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Original Article

The perception of people's occupations under palliative oncology care in view of Wilcock's dimensions of being and doing

A percepção das ocupações de pessoas sob cuidados paliativos oncológicos diante das dimensões de ser e fazer de Wilcock

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Abstract

Introduction: Ann Allart Wilcock, focusing on the occupational science, idealized the dimensions of being, doing, becoming and belonging, relating health, well-being, and occupation. In her academic and professional journey, she sought to present the interdependence of the dimensions with the person and community. When a person suffers a partial or total break in their occupations, they may suffer biopsychosocial, spiritual and occupational repercussions. Cancer is still seen as a diagnosis related to death, however, given early identification, treatments, and advances in research, it is possible to promote well-being and quality of life. Among the treatments, palliative care has as one of the principles to guarantee completeness in care, control and management of symptoms, multidisciplinary monitoring of the person, their family, caregivers, and community, from diagnosis to the post-death mourning process. **Objective:** To understand the perceptions of occupations of people in oncological palliative care, from Wilcock's perspective. **Method:** Qualitative research, with an action-research procedure. Seven semi-structured interviews were carried out from July to August 2022, in palliative care clinics. **Results:** The findings were presented in the categories of being and doing, presenting the perceptions and occupational relationships of the person with themselves and their surroundings. **Conclusion:** The relationships between being and doing in everyday life and how occupational therapists can identify impaired occupations through the dimensions and provide support to the hospitalized person. The aim is to stimulate new knowledge in academic and professional communities based on the object of study in occupation and the contexts of

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occupational therapists in the national scenario, as well as ensuring evidence-based practice.

Keywords: Cancer, Palliative Care, Activities of Daily Living.

Resumo

Introdução: Ann Allart Wilcock, tendo como foco a ciência da ocupação, idealizou as dimensões ser, fazer, tornar-se e pertencer, relacionando saúde, bem-estar e ocupação. Em sua jornada acadêmica e profissional, buscou apresentar a interdependência das dimensões citadas com a pessoa e a comunidade. Quando uma pessoa sofre uma ruptura parcial ou total em suas ocupações, pode vir a sofrer repercussões biopsicossociais, espirituais e ocupacionais. O câncer ainda é visto como um diagnóstico relativo à morte, contudo, diante da identificação precoce, tratamentos e avanços em pesquisas, é possível promover bem-estar e qualidade de vida. Dentre os tratamentos, os cuidados paliativos possuem como um dos princípios garantir a integralidade nos cuidados, controle e manejo de sintomas, acompanhamento multiprofissional à pessoa, à família, aos cuidadores e à comunidade, do diagnóstico até o processo de luto pós-óbito. **Objetivo:** Compreender as percepções das ocupações de pessoas em cuidados paliativos oncológicos, sob a perspectiva de Wilcock. **Método:** Pesquisa qualitativa, com procedimento de pesquisa–ação, que realizou sete entrevistas semiestruturadas, no período de julho a agosto de 2022, em clínicas de cuidados paliativos. **Resultados:** Os achados se apresentaram nas categorias de ser e fazer, expondo as percepções e relações ocupacionais da pessoa consigo e em seu entorno. **Conclusão:** As relações do ser e fazer nos cotidianos e como o terapeuta ocupacional podem vir a identificar as ocupações prejudicadas por meio das dimensões e dar suporte à pessoa internada. Busca-se estimular novos saberes nas comunidades acadêmicas e profissionais com base no objeto de estudo em ocupação e nos contextos dos terapeutas ocupacionais no cenário nacional, bem como garantir uma prática baseada em evidências.

Palavras-chave: Câncer, Cuidados Paliativos, Atividades Cotidianas.

Introduction

The relationship between human beings and occupations is innate. This relationship is associated with health and well-being, with the occupation having therapeutic potential (Wilcock, 2007).

For Wilcock (1993), the occupations have functions such as: developing the body's immediate support needs, self-care, protection and safety; developing skills, social structures and technologies relate to the environment, among other functions.

When thinking about the science of occupation, especially from the perspective of Wilcock (1998, p.10, our translation), "Occupation is all the things that people do, the relationship between what they do and who they are as human." Therefore, it is necessary to reflect on human beings being the sum of their occupational relationships with themselves and around them, how these relationships are important and how they are affected or not throughout the illness. Wilcock & Hocking present us with four dimensions: being, doing, becoming and belonging (Wilcock & Hocking, 2015). These

dimensions present the person's independence, autonomy and identity, and which can suffer impacts and present interdependence between them.

Ann Allart Wilcock, Australian citizen, occupational therapist, occupational scientist and teacher, was one of the main creators of the dimensions of being, doing, becoming and belonging. According to Hocking (2020), Occupational Science was the largest academic and professional focus, making its meaning implicit and immediate, presenting the mode of relationships between aspects of human life and impact on the planet, showing the occupational perspective in the face of human evolution, society, politics, economics and the combined efforts of the World Health Organization (WHO) and the United Nations to improve people's health status and well-being.

Therefore, research has presented the relationship between occupation and health and well-being, linking the occupations they do and how they influence people and communities (Wilcock, 2007). In this sense, occupational therapist Ann Wilcock, in partnership with Clare Hocking, present four dimensions to be better analyzed in Occupational Science, in their publications entitled "An Occupational Perspective on Health", which has three editions, in English only. The author brings with her the dimensions of being, doing, becoming and belonging, with health and health problems, illness and its disorders approached from a historical point of view and links with occupation (Wilcock & Hocking, 2015).

For better understanding, according to Hitch et al. (2014), the dimensions can be defined as:

> *Doing* has been defined as the means by which people engage in occupations, and includes the skills necdeleteessary for their achievement and development over time [...].
>
> *Being* like the meaning we possess as professionals and humans, including the meanings we invest in life, in the unique physical, mental and social capabilities and abilities. Occupation can provide a direction and focus for *Being*, which also continues to exist during reflection and self-discovery, independently of occupation. Being is expressed through consciousness, creativity, and the roles people take on in life. In an ideal context, individuals would be able to exercise self-management and choice in their expression of Being, but this is not always possible or even desirable [...].
>
> *Becoming* is the continuous process of growth, development and change that affects a person throughout their life. It is driven by goals and aspirations that arise by choice or necessity of the individual or groups. In this sense, regular changes and reviews of objectives and desires help to maintain the momentum of Becoming, as well as experimenting with challenges and new situations [...].
>
> *Belonging* in Wilcock's work as a sense of connection with other people, places, communities, cultures and times. It is the context in which occupations occur, in which the person can experience several forms of belonging at the same time. To achieve this, relationships are essential – whether with people, places, groups or other factors – and the feeling of reciprocity and sharing is present, whether positive or negative (p. 238-239).

According to Carrapato et al. (2017), the health conditions for illness can be conceived of the relationship between human beings and their surroundings, so the interaction of biological factors with the environment in which they live, then constitutes a process of multifactorial relationship. Therefore, an aggregate relationship based on biological, psychological, social, spiritual, and also occupational determinants. In this way, it has repercussions on the physical-functional aspects of daily activities, gradually or abruptly, and cancer emergencies or sudden illnesses may occur.

Cancer can be understood as a process of genetic changes with the growth of successive populations and cellular replications, characterized by independent proliferation and invasion into tissues and organs, resulting in structural and functional changes in the cells that make up the organism (Sequeira et al., 2020).

It is found in the group of chronic non-communicable diseases (NCDs), a group of pathologies with multiple causes and risk factors, extensive periods of latency and a prolonged course, with non-infectious origin, which can cause functional disabilities in the affected person (Brasil, 2011).

According to the Instituto Nacional de Câncer José Alencar Gomes da Silva (2018), oncological therapeutic treatment is proposed according to the assessment of the extent of the organism's impairment, called staging. In the study by Kaliks et al. (2017), after a cancer diagnosis, the Unified Health System (SUS) offers neoadjuvant or adjuvant and metastatic/palliative treatments, aimed at chemotherapy, radiotherapy, and surgical procedures. Among the forms of treatment are palliative care, which must be inserted into the person's universe as early as possible.

The use of the early palliative care approach, for Victor (2021), occurs due to the possibilities for the team to promote the management and control of symptoms, assist in communicating the prognosis and preparing a care plan, as well as the rational use of resources and end-of-life care. According to Ryan et al. (World Health Organization, 2020), palliative care has a comprehensive vision, considering active care for people, regardless of age, through a multidisciplinary team that evaluates and seeks to improve the quality of the physical, psychosocial and spiritual aspects of people with significant health suffering due to serious illnesses and, especially, those close to the end of life. So, how can we contribute to the direction and protagonism of these people and their occupations?

Based on readings about the theme and experiences lived in the multidisciplinary health residency program in clinics aimed at assistance and palliative care, it was possible to observe questions and complaints about occupational losses, mainly occupational roles at work and at home, for through reports of personal life stories and developments after the diagnosis of palliative treatment. Questions arose through validation and reflection about being a health professional, being an occupational therapist and having occupations beyond the hospital context.

Given this, it is worth reflecting on how people hospitalized in oncological palliative care perceive their occupations in the face of illness and the imminent possibility of death?

Thus, this research has the general objective of understanding the perception of the occupations of people in oncological palliative care in the light of Wilcock, highlighting the dimensions of being and doing.

Methodology

Type of research

This is a descriptive research with a qualitative approach. The semi-structured interview and the research diary were used as research collection instruments, with Bardin analysis and descriptive biostatistical evaluation of the simple frequency of the data. For Yin (2016), the qualitative approach allows the production of studies with greater detail on a wide variety of subjects, in simple, everyday terms.

Yin (2016) also presents that the choice of qualitative research allows studying the meaning of people's lives in real conditions, in addition to representing and presenting opinions and perspectives of the target audience, covering the realistic conditions they live in and, even so, contributing to discoveries and explanations of human social phenomena through the search for a broad source of evidence.

Research location

The research was carried out at the Oncological Palliative Care Clinics 1 and 2 (CCPO 1 and CCPO2), located in a reference hospital for the treatment and monitoring of people with cancer in the Northern Region of Brazil.

Research participants

Seven people admitted to the reference hospital undergoing oncological palliative care treatment at CCPO Clinics 1 and 2 participated in the research, according to the characterization of the research participants (Table 01). According to Gil (2010), in qualitative research there is no need for numerical determination for sampling, not even a high number of interviewees. The intended sample was non-probabilistic, therefore, this research was based on the average number of beds and physical occupancy of these beds in clinics that serve people in oncological palliative care, respecting the performance and clinical condition of each person admitted.

As inclusion criteria, we had: people aged 18 years and over, hospitalized, with knowledge of the reason for monitoring the team and palliative care treatment and monitored by the clinical teams at CCPO1 and CCPO2, and who agreed to sign the Consent Form Free (TCLE) and Informed Research and the Authorization Term for the Use of Written Reports, Images and Voice Sounds for Research Purposes (TAUI).

As exclusion criteria, we had: age under 18 years, people hospitalized but not being monitored by the palliative care team, or with changes in perceptual-cognitive skills.

Data collection and analysis procedures

The research in question followed the precepts of the Declaration of Helsinki and the Nuremberg Code, respecting the resolutions relating to the Standards for Research Involving Human Beings, such as Resolution CNS 466/12 and 580/18, of the National Health Council. The work was also approved by Plataforma Brasil with opinion No. 5.393.013 and CAAE No. 57576322.4.0000.5550.

The research data were obtained after signing the TCLE and TAUI, leaving a copy with each participant. Records of the participants' sociodemographic data were recorded as coded in Table 01. At the same time, semi-structured interviews and records in the field diary were carried out. In order to guarantee the confidentiality of the participants, they were identified by the name of trees, according to their symbolic representation throughout the monitoring during hospitalization.

The interview time ranged from 16 minutes to 30 minutes with five interviewees in a single meeting, however, two hospitalized healthcare users opted for two meetings, using the following question guide: 1) Tell me about yourself. Who are you? 2) What occupations are important to you? 3) How are you carrying out your occupations? 4) How do you see your occupations currently? 5) What occupations were added or lost during the illness? 6) How do you perceive the relationship between your occupations and yourself? and 7) What meaning do they have for you?

It is worth highlighting the difficulty in understanding the term "occupation" by the interviewees, with the questions being reformulated, replacing the term with "activities", "daily activities", "routine".

The use of semi-structured interviews by the researcher helps them to stick to their objectives of understanding the bases for the occurrence of situations, when they seek to develop an understanding of the circumstances surrounding the research object (Easterby-Smith et al., 2007).

The research took place over a period of 4 months in its entirety, with the interviews carried out in July to August 2022, in the morning and afternoon shifts, according to the clinical condition and choice of participants. The semi-structured interviews were recorded using a voice recording application on a smartphone device and, later, transcribed in full and analyzed using Bardin's content analysis technique.

Bardin's content analysis is defined as an empirical method, a set of methodological instruments that seeks knowledge of what is behind the meaning of words, focuses on the message, that is, on the communication that occurs between the researcher and the participant, with its objective being to organize the message to confirm the indicators that allow inferences about realities that are not part of the message (Bardin, 2016).

The organization of the research data, after reading the medical records and transcribing the content obtained during the interviews, took place through the elaboration of the participants' profiles, using the creation of a table to characterize the interviewees. To organize the work, create tables and images, *Microsoft Office Excel®, Microsoft Office PowerPoint®* and *Microsoft Office Word®, Microsoft 365® version, Windows 11 home®* operating system were used.

The choice for this content analysis is due to the organization of the content, as Bardin (2016, apud Santos, 2012) goes through the exhaustiveness of the subject, representativeness of the samples, homogeneity of the data to the topic, relevance to the research objectives and exclusivity of the categories listed.

Therefore, data analysis occurred after detailed and repeated reading of the transcribed interviews, based on the dimensions of being, doing, becoming and belonging, which were the central categories.

Results

Table 1 presents the characterization of the research participants.

Table 1. Characterization of research participants.

IDENTIFICATION	No	%
Male	4	57%
Female	3	43%
AGE GROUP*		
35-39	1	14%
40-44	2	29%
50-54	3	43%
60-64	1	14%
CANCER AND ICD		
Cervix CA – C.53.9	2	30%
Prostate CA – C.61.9	1	14%
Breast CA – C.50.9	1	14%
Peritoneal carcinomatosis – D.48.7	1	14%
Cervical tumor – C.15.0	1	14%
Colon CA – C.18.0	1	14%
TREATMENT TIME		
1 a 2 anos	3	43%
4 a 5 anos	3	43%
6 anos	1	14%
MARITAL STATUS		
Married	2	29%
Divorced	2	29%
Widow/widower	2	29%
Did not know how to define	1	13%
SCHOLARITY		
Incomplete elementar education	2	29%
Complete primary education	2	29%
Incomplete higher education	1	14%
Complete higher education	1	14%
Technical course	1	14%
PROFESSION		
Farmer	3	43%
Mason	2	29%
Pedagogue	1	14%
Autonomous	1	14%
MUNICIPALITY OF RESIDENCE		
Belém	4	58%
Ourém	1	14%
Acará	1	14%
São Miguel do Guamá	1	14%
TOTAL OF PARTICIPANTS	**7**	100%

*Acronyms: CA correspond the cancer and TU correspond the tumor. Age group expressed according to the Instituto Brasileiro de Geografia e Estatística recommends. Table caption: (No): Absolute number and (%): Percentage. Source: survey data, 2022.

Pioneers in the study and CO researchers present their direct relationship between occupations, health, well-being and quality of life. Inviting us to reflect on how our occupations relate to the person's health and illness processes. In view of this, we observe that Wilcock presents us with health that goes beyond a limited view of illness, but also of the occupational being that we are.

Therefore, when talking about the dimensions of being, doing, becoming, and belonging, these are presented to the literature as important indicators for an issue of occupational perspective in health. Therefore, in this article, we highlight the dimensions of being and doing described as categories below, making it possible to observe the perspectives, interactions and occupational perceptions of the interviewees, as well as the occupational imbalance generated by the difficulty of maintaining the daily routine known before the disease.

Being

In this category, the dimension of being, we can see expressed the essence of the self-person, of fulfillment through their capabilities and involvement in their occupations. Such capabilities can be read in the speeches of Ipê amarelo and Jacarandá, who had positive feelings about **being** their professions.

> [...] *I worked on vacation, just me, I had fun on the beach. I sold kites, I sold pepper sauce, I sold a lot, look all day in the corner,* [...], *Man, I sold everything* (Ipê amarelo).

> *I was a pedagogue* [...]. *I really liked working in the field with young children, you know? I liked seeing their maturity, their behavior, and having fun* (Jacarandá).

Despite the verbal use used in the past (worked, was) in the cited excerpts, the **being** in front of the interviewees' working self occurred through the occupational roles assumed in a conscious and creative way. The following excerpts describe how these people recognize themselves, denote who they are, how they recognize themselves and how they present themselves to the community.

> *I am an optimistic woman. Not very patient. I really like to play, have fun with people. To know. Having a happy coexistence,* [...] *in the workplace, with my family, I don't like mixing things up, right? Friendship, friendship, work, professionalism, professionalism,* [...], *that's who I am* (Jacarandá).

> *I'm a mother, I'm a farmer* (Cerejeira).

It is possible to identify that the occupations are related, and that the difficulty in carrying out an activity(ies) has an impact on how the individual recognizes their person, their **being**. Therefore, feelings of sadness and worthlessness are present. This is an example from the following report:

> *I can't say that word, but useless, I can't define it in others* (Ipê amarelo).

If there is difficulty in carrying out occupations, the person may experience interruptions and disruptions in their daily lives. Therefore, we seek to understand the changes in Figueira's rest and sleep.

> *I don't sleep much,* [...], *I rest very little, because I really feel pain, after chemotherapy, the pain got worse, there are times when I don't do anything, my God!* (Figueira).

It is possible to observe the relationship between the characteristics of being in the direct connection with doing. Therefore, we can be invited to reflect on how our essence and existence occurs through what we do with ourselves and others. In this sense, we then arrive at the second category of analysis.

Doing

It can be understood through the performance of significant occupations, which may be healthy or unhealthy, but which are carried out throughout the person's development and involvement in their community, as shown below:

> *It was an obligation every Saturday,* [...]. *There were people who worked, far away, nearby, other mechanics, other drivers, you know? But our obligation is there, do you understand? Sometimes, I worked in a furniture polishing workshop there, you know? These furniture things, these things. So, that means I was missing a lot of work. So what did we do? We went, went to the ball. Obligation. Then I would come back after the game, stay until 2:30 am the next day, still working to deliver the service we scheduled* (Ipê amarelo).

Doing is related to the purpose, its ability to adapt to the needs and circumstances to carry out the occupations, as reported by Jacarandá slowly:

> *I can't take a shower alone, because it takes a lot of effort,* [...], *I get too tired... I need help to take a shower, but I dry myself, not much,* [...], *but it's just to move around* (Jacarandá).

The ability to carry out occupations or not, as observed in the interviewees' reports, can be a determinant of how people see and experience the disease in their lives.

> *Oh! Yes, I was fine, I was healthy,* [...]. *I would sweep my house, it still has a yard, I would clean the yard, clean the front, go to the street, sweep it to the curb.* [...], *I always liked doing my activities like this. I wash my dishes, I cook, I like to cook. All this I do. We have do to it, right? Now with this disease, I don't know* (Figueira).

> *It's being very, let's say, very cruel, you know? Did you understand? It's very strong, a very strong thing. Then, we see that even downwards, right? Because of that, sometimes you don't want to do anything, I want to drop everything,* [...], *how can we, this really affects our minds* (Figueira).

The report highlighted above presents a variable of perception regarding the lack of involvement in occupations, bringing to light how cancer can affect the person in the face of altered activities and, consequently, the feeling of sadness in relation to oneself is also highlighted.

Therefore, it is possible to observe that the connections established between the categories of **being** and **doing** presented, as well as the occupational nature of doing interrupted due to the disease, can interfere with the identity and recognition of the being, generating the most diverse feelings in the person.

Discussion

When the dimensions of being, doing, becoming, and belonging emerged in the literature and for the practice of occupational therapy professionals, the dimensions were presented in order to facilitate the understanding of the human being as an occupational being. For White et al. (2020), human occupation comprises all of a person's activities and actions, and this occupation is shaped according to changes in the life and health conditions of the person and their surroundings.

In studies by Valverde (2013), the definition of occupation, despite presenting itself as changeable within the human being, some conditions and structures may be continuous repetitions of developments, but which may be lost throughout conceptual evolution, especially when considering contexts, surroundings, culture, identity, agency, meaning, purpose or end among what surrounds it.

Our identity and our actions are best observed from where we are (Valverde, 2013). When a person finds themselves unable to carry out or maintain their occupations due to their health condition, it can generate various biopsychosocial, spiritual, and occupational reactions.

For Hoppes (2005), the person may feel disorganized and have unstable psycho-emotional conditions. Thus, consequently, health appears to decline gradually and in parallel due to the absence of the possibility of carrying out occupations, which can be understood as activities of daily living (ADLs), instrumental activities of daily living (IADLS), work, health management, social participation, among others (American Occupational Therapy Association, 2020).

According to the World Health Organization (1948), health can be defined as "a complete state of physical, mental and social well-being and not merely the absence of illnesses and diseases". In this sentence, and according to studies by Wilcock (2007), the occupational aspect is relevant and should be included in health, since occupation and health have a strong and ancient relationship with the identity and engagement of human beings, therefore, being a complementary and affectionate relationship.

Based on the results presented, we can observe that the interruption in the person's activities significantly interfered with the person's being. This is portrayed by Wilcock (1998) when presenting the being dimension as the essence of personal capabilities and skills that promote motivation and involvement in occupations, whether innate or not, and how this involvement provides feelings when accomplished. However, it also has a bias of idealism and existentialism of being. Wilcock (1998, p. 5, our translation) highlights: "Being is about being true to ourselves, to our nature, to our essence and to what is distinctive about us we bring to others as part of our relationships and to what we do".

According to Wilcock (1998, 2007), the term being can also be understood as how people feel about what they do. Njelesani et al. (2014) highlight Wilcock's suggested and observed philosophy about occupation beyond doing, involving the past, present

and people's anticipated sense of self. This happens because carrying out occupations contributes to a balanced lifestyle in terms of functional fullness (American Occupational Therapy Association, 2020).

The contribution to health through specific occupations can be significant (Hocking et al., 2002). People's involvement in occupations enables and expresses self-identity (White et al., 2020).

Wilcock (2001) considers that the interruption of a person's occupational needs could be directly linked to their health and well-being. Their words sought reflections on the occupational nature of human beings, as explained below.

> The insights I gained from a very broad concept of health and occupational needs led to a perspective of occupational dysfunction and occupational well-being that is not limited by a medical view of disorder (Wilcock, 1998, p. 248, our translation).

Therefore, it is possible to reflect that being would be directly related to the second dimension that Wilcock presents to us, doing, when we read the following phrase "[…] people feel about what they do" (Wilcock, 2007, p. 113, our translation).

According to Wilcock (2007), doing is associated with occupations that are meaningful to human beings, which may or may not be healthy and organized, but which include skills necessary for achievement and development over time. Thinking this way, Wilcock (1998, p. 249, our translation) reports that "[…] *people spend their lives almost constantly engaged in intentional 'doing', even if free from obligations or necessity, they 'do' their daily tasks, including things that they feel they must do and others that they want to do".*

Involvement in occupation is a tenuous factor between the person's illness and the experience of their illness and its consequences for carrying out daily life activities (Hammell, 2004). It is possible to identify in the reports in the category asking questions about occupations. For Maersk et al. (2019), questions about how occupations will be carried out arise and interfere with an independent and autonomous routine.

Thus, we bring to light one of Wilcock's (2007) main questions about the relationship between occupation and health, about the possibility of both being the same thing, since, according to the author, all of a person's occupational achievements can be related with physical, mental, spiritual or social health or illness.

It was possible to identify how the dimensions can be found and, even if not perceived, can be described. Given this, thinking about the dimensions brought up in Wilcock's studies, the person's engagement in significant occupations is directly related to the performance of doing something concrete and the relationship with themselves and their surroundings, sometimes invisible, but reported (Carreira de Mello, Dituri & Marcolino, 2020).

The occupational nature that we can observe from Wilcock is presented through the consonance between being or doing in occupation in the face of the health and illness process.

It is possible to observe that people's perceptions about their occupations have positive and negative potential, and that this potential demands the person's choices and significant occupations. According to Ashworth (2013), meaningful occupations have

value and special interest, and it is in light of these factors that participation and engagement occur, despite limitations.

When presenting the excerpts reported, it is possible to perceive significant occupations that denote the recognition of the person's self through being and doing with themselves and the community. The dimensions in question present a close association with the interviewees' self-perception of areas of occupation as significant, such as work, rest and sleep, health management, activities of daily living, instrumental activities of daily living and social participation.

According to Reynolds & Prior (2006), people have diverse social roles and group associations. When a disease interferes with the development of these roles, identity in groups and one's own self-image can result in displacement of oneself and others.

Who are we in the world? Are we based on what we do or based on what our surroundings determine from what we do? These are important questions to be discussed and there is no right definition, as we are beings in constant change and, if our essence of being is related to our doing, this changes constantly and in accordance with our human development and its interferences, such as lifestyle, behavior, aging, illness.

It is up to the occupational therapy professional to pay attention to identifying meaningful occupations for people and how they may have therapeutic potential in the face of illness. According to Larivière & Quintin (2021), occupations give meaning to human existence, therefore, they have the potential for recovery in the face of occupational disruption, whether to rescue the management of one's own life, functional management, and the search for an adequate quality of life.

Therefore, Wilcock's (1998) thinking corroborates the fact that occupational therapy must seek to understand the occupation in a unique way, as long as it includes everything that people do, the relationship between what they do and the perception of who they are and what these occupations may become different.

Therefore, it is up to all of us to reflect on the need to understand how occupations are perceived by the person and how they interfere in the illness process and quality of life throughout the treatment and evolution of the disease.

Thus, there is a need to seek health strategies in order to establish the maintenance, promotion and guarantee of quality of life in view of the perception of the occupational beings that we are in the world. Wilcock predicted the limits of being and doing, and brings us to reflect on how we seek to define being and doing in a person's life.

> We tend to imbue the state of being with notions of doing, particularly when we use it to describe occupational roles such as being a parent, being a student, being an athlete or being an occupational therapist. Although the notion of being is important to us in this way, cultural impulses to do better and better alter the ways of being in particular roles and burden us with a variety of being in each of which we hope to turn out to be perfect (Wilcock, 1998, p. 251).

Therefore, it is important to rediscover, review, rethink and allow the person to present themselves in their most diverse occupational perspectives to ensure an approach centered on the person and their occupations, formulate new assessments and interventions based on evidence.

For Wilcock (2001), focusing on occupation for health and in relation to people as occupational beings requires us to go back and try to think differently. There is a need to aim for a greater understanding of human engagement in occupation, a greater understanding of ideas about health, and for the development of a theory about the relationship between health and occupation from an occupational health perspective rather than a reductionist medical perspective, which, to us, seems already directed, pre-shaped, pre-established, without respecting the multiplurality of the occupational being.

Therefore, the dimensions presented here recognize a human being who cannot be summarized or reduced, due to the multiplurality and interrelations of the dimensions in the person's life. Therefore, understanding the human being as an occupational being allows us to include that the achievement or decline of occupations are related to the performance and health of that person, who is a dynamic, complex, and multifaceted being.

Conclusion

Given the above, it was possible to identify the importance that carrying out occupations and their relationships have in the lives of each participant, and how the total or partial break impacts each person's self-perception and identity. The diagnosis of a chronic disease, which still presents itself in a stigmatized and stereotyped way, such as cancer, has an impact on the personal world and everything that surrounds the person, consequently, being able to suffer physical-functional, social and spiritual losses. and occupational.

During the interviews, the importance of carrying out occupations was exposed, in which the past and present were compared by the participants, a perception that contributed to positive or negative feelings about themselves and relationships with family members, caregivers and the community.

Based on the participants' reports, it was possible to identify their significant occupations, which were cited as work, activities of daily living, instrumental activities of daily living, social participation, leisure, education, rest, and sleep, as well as the participants' identification and self-perception regarding of the illness and hospitalization process.

The occupational relationships and significant occupations identified could be analyzed by the findings of the proposed philosophy. However, the national literature still has few authors who publish in light of Wilcock's studies and their occupational health perspective. This is partly due to publications on the aforementioned dimensions being restricted to the English language, with the few existing articles being published in English or Spanish, as well as virtual access restrictions that, sometimes, are not free, and books about the subject are not available in Brazil.

Given this, this research encountered difficulties due to the scarcity and lack of research on a national level, mainly due to the difficulty encountered in accessing reading on existing international platforms.

However, this work aims to present the occupational perceptions of people undergoing oncological palliative care through the dimensions of being and doing, seeking to stimulate new research on the topic addressed with the public in question or with other audiences, in other service settings of the therapy professional. occupational.

We, occupational therapists, work with human occupations, and where there is no occupation? Therefore, we point to contexts, scenarios that can be rediscovered, improved and others explored, having as the object of study the occupation and affinity to the contexts proposed for analysis of the object of study.

It is up to us to be professionals who possess techniques, approaches, science, and evidence in health as to why we are in low, medium and high complexity services, as well as why we serve the most variable age groups of human development, and why the repercussions occupational therapists are unique and significant for each age group, person and pathology, and why we are occupational therapists.

Finally, it is necessary to reformulate these answers, and this research dares to consider that health goes beyond the complete state of physical, mental, social, and spiritual well-being, also including occupational health.

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Author's Contributions

Wiviane Kelly de Sousa Pereira participated in preparing the project, obtaining, analyzing and discussing data, in addition to preparing and reviewing the text. Aline Cruz Cavalcante de Pinho participated in guiding the research, analysis, discussion and interpretation of data, in addition to preparing, writing and reviewing the text. Victor Augusto Cavaleiro Corrêa participated in the organization of sources and/or analyses, writing and reviewing the text. Grace Kelly Cabral dos Santos and Rosiléa Mendes Boulhosa participated in reviewing the text. All authors approved the final version of the text.

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