COMMUNICATION IN ONCOLOGY AND BIOETHICS

Communication can change a situation. For better or for worse. Indispensable for maintaining the ethics of the physician-patient relationship in a cycle of care, when its meaning reveals the cruelty of a disease with poor prognosis, communication can raise awareness about transient or permanent changes in quality of life, including ideas of hastening death.[1-3]

Bad news that can adversely and seriously affect an individual's view of the future become even worse if they are delivered poorly. Some communication strategies in the field of healthcare aim to avoid both the lack and exaggerated delivery/receipt of news. A structured sequence considers gathering information from the patient, transmitting the medical data, providing support to the patient, and establishing the patient's collaboration with the treatment plan. In oncology, the SPIKES protocol exemplifies the concept of using a series of steps based on setting up (time is essential), perception (what the patient already knows), information (if desired by the patient), knowledge (disclosure of information), attention to emotion (empathic response), and cooperation (collaboration in the face of needs).[4]

Oncological diseases, as a biological system that involves the primary tumor, metastases, genetic traits, and habits of life, express the high dimension of the power of the scientific word on the patient's routine.[5] Their psychosocial aspects are influenced by the deep-rooted concept of a disease of no return, despite the promising outlook provided by the successive developments in knowledge and skills within this specialty/discipline.

Doctors and patients share words of uncertainty in oncology. These words need to add up so that decisions make sense in a situation full of dilemmas that, at the same time, flags technical and scientific limitations of medicine – allowing the coexistence of not always sufficient benefits and often excessive harms – and alerts to the possibility of shifting from therapeutic to palliative care.[6]

The expression of the impact of communication on patients is sensitive to how much attitudes employed by physicians – and the multiprofessional team – are part of the principles of good practice to explain to the layman a medicine far from perfect. Since professional disquiet makes the continuum of improvement of useful and effective methods to be commonly seen as below the desired level of security, promoting information cannot waive human acclimation between physicians and patients and harmonization with ethical and legal conventions determined by society.

Oncologists align their own experience with that collectivized in the literature and use similar clinical histories to predict a future that might pose challenges concerning the acceptance of uncomfortable realities, commitment to survival, and demand for dignity in death.

Strong emotions emerge amid the authenticity of truth, and both the charity of a possible relief and the compassion expressed in silences interspersed with the physician's intention not to be indifferent to the disease or the patient become a complex unit of conflicts. Anxiety, anger, guilt, fear of change in relationships, relinquishing of household duties and work, loss of independence, and financial concerns become combined, cause hesitancy and increase obstacles to the patient's understanding ability.

The quality of communication, especially of bad news, is associated with the magnitude of the empathy created. The bilateral desire for adjustments of understanding makes it possible to reword or add information to what has been said. Thus, the continuum of information, which is usual for the oncologist and unusual for the patient, surprised by the diagnosis and outcomes, proceeds better reorganized.

The bedside teaches how much one should not employ rigid predetermined communication attitudes involving cancer patients; there are ways of delivering bad news as well as gradations of empathy and rejection in receiving bad news which are not easily predictable.[7]

Experienced physicians collect successes and failures in the disclosure of undesirable information. They compose a rising learning curve supported by systematic and periodic analyses of actual communication facts and by the understanding of social and cultural peculiarities.

Primo and Garrafa[8] sought data from the Brazilian reality. Women (n = 120) across a broad age range (21 to 78 years; mean age, 40.3 years) were asked nine questions aiming to evaluate the quality of communication about diagnosis, treatment, and prognosis of breast or genital cancer. Based on a descriptive/analytical cross-sectional design, the authors analyzed patients with malignant disease who were under the care of an oncology outpatient clinic. Cases of advanced- and early-stage cancer were analyzed (66.6 and 33.3%, respectively).

The three questions on diagnosis involved initial information, implying the plurality of its delivery in multiple places of referral of the case, uniformity of re-information in a specialized setting, and the prospect of contrapositive information disclosure.

The four questions on treatment intended to recognize patients' desire for involvement, their understanding of differences, their ability and conditions to actively participate in the selection of treatment options.

The two questions on prognosis reinforced the aspect on treatment adherence and further knowledge of possible outcomes.

Three questions resulted in evident overlap of responses, all of them related to the statement wants to know – 83.3 and

83.4% said yes, respectively, about treatment options and everything about the disease – and the statement knows – 63.4% said they were aware of the natural progression.

Therefore, the survey revealed that the women involved wanted to feel informed about the development of the disease.

On the other hand, Primo and Garrafa[8] showed heterogeneity of responses on the behavior of doctors, assimilation by the patients, and sense of freedom/competence to actively participate in the decision-making process.

These data confirm that, even though one may count on intuition to achieve effective communication in the field of healthcare, training programs should be developed targeting greater clarity on these variables and applicability to a multiethnic country of continental dimensions.

Bioethics reinforces the concept that good practices in healthcare require effective communication. The interdisciplinary involvement in bioethics provides grounds for individualizing compositions, which are likely to result in a better understanding of benefits and harms. Greater rational understanding will then result in less gap-filling by inapplicable analogy and undesirable imagination, thereby facilitating discussion in the face of complex decisions in oncology.

Thus, bioethics emphasizes the enhancement of dialog leads to better align with all parties involved. Bioethics provides strong support to conduct the case according to a greater or lower acceptance of the exercise of autonomy offered to the patient and to any controversies surrounding the understanding of the decision making as negligent or reckless.

Primo and Garrafa,8 in their analysis of the effect of the word on what has already happened and on what might happen in a group of patients with cancer susceptible to an impact on their female identity, provide us with helpful data to build excellence in communication in the face of oncological diseases. This comes as a welcome contribution to the harmony of the triad Science-Education-Human being.

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