

INTERPERSONAL COMMUNICATION RESEARCH: VALORIZATION OF THE ONCOLOGICAL PATIENT IN A HIGH COMPLEXITY ONCOLOGY UNIT*

COMUNICAÇÃO INTERPESSOAL: VALORIZAÇÃO PELO PACIENTE ONCOLÓGICO EM UMA UNIDADE DE ALTA COMPLEXIDADE EM ONCOLOGIA

COMUNICACIÓN INTERPERSONAL: UN RECONOCIMIENTO POR EL PACIENTE DE LA ONCOLOGÍA EN UNA UNIDAD DE ALTA COMPLEJIDAD

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ABSTRACT

The interpersonal relationship between professional and patient is an important moment during assistance that offers the opportunity for a clear communication to both, and allows for a more humanized relation. The study aimed to analyze the perception of patients in an outpatient oncology clinic about the professional-client interpersonal communication. The study site was a High Complexity Oncology Unit in the South of Minas Gerais. Data were collected through semi-structured interviews, participant observations, and analysis of patients' records. The sample was of intentional mode with data saturation and featured 13 patients with neoplasia registered in the service and tended at the clinic during the period of data collection; all patients agreed to participate in the research by voluntarily signing an informed consent. The research was approved by the Research Ethics Committee from the Medical Sciences College at the Campinas State University. The data were analyzed by the thematic content analysis technique in the light of the theoretical referential of Rogers, the "Client-Centered Theory". Five major categories were identified; among them, the importance attributed to human relations in the process of balance and disease healing. It was concluded that the cancer patient values interpersonal communication and believe that it relieves symptoms, pain, and anguish; its deficiency is a major limiting factor for patient's assistance. The construction of relationships that are more client-focused and improvements in communication are suggested.

Keywords: Communication; Humanization of Assistance; Health Services; Neoplasm; Nursing Care; User Embracement.

RESUMO

A relação interpessoal entre profissional e paciente é um momento importante da assistência que oferece a ambos a oportunidade de uma comunicação clara, de modo a proporcionar uma relação mais humanizada. O estudo teve como objetivo analisar a percepção dos pacientes de um ambulatório de oncologia acerca da comunicação interpessoal profissional-cliente. O local de estudo foi uma unidade de alta complexidade em Oncologia do sul de Minas Gerais. Para a coleta de dados foram utilizados um roteiro de entrevista semiestruturada, a observação participante e a análise documental nos prontuários dos pacientes. A amostra foi composta de modo intencional, por saturação de dados, e contou com 13 pacientes portadores de neoplasia cadastrados no serviço e que frequentaram o ambulatório no período da coleta de dados, aceitaram participar da pesquisa e assinaram voluntariamente o termo de consentimento livre e esclarecido. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa da Faculdade de Ciências Médicas da UNICAMP. Os dados foram analisados pela técnica de análise temática de conteúdo à luz do referencial teórico de Rogers da "Teoria Centrada no Cliente". Foram encontradas cinco grandes categorias e entre elas a importância atribuída às relações humanas no processo de equilíbrio e cura da doença. Concluiu-se que o paciente com câncer valoriza a comunicação interpessoal e atribui a ela o alívio de seus sintomas, de sua dor, angústia e a sua deficiência é um grande limitador para a assistência a ele prestada. Sugere-se a construção de relações mais centradas no cliente, além de melhorias na comunicação.

Palavras-chave: Comunicação; Humanização da Assistência; Serviços de Saúde; Neoplasias; Cuidados de Enfermagem; Acolhimento.

RESUMEN

La relación interpersonal entre el profesional y el paciente es muy importante en la atención hospitalaria pues les ofrece a ambas partes la oportunidad de establecer una buena comunicación con miras a brindar un servicio más humanizado. El objetivo del estudio fue analizar la percepción sobre la comunicación interpersonal profesional-cliente de los pacientes de atención ambulatoria de oncología. El estudio fue realizado en una unidad

oncológica de alta complejidad del sur del Estado de Minas Gerais. Para la recogida de datos se utilizó la entrevista semi-estructurada, observación participante y análisis documental de las historias clínicas de los pacientes. La muestra fue intencional, por saturación de datos e incluyó a 13 pacientes con neoplasia inscritos en el servicio y que se trataban allí durante la recogida de datos. Todos aceptaron participar y firmaron voluntariamente el consentimiento libre e informado. El estudio fue aprobado por el Comité de Ética en Investigación de la facultad de Ciencias Médicas de la UNICAMP. Los datos fueron analizados según su contenido a la luz del referente de Rogers de la terapia centrada en el cliente. Se encontraron cinco categorías, entre las cuales figura la importancia de las relaciones humanas en el proceso de equilibrio y cura de la enfermedad. Se observa que los clientes con cáncer valoran la comunicación interpersonal, le atribuyen el alivio de los síntomas, dolor y angustia y que su deficiencia es un factor limitante para la atención dispensada. Se sugiere la construcción de relaciones más centradas en el cliente, además de mejoras en la comunicación.

Palabras clave: Comunicación; Humanización de la Atención; Servicios de Salud; Neoplasias; Atención de Enfermería; Acogimiento.

INTRODUCTION

The High Complexity Oncology Assistance Units (UNACONS) are highly specialized services for oncological treatment in Brazil, however, they are at the risk of falling into mere technical operationalization of procedures, leaving aside the human being involved in this process. Technological advances have contributed to the trivialization of health services, however, these should be prepared to receive the user and provide qualified attention aiming at solving the problems that brought that patient to the unit. One of the guidelines for the improvement in the quality of these services, previously cited situations, is the embracement that allows an analysis on attention and management practices. The embracement is not limited to the act of welcoming but constitutes a sequence of acts and behaviors that make up the health working process.¹

Communication is seen as an essential condition for the occurrence of embracement, solving problems brought by the user. It is not possible to talk about interpersonal communication without the presence of humanization. The humanization of care takes place when there is a democratization of the relations involved, increased dialogue, and improved communication between health professional and patient; the recognition of the patient's rights, his subjectivity and cultural references, or even the recognition of expectations from professionals and patients as subjects of the therapeutic process.²

Professionals who administer oncological treatment must remember that the suffering of oncological patients caused by pain and the effects of treatment have various aspects and are shared by the patient and his family with the health team.

Thus, this study was based on the assumptions recommended by Rogers about interpersonal relationship centered in the client. This author's ideas were adopted as the theoretic referential.

Closeness in relationships is what allows unambiguous communication. The positive attitude in relation to the other, allowing warmth, attention, affection, interest and respect, is what characterizes a relationship geared towards humanization. An understanding attitude is the most recommended posture because it places the patient at the center of attention.³

The relationship that promotes freedom and facilitates growth needs to contemplate three scenarios: congruence, in which the therapist must be authentic and coherent; changes in the client's personality will only occur in this way. The unconditional positive attention in which the therapist must demonstrate positive reaction even in the face of the most diverse client behaviors (fear, confusion, anger, hatred, etc.); valuing the client in an unconditional way and the empathetic understanding that the therapist understands the feelings that the client experiences and can understand him, communicating well with him. All these attitudes are more important for Rogers than the therapist's technical competence and proficiency. A relationship becomes embracing when is pervaded by affection, empathy, understanding, trust, and respect.³⁻⁶ In any relationship, the quality of the personal encounter with the client is the most important element for its efficiency.

In the humanistic model of assistance, the nurse will be able to objectively listen to the individual, identify his needs, and help him to find solutions based on information about his own mental activity, by guiding him to act.

This study aimed to analyze the clients' perception of an outpatient oncology clinic from UNACON in Poços de Caldas, Minas Gerais, about the professional-client interpersonal communication under the perspective of humanization of assistance and the user-professional bond.

METHODOLOGICAL COURSE

We opted for a qualitative approach, which is what applies to the study of relations, representations, beliefs, perceptions, and opinions, how humans perceive themselves and how they think.⁶ The qualitative dimensions are indicated when the object under study is historical and social and when work processes are complex.⁷

Given the uniqueness of the study object, we opted for the method of exploratory qualitative case study. The case study is an empirical investigation that investigates a contemporary phenomenon in depth and in its real-life context, especially when the boundaries between phenomenon and context are not clearly evident.⁸

The place where the study took place is a service of high complexity for the treatment of cancer and is managed by a large general philanthropic hospital, founded in 1904, which has 180 beds for clinical and surgical care, as well as services of high complexity. The institution is a reference for the treatment of cancer to 80 cities. The UNACON in Poços de Caldas has, currently, 5,531 registered patients and about 3,000 patients in treatment. It receives a monthly average of 226 new patients. The Oncology outpatient clinic receives 1,200 patients/month on average. The treatments offered by the UNACON are: consultations, chemotherapy, complementary exams of medium and high complexity, clinic and surgical hospitalizations, urgent and emergency care, and radiation oncology through an outsourced service.

The population consisted of patients with neoplasias enrolled in the service and in treatment at the Oncology outpatient clinic from UNACON in Poços de Caldas. The inclusion criteria were: minimum age of 18 years, ability to verbalize and understand, and agreement to participate in the research by signing the informed consent (TCLE). The sample consisted of 13 subjects and was assembled in an intentional basis. The sample composition ended with saturation and broad data homogeneity.

The triangulation collection technique was chosen for data collection. A script for the semi-structured interview, a script for the participant observation, and the documental analysis in patient records were used. The model proposed by Turato was used for the semi-structured interview and the model proposed by Triviños as used for the participant observation, both with some adaptations.^{9,10}

In the interview, variables such as gender, age group, marital status, education, household income, and origin among others were collected to characterize the subject. The thematic issues were: describe the feelings you experience when using the unit and what do think about the communication/information with professionals in this unit.

The participant observation sought to describe how individuals, professionals, caregivers, and family members present themselves and their behaviors and attitudes, the dialogue between them, and notes of reflexive nature.

The records contributed with sociodemographic data, medical diagnosis, treatments, and medical and nursing developments. This collection of data on the patients' records allowed the validation of information provided by patients and professionals and guided the interviews.

The data were collected between May 10 and July 6 of 2011. The interviews, field observations, and document analysis were performed during this period.

The data was analyzed through content analysis, which is a method widely used in qualitative research.^{6,11}

The theoretic referential was used for the external validation through an analytic generalization (testing the consistency between the study results and results from other similar investi-

gations). In addition, the technique of pair validation was used in the Qualitative Health Research Core Research Group (NU-PEQS), and the opinion of the advisor was used to validate the categories found employing the theoretic referential as support. The thematic content analysis was performed and categories were placed on a chart with the speeches from subjects illustrating each one of them. This version was also taken to the NU-PEQS research group for the validation of the collected data. Initially, five broad categories and some subcategories were created. Scripts were used for the interviews and participant observations to ensure the reliability of the study; all planned steps were executed. We chose the "*ipsis litteris*" transcription of speeches.

The research project was approved by the Ethics and Research Committee from Medical Sciences College at the Campinas State University (UNICAMP) on 1/3/2011 under the number 5916.0.000.146-10 CAAE. An informed consent (TCLE) was elaborated in accordance with 196/96 Resolution, which was signed by each subject after accepting his participation in the research.¹²

RESULTS AND DISCUSSION

In this study, the term patient will be replaced by client for the discussion of the data. According to the theoretic referential of Rogers, treatment, patient, illness, and healing are biological, medical, and pathological vocabulary terms. The term client, although not ideal because it can imply involvement in commercial relations, very different from the therapy context, has the merit of evoking notions of independence and initiative of its role.¹³

The 13 subjects in the research were named by the letter E, from respondent, succeeded by the number of interview in sequential order, being E1 the first interviewed subject and E13 the last. It is worth mentioning that none of the subjects refused to be interviewed. Table 1 shows the characterization of subjects.

Table 1 - Characterization of users served in an Oncology Unit in Southern Minas Gerais according to the sociodemographic data (n = 13)

	Variables	Total	
		F	%
Gender	Male	7	53,8
	Female	6	46,2
	Total	13	100,0
Age Group	20-30 years	2	15,4
	31-40 years	1	7,7
	41-50 years	4	30,8
	51-60 years	2	15,4
	61-70 years	2	15,4
	71-80 years	2	15,4
	Total	13	100,0

To be continued...

... continues

Table 1 - Characterization of users served in an Oncology Unit in Southern Minas Gerais according to the sociodemographic data (n = 13)

	Variables	Total	
		F	%
Marital Status	Married	8	61,5
	Divorced	1	7,7
	Single	2	15,4
	Widower	2	15,4
	Total	13	100,0
Education	Incomplete Elementary-Middle	4	30,8
	Complete Elementary-Middle	2	15,4
	Incomplete High	1	7,7
	Complete High	3	23,1
	Complete College	2	15,4
	Graduate School	1	7,7
	Total	13	100,0
Family Income	1 to 2 minimum wages	5	38,5
	3 the 4 minimum wages	2	15,4
	5 to 6 minimum wages	1	7,7
	7 to 10 minimum wages	3	23,1
	11 or more minimum wages	1	7,7
	Unemployed	1	7,7
	Total	13	100,0
Origin	From the study municipality	6	46,2
	From other municipalities	7	53,8
	Total	13	100,0

Source: survey data, 2012.

The diagnosis defined the sample as: 3 subjects (23.1%) had breast cancer, 3 (23.1%) ovarian cancer, and 3 (23.1%) prostate cancer. Only 2 (15.4%) had melanoma (7.7%), 1 with non-Hodgkin's lymphoma and 1 (7.7%) with small round cell desmoplastic tumor. This distribution resembles data worldwide regarding the epidemiology of cancer.

The configuration of categories and subcategories listed below denoted intense movement of interrelation in our professional experience, the theoretical/methodological adopted referential and subjective questions that populate this interrelationship. Therefore, five broad categories emerged from the analysis context: the importance attributed to human relations in the process of balance and healing diseases; the perception of being recognized as one and understood as the link with the service; the attendance by order of arrival (the wait); the ambience interfering with the process of treatment and quality of care; and the disease bringing learning. The first emerging category in this movement became quite clear, both in the speeches and in the chosen referential and will be the

subject of discussion in this study. Rogers brings the importance of communication in any relationship in all of his studies and, in particular, in helping relationships, such as in this study.^{3,4,13,14} In that category, the communication appeared as a way of humanization and balance needed to the healing and relief of symptoms, anxieties, fears, and barriers encountered. Thus, we decided to subdivide into three subcategories: the communication – humanization component indispensable from the diagnosis to cure; communication allowing the relief of symptoms, anxieties, fears, and doubts; and communication barriers limiting assistance.

The noisy communication is understood here as a communication barrier that can lead the recipient to understand the message inappropriately, producing an inadequate response. The noises can be screams, sirens, physical discomfort, and rumors.¹⁵ Communication is understood as a process of understanding and sharing messages and this communication can influence the behavior of the people involved. This interpersonal competence, when used in a therapeutic way, will meet the needs of the patient.¹⁵ For the author, three elements are essential for communication to happen: the transmitter or sender, who is the source of message emission, who produces; the receptor or receiver, who receives the message, to whom the message is sent; and the message itself, which is what is transmitted by the sender and must have meaning for him and for the recipient.¹⁵

From the perspective of the subjects in this research, the balance in the health-disease process and humanization in interpersonal relations were achieved when the communication was established. Communication with the patient allows the understanding of that subject in its entirety, in his worldview, in his way of thinking, feeling, and acting.¹⁵ There is no discussion about humanization without mentioning communication. Every form of humanized assistance assumes a communication that articulates the exchange of information and knowledge in which there is dialogue free of noise and listening that meets the user's demands. When speaking about care in the outpatient clinic, the respondents constantly brought up the importance of communication. The speeches showed communication in different ways and at different moments of the treatment. Therefore, we decided to split this large category into three subcategories.

COMMUNICATION: HUMANIZATION COMPONENT INDISPENSABLE FROM DIAGNOSIS TO HEALING

The dialogue has always been fundamental in human relations. Through it, health professionals can develop a unique listening and seize all clients' demands. Insofar as the dialogue progresses, the professional-patient bond emerges and the trust, so necessary in a helping the relationship, is born from this bond.

E13 underscores the importance of communication and good treatment: E13: "A good service is that, huh? ... You arrive, what do you want? Well treatment, what do you want, Sir? "

The humanization of interrelations between individuals is a fairly complex undertaking; these are people interacting with people. For this to occur, people must first get to know each other. Self-knowledge allows seeking within us the source of love, know our feelings, tendencies, impulses, emotions, conflicts, and values.⁵ There is a desire on the part of the client for effective communication, and for this to occur, it is imperative that professionals have self-knowledge. However, that is not what was observed. It was noticed that activities that allow the professional to attain self-knowledge were not included in the ambulatory.

Humanizing the nursing care has been a challenge because professionals are resistant. This challenge becomes an obstacle to be overcome by health managers, particularly those who work in Oncology, where the psychological fragility of clients, family members, and professionals is a constant. The interaction between patient and nursing staff is essential for the establishment of a bond and quality service. Through this bond, the professional is able to promote a qualified listening, valuing the patients' ideas, and learn about their emotions.¹⁶ We infer that there is no bonding and, therefore, there is no qualified listening to which the author refers between E4 and the professional.

In fact there are many people that are really from Poços who passes right in front, who are the preference, right? ... Then she called me with that kind of face [emphasis added by author] and said: wait ... So much so that now I get there, if she calls I'm not going with her, I'm just going to go with the two I know [...] Only who's sick to know, right? [...] (E4).

Health professionals, in particular those working with Oncology, constantly experience difficult situations and, at the same time, are bearers of bad news. This situation often leads to stress and feeling of loneliness, which can be minimized with dialogues that are true instruments of health promotion. These dialogues put the professional in front of himself, allowing self-knowledge, and thus improving the relationship with the other.¹⁷

The professional working in Oncology is not prepared for the confrontation of difficult situations; he does not have adequate professional or institutional training. For him, it is a lonely task, not shared with other professionals.¹⁷ This lack of preparation interferes in therapeutic relationships and, consequently, in the care.

There are several barriers that may affect the care: profession values, lack of involvement, lack of a strong sense of "self", lack of ethics, lack of knowledge, lack of time, inadequate grat-

ification, and lack of working conditions. All of these factors can lead the professional to frustration and dissatisfaction and these lead to mood changes, damaging the care provided for the other.¹⁸ The bad mood referred by the author appears on some speeches from the subjects, and in particular on the speeches from E4, cited previously.

It is inferred that professionals working in this clinic require perhaps a psychological preparation to help them in the administration of those feelings that were perceived through the professional-client communication.

Communication characterized by attitudes and manners was considered by users of a health service as being the main component for humanization. Attitudes of indifference, rudeness and dismissal, and power that is associated with the financial situation are considered dehumanizing situations for these users.¹⁹ Mood swings were perceived in the professionals at various moments of the participant observation. This liability is felt by the patient, who often labeled the professional as "rude", "impolite", "stupid". The stupidity referred by E2 is a major obstacle in the bonding formation and can even influence treatment adherence.¹⁶ E2: "No, not this time, but the last time the girl spoke, a nurse, right? She spoke so stupid to me [emphasis added by author] ... that I was so hurt, I said what the hell, my God in heaven! "

In this thematic piece, the noise communication leading to a dehumanized care is clear in addition to disclosing the lack of professional preparation. Self-knowledge, as advocated by Furegatto, is essential for a good interaction with ourselves and with each other.⁵

The E2 speech still shows the lack of respect for the client. Respect has been evaluated in another study where users attributed the lack of respect to the lack of patience from the tending professional when he is rude and when information is unclear and inadequate. The technical capacity showed the least impact on the perception of respect.²⁰ This finding corroborates the data from this study and those by Rogers when he states that the technical competence matters less in therapeutic interpersonal relationships than empathy, respect, and trust.⁴

The support and strength, and respect for individuality, intimacy, beliefs, and values is a differentiator for the treatment, and decreases the negativity that the hospital environment brings at this difficult time of the oncology patient's life.¹⁶

E3 demonstrates the lack of sensitivity by the doctor who would not stop talking on his cell phone during the appointment, once again preventing proper communication that satisfies the patient's needs.

I stood up, simply because the doctor ... passing to and from ..., walking, talking on his cell phone ... and my wife was outside, then he is in the phone here, chatting with his friends here, I don't know what for (E3).

The way of doing, working, and producing needs to change in the field of health to offer a humanized service. Still to the same authors, there is a need to tune in “what to do” with the “how to do”, the concept with practice.²¹

In another study on satisfaction of the oncological patient in an outpatient service, the appropriate interpersonal relationships demonstrated by the friendliness and interest from assistance providers was one of the aspects mentioned by the subjects.²²

The way of doing in health – and communication is included – must be rethought. Changes are necessary to ensure better interpersonal relationships reaching the humanization of care. E4 shows a real perception of the necessity of this change in the way of doing, bringing once again the importance of communication in the process of humanization, demonstrating the perception about the importance of verbal communication or for linguistics, which is characterized by the tone of voice, rhythm, and the way words are pronounced.¹⁵

[...] the way of speaking. Because the way of speaking is all [emphasis added by author], I guess that's about it. Even if you have trouble, that is. ... but If you know how to talk [emphasis added by author], you circumvent the situation, now, if you don't know, you get worse. I think that is it (E4).

As health professionals, we should worry about the human being and this only becomes possible when we develop the means, instruments, techniques, skills, capacity, and competence of a more dignified and understanding existence.¹⁵ Accordingly, E4 expresses the need for patience and delicacy upon arrival for work, he shows how much patience and delicacy are important in the service, stating that it “is everything”.

I think it's the patience [emphasis added by author] from the staff, because virtually for everything we have to have patience [emphasis added by author], right? ... And in this regard here, I think the main thing is the patience and the delicacy of the person [emphasis added by author] (E4).

E8 brings the dialogue, the importance of touch, and the client-professional proximity when commenting on the medical care for the service to be good.

[...] He didn't ask me exactly nothing, I waited to see if he would ask me, I talked and he wouldn't even give me attention. I think it's disrespectful, not by the fact of having been there, I think of the fact that every month I have to go through him, you understand? [...] Chat ... ask ... to have the liberty to ask a person (about the conversation) I think it's a difference (E8).

E8 attributes great importance to the dialogue and the inconvenience of lacking it. Dialogue, as the basis of relationships between the nurses and clients in the context of chemotherapy, was a category found when studying oncological patients and their relationships with nurses in the perspective of the client.²³

The findings of this study are similar to results found in another research conducted with oncological patients in which the authors reported the factors that contributed the most to humanization according to the patients, which were: affection, sympathy, and smiling; and those that hampered humanization were: moodiness, noise, and not being readily assisted.¹⁶

THE COMMUNICATION ALLOWING THE RELIEF OF SYMPTOMS, ANXIETIES, FEARS, AND DOUBTS

Cancer can weaken patients and their families due to the stigma it carries. This disease is considered one of the worst, much feared, always carrying the idea of imminent risk of death, beyond the fear of aggressive treatments. All these situations affect family relationships, and often talking about the disease becomes difficult, forming “islands of communication” between those who are strong and know about the diagnosis, and those who are more fragile and must be spared, including the client.²⁴ Thus, an effective communication becomes imperative.

The understanding ability from the client and family is impaired in the face of anxiety, anger, guilt, fear of change in the relationship, separation from family and work functions, loss of independence, and financial concerns.²⁵ Therefore, the health professional must, when communicating with the client and family, use all positive feelings in the relationship. The positive feelings in interpersonal relationship are: warmth, attention, affection, interest, and respect. Positive attitudes bring people together, decrease impersonality, and demonstrate acceptance of the other and of ourselves. A positive attitude is much more than a sentence properly formulated; it is a loving look, a warm handshake, a protecting hug. Is the demonstration of verbal and non-verbal behaviors.⁵

When asked if the service resolves the problems brought by them, the subjects in the research expressed positive feelings and such sentiments appear in the form of communication with professionals. E1 feels completely free to express himself with the doctor with a certain degree of intimacy, when he says “I open up with the doctor”. E2 has information and clear explanations about his feeding, which shows attention and interest by the professional;

I come here, I open up with the doctor, right, explain to him what I am feeling. It's all resolved (E1).

[the doctor explaining]: He explained, cannot eat orange, pineapple. You can eat watermelon, can eat fruit, but not those with acid. Okay, so I will no longer eat none of that (E2).

Nursing takes on a humanized behavior when it considers the human being as an individual endowed with knowledge, spirituality, culture, and sentiment. The humanization depends on the interaction that the client has with the professional.¹⁶ When nursing recognizes and values the client's knowledge and culture by adjusting the information to be given, it is providing a humanized care.

The nurse should use the literature to learn about the patient's different reactions and emotional manifestations to avoid disruption in the communication, flexibility of criteria, techniques, and methodologies. The nurse must respect the person as he is without imposing behaviors. For this communication to happen, it is necessary that the patient feels tranquility and confidence to express himself, remembering that he himself will find solutions to his problems.⁵ E6 demonstrates being satisfied with the respect that the nursing had for him through insightful information and availability of nurses assisting him.

The information, when I couldn't talk to a doctor, the nurses came and explained everything so that we could understand, so all information that I needed was always very well passed, very well explained. No doubt, nothing, nothing (E6).

Communication affects those who participate in it and provides satisfaction and growth in the communicating parties.⁵

E11 demonstrates a lot of satisfaction when he comments about his conversations in the waiting room bringing security and embracement. Communication happens when the professional uses his knowledge of communication and his professional skill and establishes a relationship of assistance.¹⁵

The people who I talked to [emphasis added by author] in the waiting room waiting for the doctor. And there in the chemo we also were trading ideas. And also the CACON team here is this way, essential for me. Because I felt very welcomed too. I had a lot of confidence in the whole team, in all of them (E11).

The oncological treatment generates anxiety and fear, however, the opportunity to dialogue, exchange experiences, and use them as support for the confrontation was reported in another study with women who underwent mastectomy.²⁶ The importance attributed to the exchange of experience

through dialogue is perceived by E11 when reporting one of his moments of conversation with another patient.

In order to help and exchange experience, like I was talking to the boy, he has abdominal tumor, and he told me he was in a lot of pain in the leg and a patient has taught me something which at the time was very good, doing foot baths (E11).

These spaces for dialogue referred by E11 may contribute to the deconstruction of myths and construction of new knowledge. The formation of groups that value acceptance, affection, respect, and individuality will make the development of a collective responsibility towards the oncological patient himself and the participants of the group possible. In that study, the authors realized that the creation of these spaces for dialogue provided the creation of bonds between users and professionals and believe that the socialization, exchange of experiences, and self-knowledge may be achieved.²⁶

Dialogue, attention, affection, and respect are perceived attributes by oncological patients as being essential in their relations with the nurse, and do not make the patient feel useless or inefficient.²³

COMMUNICATION BARRIERS LIMITING ASSISTANCE

The concept of communication barrier covered in this study includes factors that prevent or hinder the communication between people, in this case, between professionals and clients. The noises from conversations and from electronic alarms were factors observed during the participant observations during data collection. More is learned about people as they are listened, more is learned about their personality and interpersonal relations, resulting in a special satisfaction.¹⁴ Thus, it is clear that in this noisy environment there is little possibility of learning from clients and professionals, preventing the learning referenced by Rogers.

For Rogers, behind any aggression, silence, and hostility there is always a person, and if we are skillful we can reach that person.⁴ Voice alterations from professionals were observed during the observations. These professionals appeared to be impatient when clients were slow to come to the window or even for not understanding the explanation that was given about consultations, examinations, and documents.

E4 reports the lack of professional respect and the perception of mood change in the person assisting him when his appointment was delayed and his chemo session cancelled. And that became clear in the voice intonation of the professional

who tended to this client. Thus, it seems that the communication barrier caused a disruption in the assistance.

I talked to her again ... look, well ... there will not be enough time for me to do the chemo ... then she ... Oh no ... I will call such ... then she called four ... five [...] ... and she said, never mind I would call there because it is four o'clock and no longer does. But she spoke with a more altered tone [emphasis added by author] (E4).

The professional who tended to E4 was not able to understand his needs and either used empathy. Communication is empathetic when we perceive the world of the other and it can occur through verbal or non-verbal communication.¹⁵

For subject E4, no progress in the relationship happened, the aid did not happen, there was no communication with empathy, and the client lost his chemotherapy session. Empathy and involvement with the client's situation are indispensable for the relationship of care. The efficaciousness is closely related to the humanization of assistance.²⁷ In the speech of E4, no resolution was achieved in addition to a hostile service, featuring the dehumanization of assistance. The communication in this case was very deficient.

Communication is essential to the occurrence of changes in the forms of relationships in health practices to make them more humanized.²¹ It is not possible to talk in a purely technical and scientific assistance unlinked to the ethical and humanitarian knowledge.¹⁶ E4 has the perception of the professional's voice alteration so as to assign a bad classification to this service. The mood swings in professionals, often made explicit in their voice intonation, in abbreviated information, and lack of patience are easily perceived by the patients, as shown in the speech from E4 mentioning the rude way he was treated. "It was the only situation that I was upset, I said heck ... I told you three times, and then she was still rude [emphasis added by author] with me" (E4).

Facing the threat of loss of bonding, healthcare professionals can experience feelings of crying, screaming, distancing, and apathy among others. These reactions consist in defensiveness attitudes towards mourning because of a death or any loss, and are not necessarily pathological. The historical and socially constructed taboo about death ends up influencing the work of professionals.¹⁷

The reports from the subjects in this study allow us to infer that professionals are in a defensive situation and such behavior is perceived by the client. Because there are no spaces for the exchange of experiences or psychological support for these professionals, a major influence on their everyday work occurs.

In some interviews and during the field observations, the event reported by E4 repeated in various ways from the suspension of the appointment, procedure, surgery to the prolonged wait for medical attention. The greater or lesser com-

mitment to the job is directly related to an improved quality in the employee-user relationship.²⁸

An interpersonal relationship may be impaired when the professional has difficulty in listening; this can be caused by environmental or personal problems, incompetence or lack of training, or need for commitment to the interaction. There may be still difficulties in the interpretation of the message. An inappropriate interpersonal relationship may produce negative results in the client's personal development.⁴

For E5, the dialogue is necessary to the treatment and explicitly indicates how much this influences his state. He attributes the improvement of patients to an empathetic dialogue.

It is the doctor's dialogue with the patient. Because I go ... there are certain doctors who can't talk with the patient. They only question and such. I think that a good service is having a dialogue with the patient. It's not true? He has to give you the opportunity to speak, expose what you're feeling, huh? (E5).

Once again the dialogue appears as being essential to the client; he notices when the dialog does not occur or occurs in a non-satisfactory way. The face-to-face relationships build the everyday that we call "assistance" and the labor relations develop through the flow of information and communication during the work process.²⁹ There is no way to provide humanized care without good communication, a good professional-client relationship when considering this assumption and appending the client's perception.

The deficiency in communication is seized by E5, who realizes that the professional barely look at him when he is being assisted and assigns a representative value to that relationship when he says that patients improve when the doctor talk to them. The depersonalization often experienced by users prevents the service from being warm and resolute.²

[...] then, depending on the doctor there he barely look at you and ..., I think that a good service is we being here talking. The patient feels well, it seems that just to talk with the doctor is a stimulus. I think so (E5).

The fact of not being called by the name, a language not understandable, and not even being looked at with interest were factors that users attributed to unfavorable communication in another study.¹⁹

The professional in the area of Oncology experience various kinds of pain: pain of the human condition, of the fragility of life, of finitude, of the impotence of wanting to cure the incurable, of aging, of separation, of the condition of being those who live in a health institution, subjects, and objects of health policies.¹⁷ The doctor, with his technical and biomedical vision,

and adding the fact of working with Oncology, ends up underestimating the value of communicating with the client.

In describing the service done by a doctor, E8 realizes that the doctor does not give him the chance to express himself, limiting his actions to dispensing the prescription. E8 reports that he had just one document signed by the professional and was blocked from expressing his longings, anxieties, concerns, or wishes. He states that during medical care he has no chance to express himself and the professional simply dispenses the prescription.

Now, I was there for three and a half hours, almost four hours, to enter and the guy did not even said good morning to me, just simply signed a piece of paper and send me away, so I guess that if it's just to sign a paper, I didn't have to stay there (E8).

The relationship doctor-patient was related to the rationalized objectivity in detriment of the awaited subjectivity for this kind of relationship. Doctors and nurses have acted more like technicians bureaucratically controlled than as professionals with technical autonomy.²⁸ This situation has brought significant damage to health relations.

A very technical relationship is observed between doctors and clients, however, a more affective and intimate relationship with nurses. All nursing staff knew of clients' details, personal lives, family backgrounds, emotional states, economic situations, and treatment difficulties. Therefore, it seems that the nursing team goes beyond the technical objectivity giving opportunity to the client to share their needs.

E8 mentions the importance of the dialogue and the indignation caused by its absence demonstrating that he did not obtain a therapeutic relationship. Medical professionals seem to not have the concept of the importance of this relationship to the patient. A therapeutic relationship needs to provide relief to someone who needs to be relieved; assumes a restoration to the previous state with a view to balance.³⁰

And I stood there waiting and I walked in his office, he simply didn't ask me anything [emphasis added by author], did not prescribe anything ...but the paper for me to go get [medicines] that are the injection, other than that he didn't ask anything, didn't write anything (E8).

In this study, the noises of communication were not statistically measured, however, through the speeches and field observations, it was noticed that it occurs in all occupational categories; however the lack of communication seems to have more relevance to the patient when it comes from the doctor. E8, when reporting that he waited, reveals a noise in communication or even lack thereof.

When there is a mutual desire between two parties to get in touch and communicate, there is a high degree of agreement achieved by the experience, perception, and behavior from one of the parties. There is a tendency towards mutual communication, mutual understanding, and a better psychological functioning of both parties and the satisfaction caused by this relationship.⁴ The speeches from E8 shows that good communication or understanding did not occur.

Research has shown that the doctor learns to cope with the disease and not with the patient. In the health professions, the doctor in particular should be fundamentally humanist. In addition to the biological aspect, the cultural, social, family, psychological, and spiritual aspects should be perceived.³¹ It is believed that without dialogue, without good communication, there is no humanization.

The affective aspect is fundamental in communication and makes a significant difference in the context of Oncology.¹⁷ To think that perspective is rethinking the way a relationship, that is so valued by the client and his family, is happening in the hospital environment and what is the role of health professionals in the quest for this relationship.

We often live in perfect technical environments but totally unattended with affection, attention, and solidarity. People are no longer the center of attention and become the object of care, source of profit, without personal identity, at the mercy of the "scientific power."³⁰

CONCLUSIONS

In this study, the oncological patient seemed to have a consensus about the importance attached to communication. It brings comfort, soothes and relieves symptoms, decreases anxiety, and balances. Conversely, the noises from a noisy communication cause anguish, fears, and anxiety among other negative feelings. The relationships of care must be based on coexistence and healthy interactions, and not on relations of dominance over others. It becomes imperative that professionals change their stands in the face of life, pain, and sufferings from the other.

Oncology services are highly specialized services for the oncological treatment in the country, but they are at risk of falling into mere technical operation procedures, leaving aside the human being involved in this process. This human being, represented by the patient, family members, and primarily professionals involved in the service have the perspective that human beings must take care of themselves before taking care of others.

Interpersonal relations, with interpersonal communication implied in them, are fundamental elements for the health professional that seeks a humanized assistance and has the client as the center of his attention.

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