

Conspiracy of Silence in Oncological Palliative Care: Perspectives and Strategies of the Healthcare Team

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Conspiração do Silêncio nos Cuidados Paliativos Oncológicos: Perspectivas e Estratégias da Equipe de Saúde
Conspiración del Silencio en Cuidados Paliativos Oncológicos: Perspectivas y Estrategias del Equipo de Salud

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ABSTRACT

Introduction: Silence about dismal news is common in palliative care, involving patients, family and the healthcare team. This phenomenon of hiding the truth – conspiracy of silence – has negative consequences and deserves attention from professionals. **Objective:** This study investigates and explores the strategies used by healthcare professionals to prevent and intervene in the conspiracy of silence in the context of oncological palliative care. **Method:** Cross-sectional qualitative study using the Interpretative Phenomenological Analysis approach. The participants were nurses, doctors and a psychologist who work in the palliative care unit of a cancer center. A semi-structured interview was applied to a sample of 12 healthcare professionals. **Results:** The age of the participants varied between 31 and 64 years old, mostly females, ten nurses, one physician and one psychologist. From the analysis of the interviews, the following themes emerged: perception of the phenomenon of the conspiracy of silence; difficulties and challenges in dealing with the conspiracy of silence in palliative care; professionals' feelings about the conspiracy of silence; strategies to intervene and prevent the conspiracy of silence. Important strategies were reported such as honest communication without impositions, listening to the motivations that led to the silence. **Conclusion:** Professionals are aware of the ethical duty to tell the truth when faced with a conspiracy of silence. However, continuous training is needed to develop skills for communicating dismal news in clinical settings and in medical education.

Key words: Palliative Care/ethics; Health Communication/ethics; Neoplasms/epidemiology; Health Personnel/ethics.

RESUMO

Introdução: O silêncio sobre notícias difíceis é comum em cuidados paliativos, envolvendo pacientes, familiares e equipe de saúde. Esse fenômeno de ocultação da verdade – conspiração do silêncio – tem consequências negativas e merece atenção dos profissionais. **Objetivo:** Investigar e explorar as estratégias utilizadas pelos profissionais de saúde para prevenir e intervir na conspiração do silêncio no contexto dos cuidados paliativos oncológicos. **Método:** Estudo qualitativo transversal utilizando a abordagem da Análise Fenomenológica Interpretativa. Os participantes foram enfermeiros, médico e uma psicóloga que atuam na unidade de cuidados paliativos de um centro oncológico. Aplicou-se entrevista semiestruturada a uma amostra de 12 profissionais de saúde. **Resultados:** A idade dos participantes variou entre 31 e 64 anos, a maior parte da amostra é do sexo feminino. Quanto à profissão, dez são enfermeiros, um médico e um psicólogo. Da análise das entrevistas, emergiram os seguintes temas: percepção do fenômeno da conspiração do silêncio; Dificuldades e desafios para lidar com a conspiração do silêncio nos cuidados paliativos; Sentimentos dos profissionais sobre a conspiração do silêncio; Estratégias para intervir na conspiração do silêncio; Estratégias para evitar a conspiração do silêncio. Foram relatadas estratégias importantes como a comunicação honesta e sem imposições, ouvindo as motivações que levaram ao silêncio. **Conclusão:** Os profissionais estão conscientes do dever ético de dizer a verdade diante de uma conspiração de silêncio. No entanto, é necessária formação contínua para desenvolver competências de comunicação de más notícias no contexto clínico e no ensino médico.

Palavras-chave: Cuidados Paliativos/ética; Comunicação em Saúde/ética; Neoplasias/epidemiologia; Pessoal de Saúde/ética.

RESUMEN

Introducción: El silencio ante noticias difíciles es común en los cuidados paliativos, involucrando a pacientes, familiares y equipo de salud. Estas características de ocultar la verdad – conspiración de silencio – tienen consecuencias negativas y merecen la atención de los profesionales. **Objetivo:** Investigar y explorar las estrategias utilizadas por los profesionales de la salud para prevenir e intervenir en la conspiración del silencio en el contexto de los cuidados paliativos oncológicos. **Método:** Estudio cualitativo transversal utilizando el enfoque de Análisis Fenomenológico Interpretativo. Los participantes fueron enfermeras, médico y un psicólogo que trabajan en la unidad de cuidados paliativos de un centro oncológico. Se aplicó una entrevista semiestructurada a una muestra de 12 profesionales de la salud. **Resultados:** La edad de los participantes varía entre 31 y 64 años, la mayoría de la muestra es femenina. En cuanto a su profesión, diez son enfermeros, un médico y un psicólogo. Del análisis de las entrevistas surgieron los siguientes temas: percepción de las especificidades de la conspiración del silencio; Dificultades y desafíos para afrontar la conspiración del silencio en los cuidados paliativos; Sentimientos de los profesionales sobre la conspiración del silencio; Estrategias para intervenir en la conspiración del silencio; Estrategias para evitar la conspiración del silencio. Se reportaron estrategias importantes, como la comunicación honesta y no impuesta, escuchando las motivaciones que llevaron al silencio. **Conclusión:** Los profesionales son conscientes del deber ético de decir la verdad ante una conspiración de silencio. Sin embargo, es necesaria una formación continua para desarrollar habilidades para comunicar más noticias en el contexto clínico y en la educación médica.

Palabras clave: Cuidados Paliativos/ética; Comunicación en Salud/ética; Neoplasias/epidemiología; Personal de Salud/ética.

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INTRODUCTION

Palliative care emerged due to the necessity of specialized care for people with serious, progressive and chronic illnesses¹. It is patient and family-centered during various stages of the disease and also in death and mourning². Silence often appears in the initial phase of palliative care, it is a quite frequent social phenomenon, involving the patient, family/caregiver and the healthcare team, and is called a conspiracy of silence or pact of silence³. Unpleasant news are often denied when the patient is vulnerable, especially older adults, teenagers and children. To protect the patient, the family omits information and avoids talking about the disease, because they believe the patient will suffer, contributing to its death^{4,5}. In this context, the healthcare team needs to avoid conspiracy, facilitating and encouraging the truth-telling, and placing the patient as a protagonist of the disease process and a participant in care decision-making, and consequently preserving their autonomy^{5,6}.

This bioethical principle requires honest communication from the first contact at diagnosis and through treatment⁷. The patient is the main subject of treatment and has full decision-making power over sharing information about the disease process⁸. After becoming aware of the actual health condition, the patient may also go through a period of denial and prefer not to discuss the matter⁹. After hearing dismal news, when the person decides not to share it with family members, Lemus-Riscanevo et al.⁵ define this situation as an “adaptive conspiracy of silence”.

It brings negative consequences for the patient and family members, who begin to live with doubts, anxiety, fears¹⁰. The patient experiences signs and symptoms resulting from the progression of the disease and they may face the end of their lives without knowing the truth and unable to communicate and resolve issues important to themselves. Therefore, it is necessary to overcome the paternalism implicit in the attitude of omitting the truth with protective intent¹¹.

However, the health professionals have an ethical duty to always tell the truth as best as possible, considering the patient's refusal of treatments¹²; in Portugal this is a patient's right guaranteed by the Basic Law of Palliative Care n° 52/2012, as well as being informed about their clinical status, if that is their wish, choose the place where care will be provided and participate in decisions about care provided by the team¹³. Kübbler-Ross⁹ affirms that telling the patient the truth is unquestionable, the central concern should be “how to tell”.

Strategies for effective communication in palliative care and to prevent/deal with the conspiracy of silence

with the family go beyond providing information. Initially, they comprehend the confirmation of the patient's inclination to discuss key topics, check their expectations regarding treatment and prognosis and encourage the expression of feelings¹⁴. The biopsychosocial vulnerability caused by a serious and advanced disease requires skilled and experienced healthcare professionals to meet the complex demands of palliative patients and their families. Professionals should use communication skills and adequate attitudes to give the information and offer emotional support^{4,14-16}.

The conspiracy of silence still constitutes an obstacle in the care process, probably because some professionals try to respect the family's wishes and maintain silence to protect the patient¹⁷. The lack of professional training to deliver dismal news and the reluctance to deal with the patient's feelings also appear as a cause, as it is a task that involves discomfort and stress, a challenge for many doctors^{6,18}. In this sense, research about the conspiracy of silence is justified, as it is perceived and managed by health professionals in clinical practice to communicate effectively with the family and patient and help the multidisciplinary healthcare team in palliative settings. The main objective of this study is to investigate and explore the strategies used by healthcare professionals to prevent and intervene in the conspiracy of silence in the context of oncological palliative care.

METHOD

Phenomenology as an investigation method was conceptualized and theorized by the philosopher Edmund Husserl in 1931 in Germany as a way of understanding the context of experiences lived by participants in qualitative studies, as well as the meanings attributed to these experiences^{19,20}. Then, many theorists expanded the use of this theory to align with current qualitative research methodology¹⁹⁻²¹.

Interpretive Phenomenological Analysis (IPA) is an approach developed in the second half of the 1990s by Jonathan Smith, Paul Flower and Michael Larkin, psychologists and professors at British universities. These theorists followed the concepts and articulations of three intellectual currents: phenomenology, hermeneutics and ideography, and developed their methodology from the assumptions of Husserl, Heidegger, Sartre and Merleau-Ponty¹⁹. According to Alase²¹ the use of the phenomenological approach enables the use of a structured method of data analysis developed to help phenomenological researchers in qualitative research to understand, interpret the experiences of people who have experienced similar phenomena and to give

meaning to these experiences²¹. Thus, it can be stated that this theoretical-methodological framework is not just a description of events, but has the greater purpose of investigating how people give meaning to their most significant life experiences¹⁹.

Intentional sampling method was used, twelve healthcare professionals of both sexes participated in this study, including ten nurses, one doctor and one psychologist, in a palliative care unit for adults in Porto, Portugal and all of them accepted to participate. The participants had at least one year of experience, and had already dealt with the conspiracy of silence in their practice. Professionals with less than one year of experience in the service and who were on medical leave or on vacation were excluded.

In the Palliative Care Unit, the participants were addressed by the reference healthcare professional as requested by the institution's ethics committee to verify compliance with the selection criteria and interest in participating in the research. If they accepted to participate in the research, an email was sent with the official invitation and the scheduling of the interview online or in person. This study was submitted and approved by an Ethics Committee of the Portuguese Institute of Cancer (number 08/2022).

Eligible participants were interviewed individually by one investigator who collected their data as age, sex, professional occupation, years of professional practice and education in a single form.

Prior authorization was requested for the audio recording of the interviews, the interview time ranged from twenty minutes to one hour. Each interviewee received a code formed by the letter P (Participant) and a number. The audio recording and data analyses were deleted after transcription to protect the participant's anonymity in accordance with the General Data Protection Regulation (European Union) 2016/679.

The data collected were coded, transcribed and each interview was analyzed systematically and qualitatively by one investigator who followed the hypothesis of the Phenomenological Interpretive Analysis by Smith, Flower and Larkin²². In the first moment, the interviews were transcribed and read exhaustively at least three times; initial themes were raised and, later, they were grouped and reorganized. In the second moment, the themes were refined and condensed into a category.

RESULTS

The participants characteristics are presented in Table 1: age (31-64 years old, mean of 41.8 years), sex, education and professional category. Their professional experience ranged from 9 to 42 years, mean of 18.4 years.

The following themes emerged after the analysis of the interviews: (1) Perception of the phenomenon of the conspiracy of silence; (2) Difficulties and challenges in dealing with the conspiracy of silence in palliative care; (3) Professionals' feelings about the conspiracy of silence; (4) Strategies to intervene in the conspiracy of silence; (5) Strategies to prevent the conspiracy of silence.

THEME 1. THE PERCEPTION OF THE PHENOMENON OF THE CONSPIRACY OF SILENCE

The conspiracy of silence occurs quite frequently and diversely in the routine of the participants in different caring environments. It was found between patients and caregivers or vice versa and also between health care professionals and patients. It is often found among sick parents and sons, where the son or daughter asks the professional to not inform the patient about the cancer diagnosis, dismal prognosis, use of opioid medication, short time of life.

In this context, in addition to the family opting for the conspiracy of silence, they are sometimes anxious to involve the healthcare team, requesting or even demanding that they deny, omit or lie to the patient, as Participant 3 described:

The family of an older patient with anxiety and depressive asked: Oh, don't say anything that the disease is advancing, don't say anything that we know because that will bring a lot of suffering.

There are professionals who practice the conspiracy of silence when they talk about the disease to family members and not to the patient. As explained by the Participant 9:

It's the conspiracy of silence also practiced by the medical team, because they don't say anything (...). And then the doctor in charge of the patient spoke only with the daughter and said that they were going to ask for palliative care because she no longer met the conditions to be treated.

Cases of patients who asked the professional to avoid sharing their health conditions with family members were found. Nevertheless, Participant 2 states that signs of organic deterioration are evident and the main problem in these cases is that there is no open dialogue between patients and family members who prefer to keep silent about the issues:

Often, what we realize is that everyone knows, but no one talks about it, because the patient notices his deterioration. (...) the patient asks us to not talk to the family because he is afraid that the family does not want to take them home.

Table 1. Demographic information of the interviewees

Variable	Number of interviewees	Percentage
Sex		
Male	1	8.3%
Female	11	91.7%
Professional category		
Nursing	10	83.3%
Medicine	1	8.35%
Psychology	1	8.35%
Education		
Specialization course	5	42%
Specialization and Master	6	50%
Graduation only	1	8%
Doctorate	0	0
Specialization courses		
Continuing care	2	16.6%
Palliative care	2	16.6%
Medical-surgical nursing	2	16.6%
Medical-surgical nursing with a focus on palliative care	2	16.6%
Advanced nursing	1	8.3%
Health services management and administration	2	16.6%
Clinical psychology	1	8.3%
Education and development psychology	1	8.3%
Pediatric palliative care	1	8.3%
Master		
Palliative Care	4	33.3%
Oncology	1	8.3%
Medical-Surgical nursing	1	8.3%

Note: A professional has more than one post-graduation degree.

THEME 2. DIFFICULTIES AND CHALLENGES WHEN DEALING WITH THE CONSPIRACY OF SILENCE IN PALLIATIVE CARE (PC)

The professionals interviewed were concerned when they found the conspiracy of silence and did not know how to address it as, for instance, families creating obstacles to the team or their own communication skills while dealing with dismal news. The narrative of Participant 4 expressed this theme:

(...) with the family, sometimes there are conflicts.
 (...) A young patient with young daughters, the conspiracy of silence was there, (...) the family was upset because we spoke with the patient, and it was a bit complicated for us to manage.

Participants also reported that the time plays an important role in the communication process in the conspiracy of silence, it takes more than one approach

with the patient and family to gradually clarify the most essential issues, and sometimes this time of life for patients is too short, since many are referred to the service already in the final stage of life, as the narrative of Participant 5 made clear:

The process since their admission to the service and their end of life is very short and, therefore, we have little time for effective communication and sometimes we have a patient who is admitted and dies in 2 or 3 days (...).

THEME 3. FEELINGS WHEN DEALING WITH THE CONSPIRACY OF SILENCE

Feelings of uneasiness, impotence and rejection were detected by healthcare professionals when realizing the existence of the conspiracy of silence and not being

able to solve it as expected, also highlighting that even with experience in working with similar situations there are cases that will not be solved due to the decision and persistence of the own family in maintaining the conspiracy of silence, as described by Participant 8:

(...) I would say that I feel calm to deal with the family, however there are mixed feelings (...), sometimes I feel they are adamant even after we explain, the persons are reluctant and don't want to share with the family.

Participant 12 adds:

(...) palliative care is a constant challenge naturally, of course there are things that frustrate us a little more (...) we have to be aware that there are situations that cannot be resolved no matter how good we can be as professionals and do our job the best way.

However, the feeling of security and tranquility was also reported when dealing with the conspiracy of silence, associating this feeling with the longtime of professional experience, as Participant 4 explained:

(...) I feel calm, at the beginning when I started working in palliative care I felt a little frustrated, I couldn't handle death very well, every death situation is complicated and when you start working and don't have experience (...), but right now, with these years of experience, I don't feel embarrassed about these situations.

THEME 4. STRATEGIES TO INTERVENE WHEN THE CONSPIRACY OF SILENCE EXISTS

Aspects of communication and attitudes are essential strategies to address the conspiracy of silence with the family and the patient, including honest communication without demands or impositions to family members and patients, as Participant 1 described:

The first important thing in the conversation is not to insist with the patient and leave it for the next day, not to force the patient (...).

In addition, another strategy is to explore the family members motivations for opting for the conspiracy of silence and then try to demystify erroneous ideas as the conception that many people have that the truth harms the patient as explained by Participant 4:

First you have to try to understand the reason for the conspiracy of silence, what is behind the conspiracy

of silence and then have an assertive attitude with the family, speak openly (...).

As another strategy to intervene, it is necessary to check the knowledge the patient and the family have about the disease, the prognosis and palliative treatment, and also what they need and want to know, as Participant 11 explained:

(...) many times, we must know how far we can go (...). I always try to find out what the patient and the family know, and the strategy is to guide them, to get them to talk about the subject until it becomes clear (...).

Professionals reported conversation environments and where they performed the approach to the conspiracy of silence with the patient and family: at the patient's room, medical visit, family conferences, for instance. The Participant 2 described:

(...) first palliative care consultation where the doctor and the team talk about the health situation, prognosis and follow-up, that is, everyone will know the disease's stage and what the prognosis is in terms of evolution. However, in specific situations we see this conspiracy of silence (...).

Regarding family conferences, Participant 10 states that:

(...) we need to have a family conference so we can talk about this (...) and it was really a struggle for everyone to be able to talk to each other.

The presence of doctors, nurses, psychologists and social workers that deal with the conspiracy of silence in an integrated and continuous manner during the communication process in palliative care is fundamental to have open conversation and intervene in the context of silence, according to the narrative of Participant 2:

(...) we manage to work very well as a team, and this is already intrinsic to our work. (...) Sometimes one day or one work shift is not enough, this is a continuous work, therefore the information must also be passed on in shifts changing, the nursing records need to reflect this clearly to help the team to be aware of what is being done and maintain the continuity.

The attitude of the teamwork during the intervention needs to be reinforced as Participant 4 described:

(...) the conspiracy of silence is never handled by a single person alone (...), this is a team situation

shared with nurses and doctors as a whole, so we are able to unravel these situations with the family.

THEME 5. STRATEGIES TO PREVENT THE CONSPIRACY OF SILENCE

The participants identified attitudes that contribute to the perpetuation of the conspiracy of silence, identifying these attitudes is necessary to understand what the professionals need to avoid or change the behavior to prevent the conspiracy of silence, among them: the doctor communicating something first to a family member, without the patient's authorization; the palliative care team does not accompany the patient at the moment of diagnosis of the disease; the use of overly technical language and the unrealistic approach to mitigating the severity of the clinical situation as described by Participant 8:

(...) talking only to family members and not to the patient, there are cases that the doctor himself addresses the family and not the patient, and I think this validates with family members that it is right for the patient not to know.

Participant 9 adds:

(...) we fail a lot in our communication, we cannot count on the doctor's communication, because it is very limited, they are not prepared to talk. And to protect themselves, they speak in scientific language and anyone who is not in the medical field is not obliged to know scientific language.

DISCUSSION

Smith, Flower and Larkin's Interpretive Phenomenological Analysis²² allowed to understand the experiences of the study participants with the conspiracy of silence in their routine with cancer patients in palliative care and their families.

The communication process in palliative care assumes a complexity already reported by the participants, it often involves the information of dismal news with people in a situation of physical and emotional vulnerability, and the conspiracy of silence is a negative phenomenon that configures itself as a failure of this communication in the team-family-patient triad. Volles et al.⁸ corroborate this finding by stating that silence constitutes a failure in the communication of those involved, as well as contributing to weaken the affective bonds and causing isolation.

A convergence of the perception of the conspiracy of silence was noticed although each situation is different, having in common the total or partial concealment of information such as diagnosis, prognosis and end of life. The literature emphasizes that it is essential that the

professional seeks to understand the family's fears and avoidance behaviors in the communication process in order to identify the reasons for the conspiracy of silence²³.

Mendes¹⁷ states that when investigating the background reasons that justify the conspiracy of silence, he identified that family members do not want to cause more concern to the patient, nor trigger distress, considering that the patient is already sufficiently affected by the disease.

The professionals (palliative or not) need to be assertive while communicating with a family or one member who has opted for the conspiracy of silence and at the same time requires the team to reach an agreement, based in what is best for the patient²⁴.

Bicho¹⁸ states that training is important to improve communication skills as active listening, assertive training, conflicts resolution and negotiation and disclosing dismal news utilizing recognized protocols. A study carried out by Araújo and Silva²⁵ identified that active listening was the most used strategy for communication in a group of 303 professionals working in palliative care, this practice is very useful as it is focused to the other and their needs. The same authors state that the practice involves: "eye contact with the patient, positive head nodding, the therapeutic use of silence, physical approximation and orientation of the body with the trunk facing the person and the use of short verbal expressions that encourage the continuity of speech, among others"²⁵.

The interviewees reported that some family members insist on maintaining the conspiracy of silence, even though the entire multidisciplinary team has used the appropriate tools, however they were unable to resolve the situation due to the temperament or personality of the actors in the conspiracy, for example, chronic failures in communication among family members.

Being aware that not always the expected outcome is achieved is part of the interaction with the family and the professional's routine, it is important to know how to deal with frustrations in the work environment and continuously dealing with multiple stressful events, otherwise they can trigger physical and emotional exhaustion as a consequence²³.

Silence and introspection can be signs of reflection or denial, the first stage of grief very well described by Kubler-Ross⁹. This author even states that the denial is quite common in patients who are abruptly or prematurely informed by someone who does not know them well, without taking into account the patient's preparation⁹.

According to Rodriguez¹⁰, the care team is responsible for supporting and creating an ideal communication channel so that the family member can reflect on the disease and express the suffering experienced¹⁰, and offer

support to prevent or alleviate the patient's suffering until the end of his life⁹.

Arantes²⁷, a Brazilian palliative doctor, reports in her book "Death is a day worth living" that she faces the conspiracy of silence almost daily, with situations in which family members implore her not to inform the truth about the advanced disease to the patient, and this professional acknowledges facing major challenges with these families who refuse to understand that information is a patient's right, believing that the truth will make him worse or kill him.

Family conferences were used in several cases of conspiracy of silence among the interviewees to bring together the multidisciplinary team, the family members and the patient to talk about various emerging issues at the time, such as the prognosis of advanced disease, and give the ideal opportunity for them to ask necessary questions to the team. Silva et al.²⁸ define family conference as a therapeutic instrument used by the inter and multidisciplinary team, as a moment of planned dialogue between patient, family and team.

According to the experiences of the interviewees regarding professional intervention, the strategies were analyzed and organized as follows:

1. Talk with the patient and family member to, above all, ask questions to understand what they know about the diagnosis, prognosis or palliative treatment.
2. Realize the existence of the conspiracy of silence, look for an environment with privacy and comfort to start a conversation either with the family and/or caregiver.
3. Listen carefully, asking questions, if necessary, in order to try to understand the reasons for the family member withholding information from the patient.
4. Avoid using disapproving facial expressions, or judgmental phrases such as "you are wrong", "this is not right", "you are being unfair".
5. Show the family member the patient's real situation, and point out how obvious the severity and progression of the disease is, if applicable.
6. Explain that it is a patient right guaranteed by law not to be withheld the truth about their health condition by the care team, and if the patient asks anything it will be answered honestly and sensitively.
7. Offer help by a multidisciplinary team that can collaborate with communication between the family member and the patient, speaking honestly without taking away their hopes, so that the family member feels that he/she is not alone in the dialogue with the patient.
8. Offer the support you feel necessary: emotional, spiritual, religious and/or social.
9. If the person insists on remaining with the conspiracy of silence, do not impose attitudes. And don't give up

with just one try, as the person will probably reflect on what was said.

10. Organize a family conference with the multidisciplinary team, after the patient's authorization, so that the topic can be discussed among all.

11. Never omit information or lie to the patient if he asks something, as it means he wants to know the truth.

The process of serious illness and the end of life is a difficult and stressful period for everyone involved – professionals, patients and families – when it is inevitable to deal with changes, losses and uncertainties, and going through this moment in silence makes it even more painful¹⁰.

CONCLUSION

The professionals interviewed have knowledge and practice in intervention strategies to deal with the conspiracy of silence, among which: honest communication without impositions, listening to the motivations of family members who opt for the silence, trying to demystify erroneous ideas, check the knowledge of the patient and family about the disease, prognosis and palliative treatment, and what they want to know.

It is also important to reduce the occurrence of the conspiracy of silence, expand prevention strategies through early referral of the patient to the palliative care team. Furthermore, the organization of courses and workshops promoted by health institutions and the education of professionals from university and postgraduate courses is a great contribution.

The present investigation can contribute to scientific knowledge in the area of communication and conspiracy of silence, so that it is better understood by professionals and society, to further strengthen ethical principles in patient care and the assumptions of palliative care. Among the limitations of the investigation, the sample had a higher proportion of nurses compared to physicians and psychologists, because the nursing team is usually the most numerous professional category in the hospital environment.

CONTRIBUTIONS

Ana Carolina Ferreira contributed to the study design, analysis and interpretation of the data, wording and critical review. Margarida Alvarenga contributed to the study design, acquisition, analysis and interpretation of the data, wording and critical review. Francisca Rego contributed to the study design, analysis and interpretation of the data, wording and critical review. All the authors approved the final version for publication.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

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