CONTRADICTORY DECISIONS: REASONS THAT LEAD THE FAMILY CAREGIVER TO OMIT CANCER DIAGNOSIS

DECISÕES CONTRADITÓRIAS: MOTIVOS QUE LEVAM O FAMILIAR CUIDADOR A OMITIR O DIAGNÓSTICO DE CÂNCER

DECISIONES CONTRADICTORIAS: RAZONES QUE LLEVEN AL FAMILIAR CUIDADOR A OMITIR EL DIAGNÓSTICO DE CÁNCER

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ABSTRACT

Objective: to know the reasons/reasons that lead the family caregiver to omit the diagnosis of cancer for the sick person. Method: an exploratory, descriptive, qualitative approach, developed in a school hospital, with six family caregivers, through a semi-structured interview recorded. For the analysis of the data, the Operative Proposal was used. Results: it was identified that family-caregivers presented difficulties in understanding what cancer is; Reported to the patient the information they think is not harmful to their health, to spare them suffering; Still demonstrate an expectation of clarification on the technical issues of the disease and the emotional support to face the process of illness on the part of the health team. Conclusion: the study showed the need for Nursing to strengthen the care of information on the disease for the patient and the family, empowering them to make decisions. Descriptors: Nursing; Cancer; Communication; Family; Carers.

RESUMO

Objetivo: conhecer os motivos/razões que levam o familiar cuidador a omitir o diagnóstico de câncer para a pessoa doente. Método: estudo exploratório, descritivo, de abordagem qualitativa, desenvolvido em um hospital escola, com seis familiares cuidadores, por meio de uma entrevista semiestruturada gravada. Para a análise dos dados, foi utilizado a Proposta Operativa. Resultados: identificou-se que os familiares-cuidadores apresentaram dificuldades na compreensão de que o é câncer; referiram repassar ao enfermo as informações que julgam não serem prejudiciais à saúde; ainda demonstram expectativa de esclarecimento sobre as questões técnicas da doença e o apoio emocional para o enfrentamento do processo de adoecimento por parte da equipe de saúde. Conclusão: o estudo mostrou a necessidade de a Enfermagem fortalecer os cuidados com a informação sobre a doença para o paciente e a família, empoderando-los para a tomada de decisões. Descriptores: Enfermagem; Câncer; Comunicação; Família; Cuidadores.

RESUMEN

Objetivo: conocer las motivos/razones que llevan el familiar cuidador a omitir el diagnóstico de cáncer a la persona enferma. Método: estudio descriptivo, exploratorio, de enfoque cualitativo, desarrollado en un hospital de enseñanza, con seis miembros de la familia, cuidadores, mediante una entrevista semiestructurada registrada. Para el análisis de los datos se utilizó la Propuesta Operativa. Resultados: se identificó que los familiares cuidadores mostraron dificultades en la comprensión de lo que es el cáncer; informando al enfermo las informaciones no consideran no serien perjudiciales para la salud, para librarlo del sufrimiento, aún demuestran expectativa de aclaración sobre cuestiones técnicas de la enfermedad y apoyo emocional para enfrentar el proceso de la enfermedad por parte del equipo de salud. Conclusión: el estudio demostró la necesidad de fortalecer la atención de enfermería con la información de la enfermedad para el paciente y la familia, apoderándolos para la toma de decisiones. Descritores: Enfermería; Cáncer; Comunicación; Familia; Cuidadores.

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INTRODUCTION

There is a relation of cancer to pain, suffering, deterioration of being and sensation of finitude, which refers to the importance of care and which should not be limited to the disease and its physical manifestations. In addition, cancer carries with it the belief that it is a cruel and a not understood evil, conceptions that come from the last century. In this context, the family must be prepared to understand and offer support to the person with cancer in the face of conflicts and difficulties, in short, the care needs.

The impact of a disease such as cancer does not only affect the sick subject, but extends to all of their conviviality, imposing changes, requiring reorganization of the family routine, to incorporate daily activities and care that the illness and treatment of the patient require. Such conformation tends to increase the overload of caregivers, requiring diligence and, often, decision-making on diagnosis and treatment.

In this perspective, the family should in no way be excluded from the care process, since it is part of the individual’s life, it is their reference of love, trust and, often, the reason for their existence. Therefore, it is necessary to realize that the disease situation generates anxiety and uncertainties and shows the health professional’s need to know the family, their values, beliefs and worldview that influence their care. From this perception it is possible to guide and assist the patient and the family in a way that is more appropriate and integrated to their needs and their culture.

Communicating the diagnosis of a serious illness, such as cancer, is a delicate moment that can generate intense discomfort for both the patient and his/her family. In this regard, it is up to the health team to rescue the interpersonal, empathic and compassionate relationship with the patient and their family, aiming for established communication to strengthen the bonds of trust and complicity, also contributing to the choice of the most appropriate treatment.

Thus, it is imperative that health professionals be sincere and understandable by providing clear and consistent information so that the best actions can be taken. However, while most patients want to be informed about their health status, they can also interfere with the communication process as they make it clear that they want to receive as little information as possible. Thus, their desire must be respected and a family member should be responsible for receiving information about the patient’s illness process.

Understanding cancer can compromise family relationships and hinder dialogue on the disease, becoming increasingly difficult as the disease progresses, since the very word “cancer” is considered to be a complicating factor when it is mentioned to the patient. In this way, “communication islands” are formed, evidenced by the attempt to save the fragile person from the diagnosis, since, on the one hand, there are the strongest ones and those who are potentially more indicated to receive the diagnosis and, on the other, the sick person.

In this sense, it is important to identify the reasons that cause families to be omitted, taking into account the patient’s rights to know the disease, since the Code of Ethics of Nursing Professionals, 8 in article 26, predicts the duty to provide adequate information to the patient and the family about Nursing care, possible risks and consequences that may occur, as well as article 2, inc. VII of Law No. 10,241 of 17 March 1999, takes into account the patient’s rights to know the diagnosis and the right to consent or refuse any procedure.

Such situations were observed in patients who were hospitalized, receiving all the necessary support to treat the disease, but without knowing the real reason for their hospitalization. Faced with this problem, one can verify the importance of the family member, who sometimes takes responsibility for the physical and emotional needs and also for the omission of the diagnosis. Therefore, this study aims to know the reasons/motives that lead the family-caregiver to omit the diagnosis of cancer for the sick person.

METHOD

An exploratory, descriptive study of a qualitative approach developed in hospitalization units of a school hospital in the southern region of Rio Grande do Sul. Six family-caregivers responsible for the care of their respective relatives were included in the study. The number of participants is justified due to the low turnover of patients at the study site during the period of data collection, as well as the criterion of omission of diagnosis to the sick family member. However, the conceptions, explanations and senses attributed by the participants had a frequency of presentation.

The search for participants took place, firstly, through a conversation with the nurses of the units where oncological patients were hospitalized, thus explaining the purpose of the study. In contrast, they reported that
there were no patients who did not know the disease, after all, how will the patient not know that they have cancer? Then, it was decided to talk directly with the relatives of the hospitalized patients. Thus, the participants were quickly found, evidencing that the nurses were not aware of the situation in which the patients and their respective relatives were.

After receiving a favorable opinion from the Research Ethics Committee under No. 861,843, data collection began, which occurred in October and November 2014, through semi-structured recorded interviews. An individual interview was held with each participant, lasting approximately thirty minutes, after signing the Free and Informed Consent Term (FICT) in two copies, in accordance with the ethical principles contained in CNS Resolution 466/2012 and Resolution 311 / 2007 of the Code of Ethics of Nursing Professionals. The interview is the most used means in the work field, because, through it, the researcher investigates and seeks to obtain the necessary information in the speech of the collaborators and, in this way, obtain objective and subjective data. In addition, in the semi-structured interview, a closed and open question method is used, in which the interviewer freely approaches the proposed theme, in addition to the previously formulated approach.9

As a way of preserving identity, the participants were identified by the letter “F” of the family and the number corresponding to the order that the interviews occurred, being F1 the first, F2 the second and so on, followed by the degree of kinship with the patient, such as “F3, daughter of the patient”.

For the analysis of the data, Minayo’s Operative Proposal was used, structuring and organizing the content in two moments: the first one refers to the exploratory phase of the investigation, constituting the fundamental theoretical framework for the analysis, and the second moment is the interpretive one, in which the informants' reports are used to give meaning, logic and projection. It seeks to understand and aggregate the answers, making an interconnection of the objectives and assumptions of the research with the theoretical reference.

**RESULTS AND DISCUSSION**

To better understand the results, we chose to present the data in three categories: Cancer: the perception of the family caregiver; The silencing of the diagnosis; Communication: the role of the health team.

**Cancer: the perception of the family caregiver**

Historically, cancer is a disease associated with experiences saturated with suffering and pain, followed by death. Because of the stigma surrounding it, it may be related to a fatal, shameful disease, marginalizing the patient, and cultivating pessimistic feelings about disease and treatment.10-11

In order to understand the reasons that led the participants not to talk openly about the illness with their sick relative, it was considered important to investigate the understanding that these family caregivers have in the face of this illness.

I think cancer is the disease of the century and the cure does not come, but there are a lot of treatments and where the hope is still the day that the cure for cancer comes. But it really is a cruel disease, it really takes us. (F4, ex-wife of the patient)

I believe that cancer stands out from other diseases because it is a more aggressive disease, so we see it with other eyes, you have an idea, a conception of a disease that is a little difficult to treat. It is difficult to receive the news of a cancer [...]. (F6, daughter of the patient)

The fear of death is seen as something that accompanies the individual throughout his or her journey in coping with the disease. In this sense, for the relative there is a great possibility of relapses of the disease, causing them suffering and anguish with the possibility that, in case the illness is cured, it returns and leads to death.

For me, cancer is the worst disease there is. For me there is no cure, like you healed, but in a while it comes back and, when it comes back, it takes you. I think like this, for me there is no cure. (F5, daughter of the patient)

Thus, the stigma of a degenerative and incurable disease is reported as a major feature of cancer, which is presented as a termination process, which can be noted in the expression “it takes you”. In that sense, as long as the disease is treated as a curse and considered as an invincible destroyer, there will be discrimination and a feeling of impotence.

Cancer is considered one of the worst diseases due to aggressive, mutilating treatments and because it is a chronic, life-threatening disease. Chronic diseases are long-term diseases, which can be incurable and, most of the time, cause sequelae and functional limitations. Thus, the chronic patient faces changes in his/her lifestyle caused by the disease itself and by the recurrence of hospital admissions.12 In addition, this fact is shared by the family.
Look, I think it’s a terrible disease, the moment it manifests and goes into the bloodstream, I think that unfortunately the thing is very complicated. It is the case of my mother, I find my mother a very difficult situation, despite being lung cancer. But I think it’s getting late every day, so for me cancer is a terrible disease. (F3, daughter of the patient)

These people who are mainly in this oncological situation, let’s say like this […] they are getting thinner, they are seeing their bodies transform, it is a process of physical degradation let’s say like that (F6, daughter of the patient).

The family realizes that the patient faces a change in their functional capacity because of their physical condition, because cancer results in changes such as alopecia, pain, nausea, vomiting, diarrhea, mucositis, fatigue and muscular atrophy, altering body image. 12

In view of this, it can be seen how much the disease affects the family environment and generates great difficulty in dealing with the situation, because despite the technical-scientific advances achieved, which make prevention and early detection possible, the diagnosis of cancer is still done late, reinforcing the idea of a disease without cure.

It should be noted that although cancer is a relatively well-known disease, some participants did not know how to express their understanding of the disease clearly.

Yes, but what can I say what I think about cancer? I think it’s a disease that I do not know if there is a cure or if there is treatment. We’re here to fight. (F1, patient’s wife)

What I think [silence] I do not know, I already lost my father now two years ago with cancer, his father actually that I call father, from prostate cancer. So it’s kind of difficult, it’s a complicated situation for us [silence], I do not know how to explain. (F2, patient’s niece)

Because of this, it is evident that relatives do not have information about the disease, do not seek information, nor are they informed by the multidisciplinary team. For this reason, the patient and the family need to receive attention from the health team, as well as the information necessary for a good coping of the disease, for better adherence and response to treatment and, consequently, for the continuity of the family balance.

However, it is noticeable that this gap in communication makes it impossible for family members to be properly informed and participatory in the disease process. In view of this, it is argued that one of the complicating factors for coping with the disease is poor communication between the health team, the family and the patient. 14

It is worth noting that family members feel helpless, not knowing how to deal with the situation, preferring silence, since the subject requires an adequate verbal management, integrating support and clarification, and this is one of the problems identified in family speech: lack of knowledge about the disease.

In this context, in relation to the family-caregiver’s perception about the disease, it has been identified that cancer is seen as overwhelming, without cure and therefore without a life perspective. This fact is evidenced when they use the expressions “disease of the century” and “it excels all the other illnesses”. However, some relatives were uninformed because when they were questioned, they reported “I do not know how to explain”, “I do not know if there is a cure or if there is treatment.”

The silencing of the diagnosis

Cancer is still considered one of the worst diseases by common sense, which generates a fragility in the relatives by the diagnosis itself. Likewise, faced with this idea, cancer compromises family relationships, making it difficult to speak about the disease, which becomes progressively larger, according to its progress. 5,12 In addition, when imagining that they may have a serious illness, the patient enters into a phase of denial that is perceptible when inferring negative attitudes if they knew about the disease. The denial phase is characterized as a psychic defense and serves as a temporary defense mechanism, as it alleviates the impact of the news.15

Taking into account the difficulty of the family member to talk about the situation experienced by the patient, there is, in the speeches, the concreteness of the evidences raised:

When he started to get sick, when he found out [that he was sick and not the disease], because who got them most of the exams was me, who went in there more with the doctor. I already asked not to say anything, that’s what he said to me: “If I find out that I have a serious illness, I’m going to kill myself”, and so we kept silent, all the children knew, but we were quiet […] The only one who does not know is him […] nobody wanted to tell, everyone is afraid. (F1, patient’s wife)

Moreover, in the F1 report, it can be seen that the patient is excluded from the diagnosis-treatment process, since the family member assumes the role of caregiver and information holder, passing on only what he deems necessary, that which in his
understanding, will not further harm the health of the patient.

Thus, the most striking factor is the patient’s vulnerability in relation to the content of the communication and their sensitivity due to the situation they are experiencing, because when it comes to information about the prognosis of the disease, the patient who wants less information is the one with the worst prognosis and who avoids thinking about death.7

Who knows even from the situation that he is living and that he has been caught in, we continue in this silence. As he never asked us, we continue in that silence that seems a secret, we deal with it [...] As he closed himself to this side of this disease then we felt that there is a closure in him, so we do not talk about it either, we take care [...] we treat it in a good way without there being communication of speaking in cancer [...] It may be worse, he may panic, that is our expectation, then, we do not to tell him not to make things worse at his difficult time. (F4, ex-wife of the patient)

Therefore, the existence of the disease causes suffering to all family members, and therefore, in trying to protect and save the patient from suffering, it creates a “secret” about the disease. Nevertheless, this attitude can also cause suffering because it restrain the feelings of both parties.2, 3

Thus, the participants talk about the fear of revealing the diagnosis, since they presuppose the feelings and unfavorable reactions that their relatives can demonstrate to the knowledge of the disease. Thus, with each examination requested by the physician and according to the worsening of the patient’s prognosis, the relatives end up postponing the conversation about the diagnosis.

We’re waiting for all the exams to be ready to have everything right and then talk to him to see if he’s going to take it, we’re afraid he will not be able to [...] We do not want to drop the whole bomb on him, like that once and for all. (F2, patient’s niece)

Failure to communicate, in order to “preserve” the patient, is an erroneous conduct that disparages the reality of the facts. On the other hand, family caregivers, with the intention of protecting the patients, end up choosing not to tell them about the reality, because they believe that if the patient knows about the disease, the clinical condition will worsen.16

Because I think that when the person knows that he has, he knows most of the time the depression comes, if it is not already coming and is where the person ends up becoming more and more debilitated. I guess you should not know, at least my mom I do not want her to know. (F5, daughter of the patient)

In the field of Nursing, communication represents a strategy of great relevance for the practice of care, being one of the main instruments of health care, especially when addressed to patients facing a daunting diagnosis such as cancer. In this situation, communication and interaction are considered important processes, by inducing actions and reactions between individuals and groups, assuming that communication goes beyond words and content, since it contemplates other senses and perceptions, such as attentive listening, look and posture.17

The communication of the diagnosis of cancer represents the beginning of very suffered experiences that can generate varied emotions, since being diagnosed with cancer is understood as a dramatic, unexpected and shocking experience. As a result, the participants, when questioned by their relatives about the reason for the hospitalization, are faced with the dilemma of what to say so as not to frighten or depress them, so they end up hiding the real situation, presenting, as justification, conducting research tests and designating cancer as an “injury” or a “problem”.

In this context, communication is affected by the fact that communication processes are depleted of content, providing mechanisms of escape, use of euphemisms, so as not to run the risk of lack of transparency and omission.18

No, now quite accurate like this cancer he does not know, but he knows he has a lung injury, that he knows, but he does not know what it is. (F1, patient’s wife)

 [...] she already asked me this: why was she in the hospital? Then I just said that there had been some problems in the gut and liver, and that we were in the hospital just to investigate and treat this problem. (F6, daughter of the patient)

In short, the importance of the family member as support and support to the patient is unquestionable because, although they are a lay person, they take responsibility for the physical and emotional needs, resulting in overload, anxiety, depression and uncertainties, which requires patience on the part of the care team.
Neves FB das, Noguez PT, Guimarães SRL et al.

Therefore, this situation demands of Nursing a comprehensive care of support and education, in order to clarify the circumstances presented, to attend the needs of the patient, not forgetting that their caregivers are also part of the recovery process and, the better informed, the better the patient's empowerment, making care complete.

Another important factor to consider is the family members' knowledge about the patients' rights to know their health condition. When asked about this question, the participants were apprehensive, most of which answered yes, but without justifying and exemplifying.

Yeah, kind of. Right now she's pressuring the doctors, pressuring one and another, she wants to know what she has. I do not know how much we'll be able to hide from her, so it's a right she has, if she really wants to know what she has, it's not going to be me, I cannot stop her. (F3, daughter of the patient)

Yes I have, I have, but I do not know, I do not believe that much, like this you know, because I think when it is, it is and there is nothing to change [...]. I do not know, I think differently, you know, there are people who have [silence] it is not that I have faith, something like that, I have, you can have faith, you can have willpower, but it is beyond, you know, [That goes beyond rights], then it's something that happens. (F5, daughter of the patient)

Yes, I believe that every person has every right to know what is happening to them, it is a right that every human being has, in any way even if you do not communicate [...]. (F6, daughter of the patient)

The testimonies reveal that family-caregivers recognize that the patient has the right to know about the disease, however, they do not know how to theoretically refer to the legal formal and, therefore, escape the focus of the question. In addition, despite the patient questioning about their health condition, the information is not passed on or is partially passed on. This fact is consistent with the health team, which disregards the fact that information is a right and not an obligation.

In this conception, it is frequent to come across facts that seem to show attitudes of disrespect to patients' rights, which gives an impression that Nursing professionals are not able to adequately provide information, either for the patient or for the relative. Therefore, it is essential that Nursing consider that the responsibility of caring implies awareness of ethical attitudes in daily practice with the patient, in the analysis of ethical and bioethical conflicts and dilemmas encountered. Thus, thinking about values, meanings, beliefs and behaviors, in the face of the conflicts that emerge from care in practice, is a sign of concern for the other, maturing and professional and personal growth.16,19

In this perspective, according to family members, communicating becomes an aggravating factor in the recovery of the patient, because "they do not want to hurt him", "most of the time comes depression" or "we are afraid that he will not stand." In the same way, relatives refer to some manifestations of the patients about the disease as "he is stuck", "only the word cancer is already a terror to her" and "if I find out that I have a serious illness I will kill myself", justifying, therefore, their decision not to disclose the diagnosis.

♦ Communication: the role of the health team

In order for the care provided to cancer patients to be truly holistic, they must be cared for by an interdisciplinary team, since they need, above all, psychological support, which must also be extended to the family, because transmitting bad news, as in the case of diagnosis of cancer, requires preparation and sensitivity, since there is a strong psychological, physical and interpersonal implication.20 Therefore, when asking the next of kin about the decision to omit the diagnosis, the following answers arose:

It was mine, for fear and fright [...], I live with him more and if he has anything he usually talks more to me. [F1, patient's wife]

The daughter, his daughter, for all her love she asks: if he is stuck let's not say anything not to hurt him. It came from the daughter and everyone accepted because we know and we know how to deal with this situation. (F4, ex-wife of the patient)

My, myself [...]. At least I said this: I do not want her to know. (F5, daughter of the patient)

In most cases, the decision to omit came from the family member, however, in one case, the decision was made by the doctor and, in the other, a consensus between the family member and the doctor.

The doctor. Her physician, when he found out she had lung cancer, he asked me to spare her as much as possible this of telling her. Because the word cancer, only the word cancer for her is already a terror. So he asked me to spare her from this suffering even more, as much as possible to tell her. (F3, daughter of the patient)

You want to know the truth [silence] I do not even know if it was from my sister, from
Caring for the cancer patient requires human, not just scientific, attitudes. It is necessary that, besides seeing the disease, the professional knows that there is also a healthy side in this patient. It should be emphasized that the multi-professional team should present a work focused on comfort, dignity and respect for the patient, as well as the right to receive explanations about their illness, actively participating in informed consultations and decisions. However, such requirements imply greater availability of these professionals, who, for the most part, are overwhelmed at work, performing their duties with reduced teams and with greater demand. However, it can be observed that the conduct of the health professionals does not match the one recommended, because when asked about the doctor's behavior in the situation, the family member answered:

*The doctor has not entered this detail of talking or not talking, he talks to us. We talk about it there, we always try to improve his situation, in his bed, but the doctor is in the same situation as we are, doesn't come to say it.* (F4, ex-wife of the patient)

The restrictions of diagnostic information can start from paternalism, because with the paternalistic attitude, the doctor tries to protect his patient from bad news and from great emotional impacts. In addition, alienation, neutrality and indifference to the patient are necessary conditions for the proper development of work, since they distract the professional's anguish from the death of the other and from themselves and, therefore, doctors tend to not face the terminality, constituting a taboo they try to avoid. However, based on the principles of Bioethics, it can be said that the communication of the diagnostic truth to the patient and his/her relatives is a benefit for them, since it makes it possible for their active participation in the decision-making process.

In addition, communication difficulties occur especially in discussions involving issues of illness and death, more precisely in the case of oncology, which is stigmatized. These implications are that they contribute to the omission of truth, to the use of lies or even silence in the oncological physician-patient relationship, establishing this pattern of behavior as being morally correct.

Not only is the physician placed as a bridge between the knowledge of family members and patients, but Nursing is also present in this communication process. However, when questioning family caregivers about the role of the nurse in the unit where the patients are hospitalized, such responses were obtained:

*I do not have much intimacy with her, she did not talk to me.* (F3, daughter of the patient)

*She treats us like the technicians who help us, she also attends to us, we know that she is a nurse by the clothes [...]. But she also never stopped and did not even call us to talk about what the cancer does, what will happen to our patient there, what can happen, how it will be dealt with or will not be dealt with. No, at least our nurse, in our sector, she remains as the technicians [...]. As I say, from her superior study compared with the others, the difference in that is not doing anything, because they treat us well, but there is no dialogue.* (F4, ex-wife of the patient)

It is observed in F4's testimony, that she hoped for a dialogue on the part of the nurse about the condition of her relative, since the latter has higher education and should interact with these clients, however, there are communication difficulties between nurses and patients. Such a situation is worrying, since it is also the job of the nurse to provide information or to educate cancer patients and their families about technical issues, as well as to provide emotional support...
and information that is appropriate and compatible with patient needs and to develop coping skills. Moreover, the unwillingness to communicate or interact with patients is interpreted as a distant attitude that can generate feelings of fear and abandonment.25

In view of this, the cancer patient emits psychological signals that can trigger depression, resulting in difficult moments for them and their family, such as the search for meanings that justify why they are ill, what they did to deserve such diagnoses, loss of control of their decisions, and in some cases, the family excludes the patient from his or her own treatment and stigmatizes it. Such difficulties can often be overcome with professional help, but they are usually not reported to physicians and thus go unnoticed or are not properly exploited and cared for, which can cause greater harm.26

Thus, communication is of great importance and constitutes a basic instrument for the care to be provided, as well as the creation of a link capable of satisfying the needs presented by the patient. In this way, it is possible to identify and understand the problems that occur, facilitating professional and personal interaction.27 Therefore, it can be affirmed that Nursing plays a major role with the multi-professional health team in the care of cancer patients, because it acts in the several areas that serve it and presents communication as one of the forms of care.

On the other hand, in this study, it was identified that doctors and nurses rarely intervene in the process of communication and support to these families, since the relatives report the detachment and lack of dialogue of the team with them. This fact is verified when the familiar-caregiver says: “the doctor has not yet entered this detail of speaking or not talking”, “she (nurse) treats us well but does not have dialogue” and “she did not talk to me”.

It is known that cancer triggers devastating reactions in both the organic and the emotional environment, provoking feelings, imbalances and internal conflicts.

The family is part of this process and takes care of and responsibilities that are often excluded from the patient in order to avoid worries and hassles.

Therefore, the nurse must stop being just a task-taker and assume the self-determination of their duties, articulating, in the best way, the dilemmas that arise daily in the work environment. Therefore, it is considered that it is in this conception that the vision, understanding, comprehending and care practices of the

Nursing regarding the dialogue with the patient and family about a stigmatizing disease like cancer.

CONCLUSION

This study allowed to identify the understanding of the caregiver family member about cancer, clarification and knowledge about the reasons that lead them to choose not to communicate to the patient about the diagnosis, as well as from whom the decision came from not to tell them about the disease and whether the family caregivers are aware of the patient’s legal rights to know about the disease. In addition, it made it possible to identify the participation of health professionals in these cases and that they exert a great influence on the conduct and decisions taken by the family.

It is considered that, although the communication of the diagnosis is only of medical practice, it is of the utmost importance to be open to the inclusion of other trained professionals, taking the paternalistic figure that the doctor knows and resolves, giving him the place of reverence. Increasingly, interventions are needed that can help health professionals communicate better with their patients in the face of bad news. However, it is revealed that Nursing is restricted only to procedures, not taking into account the delicate moment lived by the patient and everyone around him.

Thus, it is important to know the context of the patient, as well as the process of being part of a multiprofessional team and working in an interdisciplinary way with the purpose of an integral and effective attention. For this, it is necessary, besides quality assistance, to have a search for a greater understanding and effectiveness of the actions that are not limited to procedures, but, rather, that they expand to the humanized care in all the scopes.

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