said everything is adaptable ... the issue of commuting when you really can't go, right? In this case, my mother uses oxygen. So if I don't have oxygen at home to take it's complicated, so I have to keep controlling and thinking. Oh, and on the day you have to have oxygen here, so if something goes wrong it's that fear of missing the appointment.

In group A of the ECUI, the flow of citations about challenges was greater, due to bureaucratic issues to get face-to-face prescriptions and lack of physical contact when maintaining the teleservice for longer. They also mentioned questions about travel to the outpatient clinic, facilitated by remote care.

CATEGORY: SECURITY

Security stood out when we cross-referenced information with the number of telemonitors. EPAC in group B, less exposed, showed more trust in the team compared to group A. Patients who knew the team reported welcoming and trust, bringing security in remote care, regardless of the number of telemonitoring. Observe the excerpts from EPAC 1 – Group B and EPAC 4 – Group B, respectively:

> It [remote service] is almost face-to-face... It's because we already know everyone, we already know the work [...] every day I'm feeling better with your treatment.
> Yes [about security in remote service]. First of all, to God, and yes, we have to be safe, right?

ECUI in the security theme showed relationships of trust, welcome and intimacy. The number of citations was similar in groups A and B, indicating that, regardless of remote care, caregivers felt safe. Patients also trusted and felt welcomed, even with less contact with the team. As we see in the excerpt from ECUI 6 – group A: "I did not feel afraid of the use of distance care, the credibility for me was the same as when I went in person."

We can also see the excerpt from ECUI 3 – group A:

> (...) It seems that we get a new family, right? It's a family that we get attached to. So we have trust, we know, we have some intimacies that are not family intimacy, but it is an intimacy of people who respect, it is not just a doctor-patient relationship, it is a relationship where friendship comes.

FINAL CONSIDERATIONS

14 interviews were conducted observing challenges, facilitators, contributions and important characteristics associated with the implementation of telehealth in the care of patients in palliative oncology care.

Regarding the age group, the mean age of the patients: 60 years, 66.7% male and 33.3% female. Caregivers: average age of 50 years, 87.5% female and 12.5% male. Previous studies also show a female majority among caregivers7,8.

From the beginning, we chose not to hold remote consultations for new patients, suggesting that they attend, when possible. This decision is supported by the literature, which indicates that initial consultations are not appropriate for telecare due to the lack of trust in the relationship. Empathy, the theme with the greatest flow of information in our study, and the team-patient/caregiver relationship are crucial for the care plan9.

Another point that deserves to be highlighted is time. Appointments were perceived as less time-consuming, minimizing the dynamics of daily life, reducing transportation, parking, and waiting time at the hospital. Some patients and caregivers value the fact that they are at home avoiding entering the hospital environment.

Telemonitoring consisted of the assessment of functionality by the KPS (Karnofysk performance status) and symptom control by the ESAS symptom scale as an appropriate tool, and this point corroborates our findings on person-centered care and not disease-centered care6. Our study also performs its remote monitoring through the ESAS application and thus, the questions help guide and promote conversations during phone calls.

The theme "empathy" covers self-care, caregivers' availability, expectations, history, support and bond with the team. In the research, self-care emerged, and studies show that patients feel greater involvement and updating in their treatment with telemonitoring, becoming more active in their care11.

The reporting of the importance of emotional support12,13 and the uncertainty surrounding treatment was reduced when there was an easy way to contact the clinic about treatment-related issues11. The primary caregiver plays a much more important role when patients are being supported over the phone. It is always helpful to have a caregiver at home who is reliable and communicates well with the medical team. Good communication and reliability become fundamental to providing safe care12.

Regarding the bond with the team, one concern is the relationship and the construction of this bond through telemedicine7. Teleconsultation is part of the practice of home palliative care and, if well applied, can facilitate computer-mediated and empathetic patient-specialist palliative care relationships, which allow professional care in tune with the patient's context, as well as patient involvement14.

The theme "responsiveness" encompasses a new workflow, online support, quick responses to patients and comparison between remote and face-to-face care. In a comparative study, participants noted that telemedicine visits were equivalent to or better than face-to-face visits.[7]. Some are comfortable with telehealth but face problems. Despite this, they prefer the combination of face-to-face care and telehealth.[15].

Participants preferred in-person palliative care, but consider virtual care as a useful complement to face-to-face care.[16] An important discussion is about whether patients and caregivers are truly comfortable discussing sensitive topics through telemedicine, or whether the convenience and timeliness of telemedicine outweigh the comfort gained from an in-person visit7. In a qualitative study on families and health professionals, it was noted that telephone and video were considered effective, although not as impactful as personal conversations [8].

We found in the literature the following advantages in relation to better interaction with the team regarding the use of telehealth: access to physicians with less bureaucracy, quick responses, greater efficiency and quality of care17, after-hours support13, and the patients' feeling of security is increased by their ability to contact the clinic all the time11, increased access to care, reduced discomfort, travel time and the risk of healthcare-associated infections18.

The theme contributions to well-being brings discussions about time, communication, perception of care, use of medications, guidance and training on the use of technology. Telephone and video communication is considered to be effective, but inferior to in-person communication. Communication strategies suggested by families and clinicians for remote interactions include identifying a family reference person to receive updates, frequently checking the family's understanding8,19.

The communication and convenience of offering telemedicine visits may make some patients and caregivers feel comfortable discussing sensitive topics via telemedicine, but some drawbacks such as concern for the relationship and bonding through telemedicine in addition to the limited opportunities to see body language via video7.

Patients and caregivers did not report major difficulties in acquiring prescriptions for controlled drugs. The option of a family member going to the outpatient clinic in person to pick up the prescription was sufficient and there were no complaints about this displacement. In the study by Tasneem et al18, some participants were concerned about whether the physician could prescribe controlled substances through a telemedicine video call, such as opioids and benzodiazepines, which are commonly used.

Regarding travel to the care unit, although the feasibility is still limited for some patients, telecare can be a satisfactory alternative to face-to-face consultations for palliative care patients who need to limit access to the hospital20.

The use of technology was not a barrier for patients and caregivers. Most preferred the telephone as the main form of ICTs, considering it simple and efficient for distance communication. Phone calls achieved their communication goals and were easy to use.[7.8].

Acceptance and trust are matters that generate security. Some patients and caregivers feel comfortable discussing sensitive topics via telemedicine, and the possibility of contacting the clinic with a response at least within a day or two offers a sensation6,11 and can promote feelings of intimacy and relief14.

Qualitative research understands the user experience, improving service. It recognizes social and psychological issues, generating awareness and pressing for rights. Qualitative studies can contribute to the understanding of the reality of patients in palliative care and in the use of telehealth, offering insights for integrative care.[5.21].

Telemonitoring in palliative oncology care is accepted by patients and caregivers, mitigating challenges in the care plan. Empathy was the most relevant theme, regardless of the number of telemonitoring, and the bond with the team and support for the caregiver were fundamental. Responsiveness through the possibilities of quick responses and shorter time interval in contact with the team was a relevant point. Understanding experiences through reports can be potentiating or challenging in a work process, favoring adjustments and contributing to the effectiveness of care by both the team and managers, which reinforces the importance of guiding studies in this area.

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