INFORMATION NEEDS AND THE DEVELOPMENT OF COMMUNICATION TECHNOLOGIES IN PALLIATIVE ONCOLOGY CARE

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ABSTRACT

With the increase in cancer diagnoses in Brazil and in the world, the references encourage the incorporation of palliative care as early as possible, aiming at symptom control and relief of suffering. The study analyzed the information needs of patients with advanced cancer in palliative care, their families and caregivers. With a qualitative research approach, the location corresponded to the Cancer Hospital IV. Interviews were conducted with patients, caregivers, family members and the Focus Group with the interdisciplinary team, totaling 31

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participants. Bardin's content analysis revealed three categories of analysis: translation and meaning of palliative care, palliative care as a stigma of death and terminality, and the denial of finitude. Therefore, the most expressive information needs were captured, with a view to the protagonism of palliative care as a treatment within oncological care, aiming at quality of life and coping with death, for the development of informative material.

Keywords: Oncology, Palliative Care, Health Communication, Health Education.

INTRODUCTION

Worldwide, the burden of chronic non-communicable diseases has increased, as well as the global demand for Palliative Care (PC) for people in life-limiting conditions or with terminal illnesses. Annually, it is estimated that more than 56.8 million people need PC, but only one in 10 people have access. As a result, the projection for 2060 regarding the need for palliative care should almost double (WORLD HEALTH ORGANIZATION, 2021).

PC aims to alleviate severe health-related suffering, according to the consensual definition of the *International Association for Hospice and Palliative Care* (KNAUL et al, 2018). In recent years, the global need to integrate PC into health systems has been incipiently disseminated, especially in low- and middle-income countries (TRITANY; SON; MENDONÇA, 2021).

Cancer is a great example of the need for PC in the world. Recommendations from the *Lancet Commission Global Access to Palliative Care and Pain Relief* highlight the importance of engaging the global cancer community and its crucial role in helping to achieve universal access to PC (KNAUL et al, 2018; RADBRUCH et al, 2020).

In the context of health, at the various levels of care, the practice and development of informative materials make up the care scenario, as an orientation and communication strategy, where most professionals list data that are, in their judgment, relevant for the population's access. Such judgment can be linked to several factors that are related, such as knowledge from their training, empirical reality, experienced practice, recommendations and protocols, among others. In oncology, approaches regarding the malignancy of tumors and human finitude represent a veiled universe (VASCONCELLOS-SILVA et al, 2007).

Elisabeth Kübler-Ross (2008), considered a pioneer in the approach to the process of death and dying, proposes the investigation and understanding of one of the greatest crises of human life, the confrontation of death. And the path adopted could not be more assertive: giving voice to terminally ill patients and attention to their families. In this way, it highlights stages that may or may not follow a chronological order, namely: denial, anger, bargaining, depression and acceptance. Each individual will react differently. There is no rule, there are concrete possibilities (KÜBLER-ROSS, 2008).

In this conjuncture, several elements make up the scenario where death reveals a social behavior of confrontation, denial, isolation, selfishness and repression, contrary to its existence (MORIN, 1970; BECKER, 2019; ARIÈS, 2014). Such behaviors and reactions tend to occur due to misinformation and fear, a repressed demand with a high potential for suffering attached.

Therefore, this study analyzed the information needs of patients with advanced cancer in palliative care, their families and caregivers, with a view to the development of health technology, through informative material.

METHODOLOGY

This work used a qualitative research, which encompasses the design of methods for understanding reality phenomena in their genesis, in the various ways of investigating social and educational issues and problems (GONZÁLEZ, 2020; LÜDKE; ANDRÉ, 2018).

The planning of the approach involved interviews with patients, family caregivers and the Focus Group (FG) with health professionals. The scenario corresponded to the National Cancer Institute (INCA), Cancer Hospital IV (HC IV), Palliative Care Unit, an auxiliary body of the Ministry of Health (MS) and the Unified Health System (SUS). This unit was founded in 1998, is located in the city of Rio de Janeiro and has sectors of: hospitalization, outpatient and home care (BRASIL, 2020; NATIONAL CANCER INSTITUTE, 2021).

The ethical aspects of the research are in accordance with the provisions of Resolution 466/12 of December 2012 (MINISTRY OF HEALTH, 2012), which refers to Free and Informed Consent16 and the anonymity of each participant. The patient was submitted to the Research Ethics Committee (REC), as well as the Informed Consent Form (ICF). With evaluation processing at the CEP and the Research Institution/Oswaldo Cruz Institute (IOC) and the Proposing Institution, the following are the records and approval: IOC/CAE: 52631821.0.0000.5248 and INCA/CAE: 52631821.0.3001.5274. Data collection took place between August and October 2022.

Regarding the selection, the inclusion criterion of patients considered the preserved cognitive status and the age group over 18 years. The interview approach for the patient safeguarded his privacy, in addition to favoring the use of appropriate precautionary measures in the face of the COVID-19 Pandemic. Regarding the number of individuals to be approached in each stage of the interview processes, up to fifteen were estimated, considering the closure of each stage due to saturation of the theme.

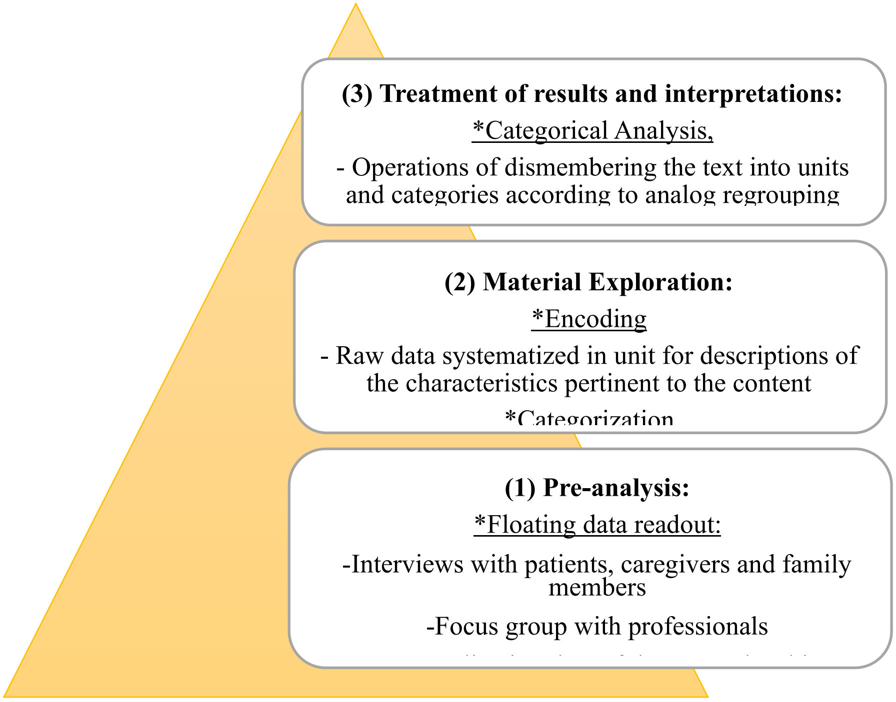
The exclusion criterion for patient selection was age under 18 years, lack of physical conditions to participate and/or the presence of any psychic condition that compromised the process or the product of the interviews.

Interviews with patients, family members and caregivers were conducted at HC IV during hospitalization or on the day of the outpatient consultation. The choice of the interview method occurred in view of the possibility of interaction and immediate capture of the desired flow of information, in the treatment of matters of a strictly personal and intimate nature, as well as the approach to complex themes, as well as the deepening of the questions (GONZÁLEZ, 2020; LÜDKE; ANDRÉ, 2018).

The exploration of the material used the methodological steps of Bardin (2016), in the case of content analysis that comprises an analysis of meanings, and therefore, the principles regarding categorization, the division of the components of the analyzed messages – a unit of records – stand out. "Categorization is an operation of classification of constituent elements of a set by differentiation and then by regrouping according to genre (analogy), with previously defined criteria" (BARDIN, 2016, pg 147).

Therefore, in view of the central theme of the research, as well as the applicability of the interpretation procedure, Figure 1 systematizes the methodological steps.

Figure 1. Method and Organization of Analysis



Source: Bardin (2016).

RESULTS

Regarding the approach to patients, family members and caregivers, some relevant points regarding data collection are highlighted:

a) Most hospitalized patients have many symptoms in quantity and intensity, which makes it difficult to approach, as well as that of their families and caregivers who experience these changes;
b) In addition to mental confusion (which is an exclusion criterion), they present symptoms such as pain, shortness of breath, nausea and vomiting, which makes the

approach unfeasible, due to the discomfort they cause. This factor mobilizes the family and caregivers;

c) Signs and symptoms such as sadness, anxiety and depression also directly interfere with participation in the interview;

d) Currently, about 70% of hospitalized patients die during hospitalization (INSTITUTO NACIONAL DO CÂNCER, 2021). As a result, many patients, family members and caregivers were impacted by the news of the reserved prognosis and the active process of death;

e) The hospital dynamics, where in the morning there are bathing routines, dressings and team care and in the afternoon the visiting hours are from 2 pm to 4 pm. Soon after this time, the routine of changes and medications takes place that end after 6 pm. As a result, many interviews were conducted after this time;

f) Outpatients usually go through the entire interdisciplinary team on the day of the appointment, which takes a while and many at the end of the appointments are already tired wanting to return to their homes;

g) Some weaker patients end up being hospitalized for symptom control during consultations.

For the approach with professionals, the FG was developed based on semi-structured questions to foster discussion, in view of the central and relevant research issues (BARBOUR, 2009; SOUZA, 2014). Due to the difficulty of reconciling everyone's agenda for the face-to-face meeting (the service schedules are at different times), the FG was carried out through the *Google Meet platform*. The meeting was recorded and the transcription made by *Microsoft Word Online*. An observer participated in the study, recording evaluation criteria, general observation of the group and the limitations found.

To conduct the debate, six questions were organized, everyone remained attentive to the reports of the other participants, and only one participant did not request extra speech. From the second question on, they began to relate their answers to those of the other participants. Question three was answered by everyone within the second question, without being directed. Finally, it was suggested to hold conversation circles periodically in the unit. Regarding the limitations: (a) Due to the quantity for the composition of the group, we invited one professional from each category; (b) Some participants were at work and had sound failures; (c) At the end of the meeting there was a heavy rain that interfered for a few moments with the internet and recording signals.

CHARACTERIZATION OF THE SUBJECTS

- Patients: approach carried out with 13 subjects, by age group we recorded the approach of adults between 31 and 60 years old, making up two thirds of the sample (69%) and the other elderly. As for gender, representing two-thirds of the sample, female. For schooling, almost half of the sample was concentrated between complete and incomplete high school (46%). For family income, a large part of the public with values between 1 and 2 minimum wages (76%). In the description of previous (chronic) pathologies, two thirds of the participants denied it (69%) and the rest confirmed that all of them were hypertensive.

As for family members and caregivers, they represent an important support and care network, so they are part of the daily care process. Depending on the care network and the family context, they may be present in full, partial, or punctual form for some activities. And so, from a single family member/caregiver to several people who take turns in care, and there are also cases in which the patient does not have a network to follow up on care. A diversity of situations can compose this scenario and dynamically influence some behaviors and decision-making.

- Family members and caregivers: approach with 11 subjects, of whom 7 were family members, 2 formal caregivers and 2 informal caregivers (not related to blood).

Regarding the age group, there was representation of all ages, with a little more than half of the sample between 18 and 50 years old (54%). Regarding gender, the prevalence of females was recorded. For education, almost half of the sample was concentrated in complete secondary education (45%), but with little difference between complete and incomplete elementary school levels (36%). For family income, there was representation of all levels, where the concentration of records occurred for those without fixed income and with income above 5 minimum wages, two extremes (both with the same quantitative/percentage and totaling 54% of the sample).

With regard to care, more than two-thirds of the sample denied being a single caregiver, a little more than half reported having taken care of a sick person before, of these almost two-thirds reported having some degree of kinship and of these more than half were diagnosed with cancer, however less than a third of this public was in palliative care, Soon the experience and experience in the theme was unknown.

- Professionals: The team was formed by 8 responding professionals, and in relation to the age group there was a concentration between 31 and 50 years old (87.5%).

Regarding gender, the prevalence for females was verified. Of the 10 professionals invited (one from each category), only 2 were unable to participate/answer the questionnaire.

Regarding professional training, almost all of them refer to some training in oncology and this proportion is close to some training in palliative care, which reveals that a significant number of the group has a specialty and expertise for this theme, and that can be seen in the level of education for Master's and Doctorate degrees of more than half of the sample (62.5%). It was also possible to verify a considerable occurrence for the length of professional experience, since the ranges over 15 years totaled more than two thirds of the sample (75%). And of this group, all currently perform care activities (direct care for patients, family members and caregivers).

SYSTEMATIZATION AND SYNTHESIS OF RESEARCH DEVELOPMENT

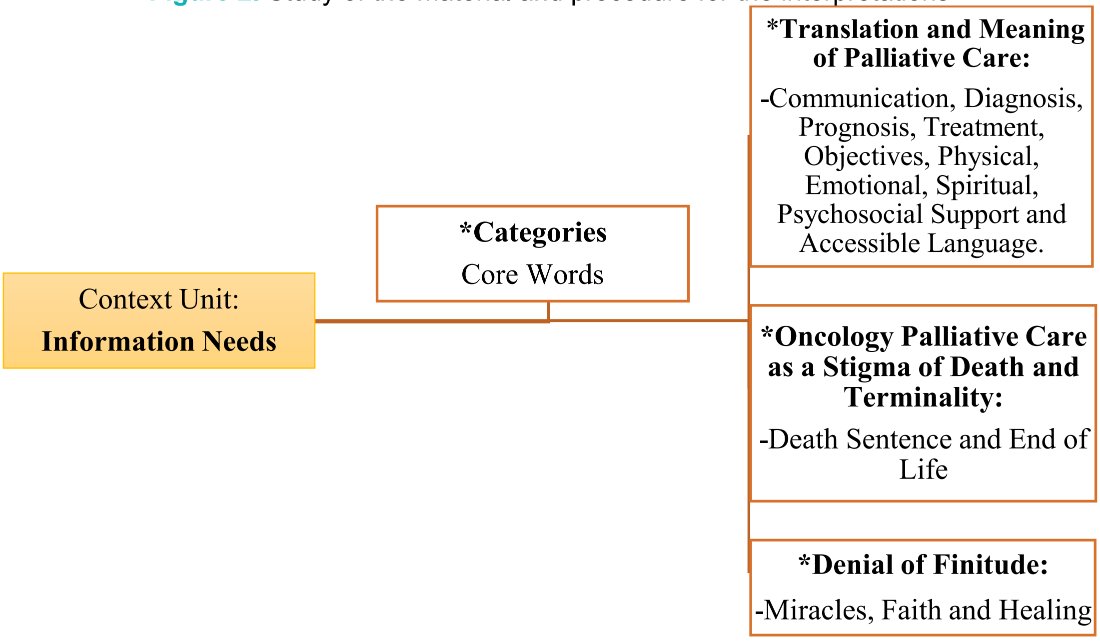
In search of the development of ethical principles and good practices in research and scientific dissemination, it was decided to follow the Consolidated *criteria for reporting qualitative research* (COREG) guide, given the nature of the research because it involves data collection through interviews and focus groups (SOUZA et al, 2021).

The instrument refers to basic domains that involve: (a) research staff with regard to training and experiences; two responsible researchers and five collaborators, of whom four had a degree in Nursing and three with a degree in Medicine, all with professional experience in oncology and six in palliative care; (b) description of the concept and design of the study; Bardin's content analysis, chosen by consecutive sampling, where the participants were personally approached by the researchers, so the sample totaled 31 subjects, of the subjects approached only two refused to participate without going into details, all data were collected in HC IV, in the Hospital and Outpatient Hospitalization sectors; (c) analysis criteria and results; coding by incidence guided by the most common themes present in the data, consequently from the method and organization of the analysis, three categories were listed, from the developed stages of pre-analysis, exploration of the material and treatment of the results obtained and interpretation, therefore, in view of the nature of the data/extensive coding unit (discourse), we opted for "an artisanal analysis", The citations are still identified in the text with inference to the number of participants and finally. We sought to highlight the highlighted themes with convergence to the data and the treatment of the results.

DISCUSSION

The information needs include notes about what would be important and necessary to contain in an informative material directed to patients, their families and caregivers with a view to favoring communication and increasing the visibility of palliative care in cancer care. As a dynamic element, information permeates the dimensions of social reality, as well as the need to know a certain theme and subject. In view of the adopted methodology, three categories of analysis emerged, as explained in Figure 2.

Figure 2. Study of the material and procedure for the interpretations



Source: Survey Data, 2025.

Therefore, the aforementioned categories will be treated sequentially based on the relevant contents:

a) Translation and Meaning of Palliative Care:

> Pacient_07: "For people to be well informed, it's not because I'm at least completely uninformed. I didn't receive any concrete information, it was that thing, confusing thing, you know and I didn't know what to do.... So, I didn't receive this information and I kept doing it and the problem appeared, I was doing it because there was no other way. Not that I was informed in advance of what could happen. That information was never given to me."
> Pacient_13: "But that I should have had this warning back then, to suddenly not be here now, at this moment, to go further ahead, yes, I think I could have done it."
> Pacient_01: "I didn't evolve into pain, into suffering."
> Pacient_11: "The best advertisement is people who come and pass on to others what it really is."
> Pacient_02: "This issue of having an INCA specialized in the case here... with this treatment, of the people who are undergoing treatment and who need this special care"
> Familiar_07: "So, things are happening and passing this reality of what will happen in one way or another and you have to prepare for it"
> Pacient_13: "Communication more between doctors and the patient"
> Cuidador_informal_02: "I would just add, I also think the spiritual part. I'm not talking about religion, but about spiritual support that also helps"

This need for objective and quality information was highlighted by all as a structuring element in this scenario, and it is expected that issues present in the diagnosis, treatment, possible outcomes (responses/reactions/complications) and prognosis will be clarified. And in some way, it is possible to bring to the attention of the population the occurrence of this specialized care within the scope of the SUS developed in an Institution designed for the treatment of patients diagnosed with advanced cancer in palliative care, their families and caregivers (BRASIL, 2020; NATIONAL CANCER INSTITUTE, 2021).

It can be said that issues pertaining to health and illness have changed over the course of social development, in part due to the fact that in modernity we observe a higher life expectancy, resulting from technological advances, prevention, and treatment of diseases (ELIAS, 2019).

Such factors are directly related to communication and a relevant element involves professional training in health centered on prolonging life and with little discussion about the recovery of a broader and more human sense of care (KÜBLER-ROSS, 2008; MORIN, 1970). As we move towards a technological world at a high level, we seem to have regressed in soft technologies in the field of relationships (ARIÉS, 2014). However, for the training of professionals, it is necessary to link the value of science, technology and art permeated by relationships, in the midst of the totality of care. To meet the relevance of the psychosocial and spiritual approach, permeated by a welcoming and non-judgmental listening (KÜBLER-ROSS, 2008).

> Profissional_07: "The question is the focus of the treatment and where we are heading with this treatment, because palliative care is a treatment."
> Profissional_02: "It's something I've been thinking about a lot, it's trying to avoid it, that's the word treatment, it's not, for example, when I went through, I had referred it to us to say that he's going to be, he's going to continue to be treated, that he's going to receive treatment... that treatment refers to the cure of something."
> Profissional_01: "I don't agree with not using the word treatment... It is a therapy aimed at controlling symptoms. Maybe we have to translate this for the patient to explain in a more accessible way to the patient"

The relevance of deciphering some content or term can be manifested by the various nuances that influence it, in this case palliative care in the social ideology suffers distortions as to its real meaning, as we can observe in view of the above. An interesting factor involved the highlighting of the word, 'treatment' which for a significant portion of society represents the idea of cure. Therefore, the use of terminology; 'palliative treatment' can lead to a distortion as to its real meaning and applicability.

However, palliative treatment applies to the physical, psychological, social and emotional needs presented by individuals. In attention to the stages that involve the process of death and dying (denial, anger, bargaining, depression and acceptance) that may emerge from the illness (KÜBLER-ROSS, 2008). Thus, treatment represents care, welcoming, and support, which is in fact up to us to translate its objective and where we want to go.

> Profissional_01: "I think that's the first point would be to really explain, what palliative care is for a population that doesn't know of course that using language accessible to that population."
> Profissional_06: "Look, I agree with the language, accessible... It's something very illustrative, very succinct, I think it's worth it. It is valid, it is worth disseminating this. What would they like to know? Then, it starts from a creativity, illustrative, accessible language."

As a terminology that dialogues with the aforementioned theme, literacy or literary involves a set of skills, such as: cultural and conceptual knowledge, oral literary (speaking and listening), printed literary (reading and writing) and numerary (dealing with numbers). With regard to communication and health, any person or institution in this field works as a common thread between scientific knowledge and the people who need this knowledge (MALVEIRA, 2019; RIBAS, 2021; PERES, 2023). And health professionals are presented with the challenge of revisiting their knowledge and practices, in order to foster such terms.

b) Oncological Palliative Care as a Stigma of Death and Terminality:

> Pacient_05: "Because I think the person has cancer, they already think that the person doesn't even want to touch them close, there are people like that nearby. I've been through this and I know it."
> Cuidador_formal_01: "Especially that bringing it here is not leading to death. It's not taking it to the last day of life, it's taking the patient to have a little more comfort, a little more dignity"
> Profissional_07: "Trying to break the stigma of what palliative care is. The lack of knowledge about what we do is very great, so I think that any material that starts is trying to show that palliative care cannot be only at the end of life."
> Profissional_05: "Because it's like a death sentence."

Myths, rites, customs and common sense are socially fed and translate a certain selfishness and distancing of the living in relation to the dying. A prejudice that isolates and refers to loneliness in a moment as delicate as that of human finitude. "Death is one of the great biosocial dangers in human life" (ARIÈS, 2014, pg 19), as a characteristic of the civilizing process, death is postponed/pushed more frequently to the backstage of social life, which for the dying can mean that they will also have the same fate - isolation. This difficulty for those who think they are far from the end to deny it is linked to the fact that dealing with the death of the other refers to the memory of our inevitable finitude (BECKER, 2019; ARIÈS, 2014).

However, an opportune path would involve empathy as a way of welcoming and supporting the other as we would like to be treated (KÜBLER-ROSS, 2008). This refers to the basic meaning of PC in terms of its early and timely applicability for the promotion of quality of life in the course of human finitude.

> Familiar_01: "Then I think it would be nice to understand when a patient is referred for palliative treatment. At what point does the doctor, at what point is it determined that that cancer is no longer worth investing in treatment, but palliative care, when does this happen? It's not at what point that, because precisely we always have the feeling that it only happens because I'm very bad about to die, and from what I could see that it's not quite like that, so I think this information is important like that."
> Familiar_02: "Because here, well, I say it's the end, right. But then taking care of it can also improve the disease somewhat"
> Familiar_03: "yes, I've identified that every day is a day, right. Just as it can make it worse, it can improve."

A complementary stigma to be treated involves showing that the opportune moment for the beginning of palliative care does not correspond to the end of life, but in a favorable way where it is possible to prevent diseases, promote quality of life, have time to create bonds and support necessary during the process of death and dying, for the patient, his family and caregivers (KÜBLER-ROSS, 2008).

Such an approach needs to be thought of, initiated and developed not only at the end of life, although the last hours are important, since in many cases people die gradually, get sick, grow old, and in this sense the departure begins earlier (ARIÈS, 2014).

c) Denial of Finitude:

> Familiar_07: "As hard as the gravity of the situation is, I will give an example from my family. We believe in miracles, so we know that things happen and sometimes they don't happen in the way we want and we also believe in God's will."
> Profissional_07: "I think that when he thinks about the issue of treatment, he said that the word confuses us in fact, when the patient, when we talk about treatment, the patient is sure that that treatment is aimed at cure, difficult"

Among the comings and goings that we can observe in the statements of the subjects involved in this process, the refusal to accept finitude can persist throughout the care aimed at symptom control, quality of life and comfort measures inherent to the process of death and dying (KÜBLER-ROSS, 2008). Because the life history of each individual, their experiences, in short, the elements of their biography in general influence the way they react and respond to adversity (KÜBLER-ROSS, 2008; ELIAS, 2001). Accordingly, this negative response can occur depending on the relationships that are established between professionals, patients, family members and caregivers, intermediated by truncated, imprecise, codified information that makes it difficult to really understand the situation (KÜBLER-ROSS, 2008).

In turn, religious belief offers the patient a sense of suffering and a reward after death7. At the same time, religiosity in this scenario safeguards dogmas of salvation, which represented forgiveness and love, the sovereign that designates mercy and perpetuates eternal life (MORIN, 1970). However, the understanding of spirituality extends beyond the religious, as an agent of meaning in the face of disease, suffering, and death, centered on man and his freedom (INSTITUTO NACIONAL DO CÂNCER, 2022).

After all, the non-recognition and acceptance of the process of finitude safeguards complications for the care provided, as these cannot be effectively consolidated in a denialist scenario.

HEALTH TECHNOLOGIES AND THEIR APPLICABILITY IN PRACTICE

As far as the concept of technology is concerned, it is possible to understand the systematic application of scientific knowledge and/or other knowledge arranged in practical activities. And Health Technology (ST) encompasses the attention and health care provided to the population, mediated by equipment and technical procedures, medicines, organizational systems, information, education, programs and care protocols (MINISTRY OF HEALTH, 2010; SANTOS, 2016). In this context, Merhy describes ST as: mild, mild-hard and hard (MERHY, 2014; MERHY; FRANCO, 2003; MERHY; FRANCO, 2008).

For the ST approach, it is essential to conceive the intercession of the work process and the construction of knowledge. A continuous and articulated movement, from the initial idea, to the elaboration and implementation, to the result, from knowledge to practice, which makes it a process and a product (SANTOS, 2016).

Therefore, soft technologies safeguard the production of health, based on relationships, with the production of care in an integrated way, throughout the extension of health services, centered on the needs of users, which unveils a 'technological transition' (MERHY, 2014; MERHY; FRANCO, 2003; MERHY; FRANCO, 2008). And within the field of relationships, it is possible to describe the production of bonds, welcoming, listening, empathy, the exchange of knowledge, information, meeting individual and collective demands, among the numerous activities arising from the subjects involved in the care process (SANTOS, 2016; MERHY, 2014).

Merhy and Franco (2003, 2008) rescue notes to think about a technical composition of work centered on the field of relations and soft technologies. In this sense, it would imply a change in the care model (hegemonic physician and procedure producer) to have an impact on the core of care, through the composition of a hegemony of Living Work (work at the moment it is producing) over Dead Work (these are the instruments).

The second approach involves the soft-hard STs, that is, the knowledge-technologies, which involve the structured knowledge inherent to the health work process, such as; theories, models of care and others. And the third approach deals with hard ST, represented by machine tools, equipment, devices, standards, and organizational structures (SANTOS, 2016; MERHY, 2014; MERHY; FRANCO, 2003; MERHY; FRANCO, 2008).

In general, the production of health technologies comprises an important field within the care of the population, where each technological approach has its relevance. In this context, the National Policy for Health Technology Management is aimed at: "the development, incorporation and use of technologies in health systems, as well as their sustainability, are inserted in social and economic contexts, which derive from the continuous production and consumption of goods and products" (MINISTRY OF HEALTH, 2010, pg 09) And as an objective, the policy aims to maximize health benefits, the population's access to effective and safe technologies, under conditions of equity.

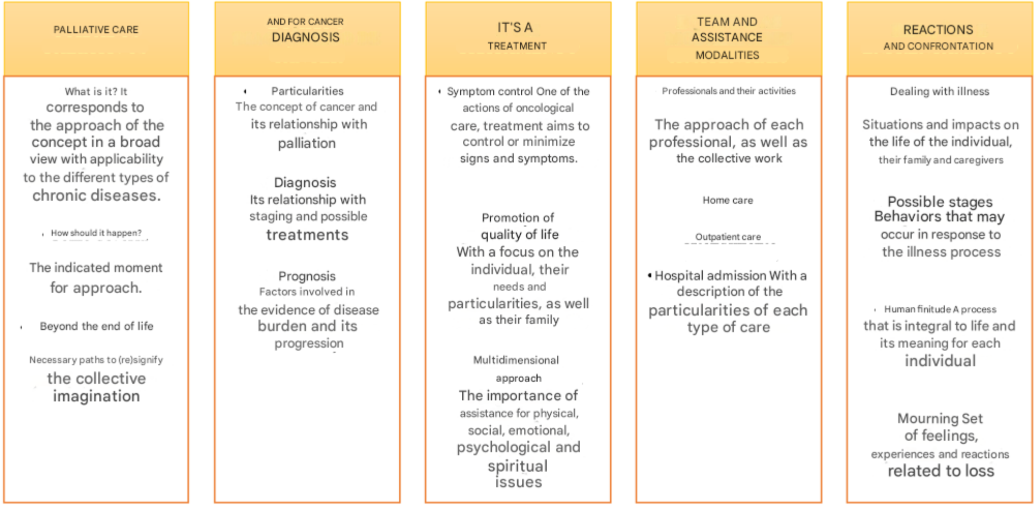
In the context of oncological care, these technological approaches coexist in the care scenario. In this case, it is up to us to reflect on the timely use of current technologies, guided by the needs of the subjects. An essential movement to highlight the importance of care that is attentive to the physical, emotional, spiritual, social and family dimensions of human suffering in the face of the diagnosis of a chronic and potentially life-threatening disease.

For PC, investment in soft and soft-hard technologies is estimated, as they include systematic and specialized knowledge, as well as the relationships and needs arising from the process of illness of the subjects in their social context (STEFANI, 2020). A convergence towards the development of products/technologies that are idealized from reality and with listening to the subjects involved in the care process.

STRUCTURING OF TOPICS AND DEVELOPMENT OF INFORMATION MATERIAL

In view of the data collected and the analysis, some indications stand out for the structuring of topics and emerging subjects to be contemplated in the conception of this material. Five thematic axes were structured, where in a light and dialoguing way, with a simple and concise language together with the use of images, drawings and figures the development of technology was viable. In summary, Figure 3 systematizes the elements for the proposed approach.

Figure 3. Design for the development of Informative Material.



PALLIATIVE CARE	AND FOR CANCER DIAGNOSIS	IT'S A TREATMENT	TEAM AND ASSISTANCE MODALITIES	REACTIONS AND CONFRONTATION
What is it? It corresponds to the approach of the concept in a broad view with applicability to the different types of chronic diseases. How should it happen? The indicated moment for approach. Beyond the end of life Necessary paths to (re)signify the collective imagination	Particularities The concept of cancer and its relationship with palliation Diagnosis Its relationship with staging and possible treatments Prognosis Factors involved in the evidence of disease burden and its progression	Symptom control One of the actions of oncological care, treatment aims to control or minimize signs and symptoms. Promotion of quality of life With a focus on the individual, their needs and particularities, as well as their family Multidimensional approach The importance of assistance for physical, social, emotional, psychological and spiritual issues	Professionals and their activities The approach of each professional, as well as the collective work Home care Outpatient care Hospital admission With a description of the particularities of each type of care	Dealing with illness Situations and impacts on the life of the individual, their family and caregivers Possible stages Behaviors that may occur in response to the illness process Human finitude A process that is integral to life and its meaning for each individual Mourning Set of feelings, experiences and reactions related to loss

Source: Survey Data, 2025.

A range of subjects and content involve the theme, and it is unfeasible to contemplate all its nuances. However, as initially exposed, the axes listed intend to bring visibility to relevant and necessary issues for knowledge and social debate.

CONCLUSION

In the field of health, communication deals with a complex reality because it involves issues about people's life and death. In oncology, the high potential for malignancy linked to the genesis of the disease process brings to light the relevance of the early incorporation of PC aimed at relieving physical, social, emotional, psychological and spiritual suffering. Timely early and essential in terms of end-of-life support and quality of death.

As a timeless activity, giving voice to the subjects and having a sensitive listening encompasses a wide range of reality that we sometimes think we know completely, in the position of specialized health professionals. There will always be new, unusual, unique situations, in short, the dynamics of life puts us in constant learning and for this we need to be attentive and willing to expand knowledge.

As for the development of informative material, it is unfeasible to contemplate themes, nuances, specificities, which provide the reach for all existing information needs. However, the research showed that people want to have accurate information and thus understand the course of the disease process This context tends to favor the other approaches resulting from this process that involve the performance of the interdisciplinary team and the care modalities. Therefore, knowledge of the care process safeguards a safe dimension of care and refers to welcoming.

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