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Transition to exclusive palliative care for women with breast cancer

Transição para o cuidado paliativo exclusivo de mulheres com câncer de mama
Transición para el cuidado paliativo exclusivo de mujeres con cáncer

Audrei Castro Telles[I]
ORCID: 0000-0002-1191-5850

Paulo Alexandre de Souza São Bento[II]
ORCID: 0000-0002-1598-3340

Marléa Crescêncio Chagas[I]
ORCID: 0000-0002-6122-7300

Ana Beatriz Azevedo de Queiroz[I]
ORCID: 0000-0003-2447-6137

Nair Caroline Cavalcanti de Mendonça Bittencourt[I]
ORCID: 0000-0002-4451-6258

Marcelle Miranda da Silva[I]
ORCID: 0000-0003-4872-7252

[I] *Universidade Federal do Rio de Janeiro. Rio de Janeiro, Rio de Janeiro, Brazil.*
[II] *Fundação Oswaldo Cruz, Instituto Nacional de Saúde da Mulher, da Criança e do Adolescente Fernandes Figueira. Rio de Janeiro, Rio de Janeiro, Brazil.*

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Corresponding author:
Marcelle Miranda da Silva
E-mail: marcellemsufrj@gmail.com

EDITOR IN CHIEF: Dulce Barbosa
ASSOCIATE EDITOR: Hugo Fernandes

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ABSTRACT

Objective: to analyze the perspectives that affect the transition to exclusive palliative care for women with breast cancer. **Methods:** qualitative, descriptive study, carried out in a public health institution in Rio de Janeiro, Brazil, between December 2018 and May 2019. 28 health professionals were interviewed. Content analysis was used in the thematic modality. **Results:** the operational difficulties were linked to the fragmented physical structure, the late and unplanned nature of the referral, the ineffective communication, and the deficit of human resources. In general, women and family members resist referral because they do not know palliative care. There is no consensus among oncologists on the most appropriate time to stop systemic therapy for disease control. **Final considerations:** the perceived difficulties configure an abrupt referral, accompanied by false hopes and, often, limited to end-of-life care.

Descriptors: Oncology Nursing; Patient Care Team; Palliative Care; Breast Neoplasms; Transitional Care.

RESUMO

Objetivo: analisar as perspectivas que tangenciam o processo de transição para o cuidado paliativo exclusivo de mulheres com câncer de mama. **Métodos:** estudo qualitativo, descritivo, realizado em instituição de saúde pública no Rio de Janeiro, Brasil, entre dezembro de 2018 e maio de 2019. Foram entrevistados 28 profissionais de saúde. Utilizou-se a análise de conteúdo na modalidade temática. **Resultados:** as dificuldades operacionais atrelaram-se à estrutura física fragmentada, ao caráter tardio e não planejado do encaminhamento, à comunicação ineficaz e déficit de recursos humanos. Em geral, mulheres e familiares resistem ao encaminhamento por não conhecerem o cuidado paliativo. Não há consenso dos oncologistas sobre o momento mais adequado para interromper a terapia sistêmica para controle da doença. **Considerações finais:** as dificuldades percebidas configuram o encaminhamento abrupto, acompanhado de falsas esperanças e, muitas vezes, limitado aos cuidados no fim da vida.

Descritores: Enfermagem Oncológica; Equipe de Assistência ao Paciente; Cuidados Paliativos; Neoplasias da Mama; Cuidado Transicional.

RESUMEN

Objetivo: analizar las perspectivas que tocan el proceso de transición al cuidado paliativo exclusivo de mujeres con cáncer de mama. **Métodos:** estudio cualitativo, descriptivo, realizado en institución de salud pública en Rio de Janeiro, Brasil, entre diciembre de 2018 y mayo de 2019. Fueron entrevistados 28 profesionales de salud. Utilizó el análisis de contenido en la modalidad temático. **Resultados:** las dificultades operacionales atraillaron a la estructura física fragmentada, al carácter tardío y no planeado del encaminamiento, a la comunicación ineficaz y déficit de recursos humanos. En general, mujeres y familiares resisten al encaminamiento por no conocieren el cuidado paliativo. No hay consenso de los oncólogos acerca del momento más adecuado para interrumpir la terapia sistémica al control de la enfermedad. **Consideraciones finales:** las dificultades percibidas configuran el encaminamiento abrupto, acompañado de falsas esperanzas y, muchas veces, limitado a los cuidados en el fin de la vida.

Descriptores: Enfermería Oncológica; Grupo de Atención al Paciente; Cuidados Paliativos; Neoplasias de la Mama; Cuidado de Transición.

INTRODUCTION

Due to the increasing incidence, morbidity and mortality and high costs of treatments, breast cancer is a global public health problem, responsible for the main cause of death among women in developed countries and the second most common cause in economically developing countries, especially in South America and the Caribbean(1-2). In 2018, breast cancer was responsible for 24.2% of the estimated global cancer burden in women(2). In Brazil, by 2020, 66,280 new cases of the disease were estimated(3).

The recognition of the triggering factors, as well as the strategies applied for screening and early diagnosis of breast cancer, have not yet managed to promote an effective reduction of its social impact, even in developed countries. However, the availability of good resources in countries with stable economies has an impact on the survival rate. In North America, Sweden, and Japan, for example, the breast cancer survival rate varies around 80%, while in middle-income countries this variation is around 60%. The situation is even worse in low-income countries, with a survival rate of approximately 40%, the main reason being the delay in diagnosis and the consequent more advanced stage of the disease(1,4).

In view of this scenario, despite palliative care aimed at preventing and relieving suffering during all stages of oncological disease, including addressing problems arising from treatments, both in survivors and in women who end up dying, studies show that, in most cases, health services, palliative care has only started when the disease-modifying treatment is no longer beneficial or possible(2,5).

In addition to the ideological issue, based on the reference to the biomedical model and its mechanistic and deterministic limitation, palliative care is unfortunately unavailable in many countries, especially in the middle and low income, which results in unnecessary suffering(2). The regulation for the implementation of palliative care in the Brazilian health system is recent, with the publication of, in October 2018, the Resolution of the Ministry of Health no 41, which provides for the guidelines for its organization, in the light of continuous care integrated, within the scope of the Unified Health System(SUS)(6).

Palliative care, especially in the case of advanced oncological disease, can assume an exclusive character throughout the patient's therapeutic itinerary, that is, in this case, palliative care is not associated with systemic treatments to control the disease or any other futile diagnostic procedures, but structured based on the acceptance of the natural evolution of the disease, including care directed to patients in an active process of death(6-7).

There are criteria for the indication of exclusive palliative care and, among them, are the person's lifetime prognosis, the assessment of scores related to quality of life and functional capacity. However, although these issues are discussed in the literature, there are many difficulties experienced in practice, which raises the need for scientific production on the subject(8-9).

Women with advanced breast cancer often receive palliative chemotherapy to improve symptoms and stabilize the disease, in addition to the possibility of hormonal and immuno-oncological drugs. However, the impact of such treatments on the quality of life of these women is controversial, especially chemotherapy, associated with greater toxicity(10-11).

Although systemic therapy with a palliative objective is the basis for the treatment of women with advanced breast cancer, it is necessary to recognize the moment when it should be contraindicated. As most oncologists do not use, in practice, clinical criteria that can guide decision-making in favor of therapeutic proportionality, beneficence and non-maleficence, women may be susceptible to therapeutic futility and worsening quality of life(12-13).

Thus, the question is: what are the perspectives that affect the process of transition to exclusive palliative care for women with breast cancer?

OBJECTIVE

To analyze the perspectives that affect the transition to exclusive palliative care for women with breast cancer.

METHODS

Ethical aspects

The research project was approved by the Research Ethics Committee of the proposing and co-participating institutions, in September 2018. The participants signed the Free and Informed Consent Form, and the testimonies were identified by alphanumeric codes (Prof 1 - Professional 1).

Study type

Qualitative and descriptive study. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to ensure better validity of methodological aspects.

Study scenario

The setting for the study was the breast cancer treatment unit of a public health institution located in Rio de Janeiro, Brazil. This institution also has an exclusive palliative care unit.

The referral of patients to the exclusive palliative care unit begins when the medical team of the unit of origin (in this case, the one specialized in breast cancer) assesses the woman's clinical condition related to the disease response to the treatments performed and defines their interruption. This woman's first contact with exclusive palliative care still occurs at the unit of origin, right after referral, from the approach of a nurse.

In each unit of the institution, there is an advanced pole of the exclusive palliative care unit, in which this nurse specialized in palliative care, after checking and agreeing with the referral, confirms the indication of this care, defines the most appropriate care modality to the condition of the patient, whether outpatient, home or hospitalization, and welcomes patients and family members, providing guidance on the objectives of palliative care.

Thus, women with advanced cancer are referred to exclusive palliative care who have exhausted the protocols for treatment or control of oncological disease, or who have no clinical indication for this approach. Women with severe and unstable clinical conditions to withstand the displacement between hospital units are not transferred, remaining in the original unit. Once referred to the exclusive palliative care unit, the woman is disconnected from the unit of origin, and starts to be cared for by a new team of professionals (specialists in palliative care).

Data source

28 professionals participated in the study, being 6 doctors, 6 nurses, 4 nursing technicians, 2 physical therapists, 2 social workers, 2 nutritionists, 1 psychologist, 2 resident nurses, 2 resident doctors and 1 physiotherapy resident.

The inclusion criteria were: health professionals with an employment relationship with the institution and who had worked for more than six months in the outpatient clinic, in the clinical ward and/or in the emergency room; professionals who were taking the lato sensu postgraduate course in oncology in the residency modality were included in any stage of the course. Professionals on leave of any kind were excluded during the data collection period.

The participants were selected in a non-random manner, by judgment, considering the interest in composing the sample with professionals from different categories of the multi-professional team.

Data collection and organization

Data were collected between December 2018 and May 2019. The interviews were recorded digitally, with an average time of 22 minutes, making a total of 10.6 hours of recording and, subsequently, were transcribed in full. The recurrence of themes and the absence of new elements were identified in the 20th interview, however, it was continued until the 28th to reach the degree of data saturation(14).

Initially, a pilot interview was conducted to test the instrument, which consisted of a semi-structured interview based on the following script: How do you perceive the transition to exclusive palliative care for women with advanced breast cancer? For you, how does the transition process interfere with the management of health care?

Based on the data collected in the pilot, the script was approved and subsequently applied to the other participants without the need for repetition of the interviews.

Data collection was performed in person by a trained researcher who was in the process of professional training as an academic master's student in nursing. The researcher is a nurse, specialized in oncology nursing, with 17 years of experience in oncology practice, of which, 8 years in palliative care.

The invitation to potential participants was made personally by the researcher, when explaining the interest of the theme and objectives of the study. All potential participants who were invited accepted to participate in the study, and so the day, time (outside working hours) and place for interviews were scheduled, which took place in rooms within the field research unit itself, where only the researcher and the interviewee remained present.

The professional profile of the participants was characterized, considering: the professional category, the time of training, the unit/sector of activity and the time of activity in the sector.

After data collection, the partial research report was presented to the group of participants at a scientific meeting coordinated by the unit's continuing education sector, which contributes to the validation of the data.

Data analysis

Thematic content analysis was used, in which the transcribed speeches went through three phases: pre-analysis (floating reading of the empirical material), exploration of the material (when the raw data were transformed into units that represented meanings, being, later, aggregated in the categories) and phase of treatment and interpretation of the results(14).

The organization of the data was carried out in the Microsoft Word, word processor. The main inferences of each interview were organized in tables during the exploration of the material by two researchers, who then grouped the themes into categories.

Three categories emanated, namely: Operational difficulties in the care transition process; Predominance of the biomedical model and therapeutic obstinacy for the control of breast cancer; and the current care model and care management aimed at women with advanced breast cancer. However, in this study, only the first category on operational difficulties in the care transition process was addressed, given the density of data regarding the perspectives that affect this process in the context of breast cancer.

Data analysis was based on conceptual bases on the theme, based on the review of updated literature.

RESULTS

From the professional profile of the 28 participants, a heterogeneous group in terms of professional categories stood out. Regarding training time, seven professionals were from 6 months to 5 years old; four, from 6 to 10 years old; six, from 11 to 15 years old; three, from 16 to 20 years old, three, from 21 to 25 years old, and five professionals had more than 25 years of training. Regarding the length of experience in the sector, except for residents, the average time was 6 years, considering the shortest time of 1 year and the longest of 29 years. The ambulatory predominated among the sectors of activity. Many professionals worked in more than one sector.

The main inferences of the category "Operational difficulties in the care transition process" are shown in Chart 1.

Chart 1 – Main inferences

Categories	Inferences
Operational difficulties in the care transition process	The transition process is not worked out properly. The transition is late, abrupt and unplanned. It is not recognized as a process.
	Lack of knowledge, on the part of the woman and her family, about the purpose of palliative care, generating resistance.
	Fragmented physical structure between care units.
	Deficit of human resources and work overload.
	Failure in communication between professionals, patient and family.
	Absence of clinical consensus on the correct time to stop systemic therapy. Availability of many chemotherapy lines for advanced breast cancer.

The transition to exclusive palliative care is a complex moment in assisting women with breast cancer, with repercussions for everyone involved:

> […] *It is not very well worked. They just say: "From now on, there is no more."* […] *It is so bad for the patient because they lose quality of life and ends up not enjoying the last days in the way they should, because there is wear and tear coming to the hospital. For the family that gets sick together because they have to be coming and accompanying and do not understand very well what is happening, and whenever they say that there is a possibility of a cure, they cling to it and always want to try. And for the professional too, because they see that sometimes, what they are doing is not being beneficial.* (Prof. 27)

Investment in palliative chemotherapy lines with no proven benefit and routine service flows that include a lack of clinical consensus on the appropriate time to stop systemic treatment delay the referral to exclusive palliative care, leading to a gradual loss of the patient's functional condition of women.

> *Generally, people transfer women when they are no longer in general condition to support chemotherapy. Or when, sometimes, they are well, but they have exhausted all lines of treatment, and we no longer have any treatment to offer* […]. *And my perception of this routine is that they are sent too late. We see very deteriorated women* […]. (Prof. 17)

The transition process investigated is marked by difficulties that interfere with its operationalization, from the recognition of the clinical profile of women, to the use of hospital resources and services.

> *Here at the breast cancer unit, without a doubt, the transfer to exclusive palliative care is late. Because women, sometimes, are already referred in a condition of great clinical severity, sometimes they are not even transferred.* (Prof. 10)

The transition process was considered abrupt and originated from a fragmented structure, from a routine based on the dynamics of transfers between units, in which palliative care does not integrate the care philosophy since the diagnosis, being indicated, mostly, at the end of life.

> *When you talk about stopping chemotherapy, it ends up being extremely blunt, because she didn't understand what the focus of treatment was, didn't understand that she didn't have a chance to cure, that the disease was incurable, and the moment you move on to palliative care, it seems that it is a situation of abandonment* […]. *The patient may finally realize - and so does the family - that the treatment was without curative intent, and then she is transferred to another unit. Go to another service that there is a whole question of a perception of proximity to death* […]. (Prof. 18)

> *I realize that it is a split and, especially nowadays, because we are not getting the same oncology doctor to see the patient, due to staff shortages. So, what happens is that a doctor who is seeing sometimes for the first or second time makes the referral for palliative care.* (Prof. 20)

The difficulty of communication between the team, the woman and their families is a problem that affects the process of transition of care. Communication is not clear, not even procedural, with flaws. In the testimonies, there is a lack of systematic to communicate the transition/forwarding process.

> […] *they go to the hospital, think they will be cured, but then they find themselves in palliative care, but in a way that is not communicated, it is not cleared up with tranquility, an environment where you have more privacy* […]. *Sometimes, they are unaware that they have multiple complications and, sometimes, they are already admitted in a palliative condition.* (Prof. 10)

> […] *I think that there is no preparation by the team to inform this at the time of an appointment, there at the clinic, I think it has to be at the consultation; and when they arrive here to intern, when they receive the news* […] *Wow! It is a shock* […]. *Even because the palliative care unit has a bad reputation* […]. (Prof. 19)

The lack of consensus among oncologists on the most appropriate time to stop systemic therapy contributes to the difficulties in decision making for the transition of care.

> […] *much of the family's resistance to the referral and the suspension of treatment, in fact, is because of the failure to communicate in the long term, because again you communicate in the acute is much more difficult than communicating in the chronic* […]. *I think most women are not very aware that when they are undergoing palliative chemotherapy, they are already in palliative care* (Prof. 18).

> […] *imagine for the patient and the relative, the doctor arrives and says: "Look, unfortunately everything has already been done and there is nothing more to do." And the other one says: "No, you're going to have chemotherapy." "But the doctor said yesterday that he wasn't going to do it." There is a protocol, and then two days later, there is really nothing else to do, and she sends the patient to the palliative care unit. Can you imagine!* […]. (Prof. 21)

The late aspect of the care transition was attributed to the availability of diverse lines of chemotherapy for advanced breast cancer.

> *The patient with breast cancer is a patient who has many lines of treatment, which will, yes, be poly-treated women, and it makes sense that they are poly-treated. This is something that, sometimes, the staff of the palliative care unit has difficulty understanding.* […] *in fact, it is clear that the patient will lose functional capacity throughout their life, but we also know that there is a patient with breast cancer who will be 12, 15 years with metastatic disease and treating it. And are you going to stop offering it to them?* […]. (Prof. 18)

DISCUSSION

The transition to exclusive palliative care is crossed by numerous obstacles, namely: the possibility of controlling the disease in the face of the various systemic treatments for advanced breast cancer; the difficulty on the part of the medical team to assess the fine line between the importance and futility of antineoplastic treatment in advanced disease; the resistance of women and their families to interrupt treatment for the cure and control of the disease; the embarrassment of professionals to communicate and accept the real situation of women, in addition to barriers arising from cultural, linguistic and religious differences(6-7).

The transition from late care directly implies the ability of the palliative care team to identify and promote the care needs of women and their families. Estimating the survival time, based on the appropriate prognosis and recognition of the clinical profile of women with breast cancer that requires exclusive palliative care, is an important determinant for the establishment of care goals and treatment decisions(15).

The main transition characteristic of the care transition process investigated is the change in the place of care, that is, the woman who is seen at one unit for curative treatment is now seen at another unit for exclusive palliative care. Early integration of palliative care is not evident, even if the treatment is for disease control. Although still in the unit of origin, the woman can be diagnosed or prognosed with advanced disease and with short survival, the offer of palliative care is not guaranteed according to the real need, since there is no integration between care.

The mode of operation of this care transition process contributes to women's lack of understanding or misunderstanding about their situation. Studies show that services that integrate palliative care with disease-modifying treatment contribute to a greater understanding by patients and family members about the prognosis and life expectancy(15-16). In addition, this early integration can favor the exercise of patient autonomy, as well as the participation of family members and health professionals in the decision-making process and shared care planning(15-18).

The particularity of breast cancer must be considered when thinking about the different treatment options, including palliative chemotherapy lines. However, it cannot be denied that, according to research, early referral to palliative care, incorporated into curative cancer treatment, improves clinical results and values health care with higher quality of care and less cost(16,19).

In the perception of the interviewed professionals, other important characteristics of this transition process stand out, which refer to the lack of consensus in the therapeutic conducts and failures in communication. The World Health Organization and research results have shown benefits of early integration of care, with a gradual evolution of the level of commitment between them according to the patient's response and the evolution of the disease(6,16). Thus, an effort on the part of the institution to expand discussions about therapeutic decisions and referral to exclusive palliative care would be positive.

Since, in practice, this integration does not happen in many scenarios, women with advanced cancer are referred late for exclusive palliative care, which makes it difficult to effectively manage physical, psychological, spiritual and social symptoms(16,20-21).

The integration of palliative care with curative treatment can, therefore, contribute to the consensus of oncologists in therapeutic approaches, especially in the prescription or ban of palliative chemotherapy. Women with advanced breast cancer who are monitored by the palliative care team and clinical oncology concurrently may receive less chemotherapy in the last six weeks of life and survive longer when compared to those monitored only by clinical oncology. In addition, there is an improvement in the perception of health-related quality of life and the onset of depression(16,19).

Thus, based on the negative perception of the health professionals interviewed about the way the transition process is implemented and the scientific evidence, the early integration of care is advocated, not only as a means of controlling symptoms and promoting quality of life, but also as a strategy to facilitate the prognosis, the prescription of systemic therapies for disease control and referral to exclusive palliative care.

The most favorable scenario for this transition, in the interviewees' perception, is the outpatient clinic, especially due to the woman's clinical condition when attending this modality, that is, with good performance status (measure to quantify the woman's general well-being), as well as it is guaranteed care in all stages of the disease, since its diagnosis, also contributing to the establishment of the therapeutic relationship and space for interdisciplinarity(21).

Therapeutic proportionality is a fine line and difficult to manage, especially when facing young women and with a range of treatments available today, which instigates investment until all possibilities are exhausted.

Arguably, survival for women with advanced breast cancer has increased in recent years thanks to advances in research on palliative chemotherapy lines, which contributes to the prolongation of the chronic phase of the disease. However, and above all, health professionals must be able to change and adapt treatment strategies to the state of the disease, to the side effects of treatment, to the priorities and life plans of these women, in order to provide a better quality of life(19,22).

Active treatment needs to be started at the right time, but it must also be stopped at the right time, and this is the big challenge. Sharing decisions based on the discussion of the longitudinally of care among professionals, moving towards the combination of knowledge and practices of the specialties, such as between curative and palliative care, facilitates the process(19,22).

In the analysis of the transition process of women with advanced breast cancer to exclusive palliative care, in the perception of health professionals, reports referring to the progressive loss of functional capacity of women due to lines of palliative chemotherapy were common. It is worth ratifying that, although there is no clinical consensus among the factors that assist in the decision making between keeping palliative therapy active or starting supportive treatment with exclusive palliative care, the inadequate prescription of chemotherapy at the end of life has been reported as costly and undisputed oncological practice(22).

Although the number of new drugs on the market has been increasing, doctors must take into account that the choice for active treatment in the last weeks of life has been associated with a worse quality of life, with the suffering of women and their families, restricted access palliative care, invasive medical interventions, in addition to high costs(22).

Within the scope of SUS, spending on chemotherapy and immunotherapy for the treatment of breast cancer has been increasing significantly. This increase is linked not only to investment in new lines of treatment, but also to the still late diagnosis of most cases of breast cancer, which implies investments in lines of palliative chemotherapy and hospitalizations to control symptoms arising from treatment complications and/or disease progression(23).

It is true that improving the quality of care depends, in part, on the introduction of new technologies (including treatments), but also reducing costs and health intelligence are necessary to improve management and ensure continuity of care. In order for the system to be able to organize itself, predictive models of cost analysis and effectiveness of procedures and treatment techniques, etc., are necessary for hospitals, even in a situation of scarcity of resources, to be able to maintain their activity(24).

It appears that offering another line of chemotherapy to women, even though it raises the cost to the institution without a guaranteed benefit, can be a wrong strategy to remove or postpone the need to communicate bad news. At this point, the communication process stands out, which, for the interviewees, does not happen in an empathetic, procedural way and, many times, does not reflect the reality of the facts, transforming the transition of care into a painful process, for which the woman and their family members were not prepared over time.

This context favors a feedback system, since, on the one hand, the woman and her ill-informed family members are unaware of the evolution of the disease and its impacts on the multiple dimensions; on the other hand, communication by the health professional is unable to meet such demands for information. This failure contributes to resistance by the woman and her family in accepting referral to exclusive palliative care. The result consists of late transitions or death in the unit specialized in breast cancer, or even in the intensive care unit, thus preventing them from enjoying the benefits of palliative care.

The communication of difficult news is considered as one of the most delicate situations when it comes to the relationship between health professionals and women with cancer, either by the severity of the news or by the questions that still persist around who, how, when and what to communicate. to the sick person and his family(18,25). Therefore, in the context of oncology and palliative care, in which bad news is present, it is necessary to train the health team for communication since the way it is transmitted often determines the course of coping with the disease(25).

Based on the problem of communication, it is learned that the use of light technologies stands out to favor the transition process to exclusive palliative care, being necessary that professionals have skills and abilities to establish relationships based on communication, interaction, subjectivity, and bonding(26). Such requirements in care management increase confidence and acceptance by women and their families, thus contributing to the transition of care between units, according to the routing routine in effect in the investigated scenario.

However, the late and abrupt transition, resulting from an ineffective communication process, directly affects the individual dimension of care(27). Women, for not knowing their prognosis, for not enjoying palliative care integrated with care to control the disease, have false hopes for a cure and are not instrumentalized in the exercise of autonomy.

In addition, it is emphasized that the transition process goes in the direction of underestimating the family's ability to produce care, when it does not adequately guide it and does not include it in the decision-making processes. One of the principles of palliative care is exactly to offer support to the family to help them during the patient's illness and in coping with grief; and for that, clear, honest, empathetic, and procedural communication is necessary. Communication noises prevent women and their families from recognizing the advanced stage of the disease, the necessary redefinition of therapy, their real goals, and accepting the end of life phase, valuing palliative care(27-28).

The meeting between health professionals and women opens space for the professional dimension of care. In this dimension, three elements need to be taken into account: the professional's technical competence; his ethical posture; and their ability to establish a bond with that person who needs their care(27). In the investigated scenario, the bond produced has weaknesses, since relationships are fragmented, often without a medical professional of reference, and communication is not effective. It is perceived that the care needs of women, as well as their families, are beyond the professional's technical capacity, requiring the mastery of social skills.

Study limitations

It is pointed out as limitations of the study, considering the process of transition of care in the investigated scenario, the need to include professionals who work in the exclusive palliative care unit. The comparison of results with other models of transition of care is encouraged, as well as of early integration between them, in order to contribute to its operationalization, with possible benefits for other types of cancer or other diseases that require palliative care.

It is also worth noting the heterogeneity of the sample, which may have hindered the comparison of data between different professional categories. And when addressing the perspectives that pertain to the care transition process itself, which bring crosscutting themes to the other categories, the authors identified the need to present only one category in this article, which can be a limitation, given all the complexity empirical reality investigated.

Contributions to the area of Nursing and Health

The study on screen intends to contribute to the attention given to the process of transition of care through which women with advanced breast cancer and their family members go through, as it brings up some considerations about autonomy, effective performance of the team in the process, comprehensive care, decentralization/sharing of clinical decisions, transversality of palliative care and indication of exclusive palliative care.

In the scope of care management, the results may contribute to the discussions regarding care models, health care networks, therapeutic itinerary, and human resources with training in palliative care. It also brings a reflection on the importance of transversalizing palliative care and not compartmentalizing it. However, it values the use of the hospice model, here known as "exclusive palliative care", in which the actions aim at quality of survival and no more interventions to control advanced disease. In this direction, it also raises discussions about the biomedical model and its impacts on the management of care.

In addition to what breast cancer represents in the female universe, the study may also contribute to broaden the discussions related to the transition of care that is present in the approach of individuals affected by other types of cancer.

FINAL CONSIDERATIONS

The process of transition of care in force in the investigated scenario gives the practice a discontinued care, not being characterized as a continuous process, because in general it happens belatedly, abruptly, and accompanied by unsatisfactory communication, which may favor deficient knowledge, false hopes and suffering by women and their families.

The lack of clinical consensus on the right time to discontinue systemic therapy, strengthened by the availability of many chemotherapy lines for advanced breast cancer, contributes to the late transition, often limited to end-of-life care.

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