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Original Article

Communication of bad news in medical practice: medical perception on facilitators andhinderers

Comunicação de notícias difíceis na prática médica: percepção médica de facilitadores edificultadores

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ABSTRACT: OBJECTIVES: to acknowledge the training of physicians regarding the disclosure of bad news and the difficulties and facilitators into the practice of communicating bad news to patients and families. METHOD: descriptive qualitative study. Data collection was carried out through a semi-structured interview with medical professionals from an oncology unit. Conventional content analysis performed according to hsie and shannon. RESULTS: it was reported a great precariousness in medical education regarding the communication of bad news, being a possible contributor to the difficulties found in the position of communicator. There were different definitions attributed to the term "bad news" by the interviewees and several factors thatmade it difficult to communicate those news. These factors maybe technical and/or socio emotional. Subject to these factors, is the very success of communication, that interferes with the treatment of the patient. CONCLUSION: some influencing factors are non-changeable; others are subject to change or prevention. Among these, are the multidisciplinary work, a good doctor- patient relationship and a suitable environment for communication. When these factors are manipulated for a better communication, it is accomplished with greater success and benefit. The prior preparation for this communication was unanimously highlighted, justifying a greater approach in academic medical education on this subject.

Keyword: Communication; Interview; Revelation of truth; Professional training.

RESUMO: OBJETIVOS: Conhecer a formação de médicos no que diz respeito à comunicação de notícias difíceis e conhecer os dificultadores e facilitadores na prática desse profissional em comunicar notícias difíceis a pacientes e seus familiares. MÉTODOS: Estudo qualitativo descritivo. Coleta de dados realizada em entrevista semiestruturada, com profissionais médicos de uma unidade oncológica. Análise de conteúdo convencional realizada segundo Hsie e Shannon. RESULTADOS Houve diferentes definições do termo notícia difícil pelos entrevistados, e diversos fatores dificultadores e facilitadores para acomunicação dessas notícias. Esses fatores podem ser técnicos e/ou sócio-emocionais. Sujeitoa esses fatores, está o próprio sucesso da comunicação, que interfere no tratamento dopaciente. CONCLUSÃO: Alguns fatores de influência são inalteráveis, outros são passíveis de mudança ou prevenção. Entre esses, estão a atuação multidisciplinar, uma boa relação médico-paciente e um ambiente adequado para a comunicação. Quando esses fatores são manipulados para uma melhor comunicação, essa é realizada com maiores sucesso e benefício. O preparo prévio para essa comunicação foi unanimemente realçado, justificando uma maior abordagem na formação acadêmica médica sobre esse assunto.

Palavras-chave: Comunicação; Entrevista; Revelação da verdade; Capacitação profissional.

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INTRODUCTION

The term "bad news" designates information that leads the patient to a change in their future perspective, in a negative way. Such information will have different consequences for each individual, depending on several factors, such as the individual hope and the psychosocial context[1,2].

It is known that a fundamental aspect for establishing a good doctor-patient relationship is the information exchange. The diagnosis of a serious illness, involving the risk of death, disability or other losses, can provoke intense and painful feelings. Despite being an unavoidable task for the physician, transmitting bad news is a complex part of the health professional's work[3].

The moments of bad news communication (BNC) cause concerns in the doctor and the patient, and can cause fear, anxiety, uselessness, discomfort and disorientation, feelings that can lead to escape mechanisms in professionals, making them communicate with less care and empathy .

Among the physician's difficulties in delivering bad news, there are fears of being considered guilty, of therapeutic failure, of feeling impotent, of professional failure and of his own illness and/or death. Physicians' feelings make BNC an even more complex task and may lead them to blame themselves for the patient's poor prognosis. As for the patient, psychic pain and discomfort are the feelings most commonly generated at the time of communication[3].

Due to the incipient knowledge regarding the physician's training to deal with the subjective aspects that involve the BNC process, such as the professional's discomfort and the patient's reactions, the BNC is a laborious task[2]. Therefore, verbal and non-verbal interpersonal communicative skills are needed to make this fragile moment of interpellation a gradual, milder and more welcoming process[4,5].

It can be said that proper communication manages to reduce conflicts and misunderstandings, with accurate transmission of the message. For the patient, bad news can take many forms; from a poor prognosis, a difficult treatment or the possibility of death[4]. Given the importance of the BNC, both for the patient and his family and for the doctor, the factors that could influence this communication and the preparation of the professional for such communication are questioned.

The justification for this study is due to the incipient publications on this subject, in addition to the perception of the deficit in approaching the subject in medical academic training, which may interfere with their professional practice, affect the doctor-patient relationship and negatively influence the patient's life[6]. Still, it is justified by the possibility of supporting further studies, complementing the direction of strategic measures used by physicians seeking a better BNC.

This study aims to find out facilitating and hindering factors that interfere with BNC and to learn about medical training in the area.

METHODS

This is a descriptive-qualitative study[7]. The research was carried out in the oncology ward of a medium-sized hospital, located in a city in the midwest region of Minas Gerais - Brazil. This research field was chosen because it is a regional reference center in oncology, with a large volume of consultations and active professionals, in addition to having a field internship link with the institution of origin of the authors, facilitating access and data collection. The participants of this study were physicians enrolled in the Regional Medicine Council (CRM - MG) and working in the Oncology sector of the aforementioned hospital unit. Participants were selected due to the frequency of the BNC during their professional practice. Physicians who were on vacation/leave were excluded.

The project was analyzed and approved by the Research Ethics Committee of the Federal University of São João del-Rei (CEPES-UFSJ), through Opinion 2.931.071. All volunteers signed the Informed Consent Form (TCLE), guaranteeing their understanding of the research, its risks and benefits, and accepting its conditions.

Data collection involved interviews with a semi-structured script, prepared by the authors. The interview was conducted in person, in a place chosen by the volunteer, and recorded in mp3, for transcription and subsequent analysis. The sample consisted of 20 participants, being determined from data saturation, identified through the analysis of the content of these interviews.

The presented results are products of conventional content analysis. According to Hsieh and Shannon (2005), after organizing the material (interview transcription), the content analysis began, with repeated readings of the texts, in order to obtain the meaning of the whole. Subsequently, the reading was carried out in detail, highlighting words and expressions in the text that made it possible to capture thoughts or concepts, so that codes could be derived from these data, that is, words or terms that define meanings found in the content analysis[8]. For data storage and encoding process, the MAXQDA® software version 12.2 was used.

The pre-established codes were: definition of bad news; facilitating factors of the BNC process; factors hindering the BNC process; influences of professional and individual training in the BNC process.

The next step, after the initial analysis, was the re-reading of the pre-established codes and, from that, the categorization, through the formulation of labels and

names, for possible groupings of codes. The categories and their meanings arise from this analysis dynamic, allowing interpretations and new conceptions about the theme[8].

Because it is a qualitative study, in which both investigated and investigator are direct agents of the research, a possible limitation is the loss of objectification, due to the subjective analysis and interpretation of the researchers, as well as the limited understanding and representation of the interviewees' information. Another possible limitation is the sample size. Despite reaching data saturation, as this is a content analysis study, new information could be obtained from a larger volume of interviews, requiring a new, larger study. In addition, the selection of interviewees underwent a subjective analysis by the researchers, and different results could be obtained through other selection methods[9].

There were no potential or current institutional, personal or financial conflicts of interest that could compromise the results of this study. There were also no sources of funding or support for its realization.

RESULTS

Three categories emerged from the data obtained, according to the described methodology. In the first, definition of bad news, reports were included in which the interviewees informed what was their understanding of what constitutes bad news. This definition is based on the analysis of the interviewee's understanding of the term.

In the second, influence of professional and individual training on the BNC process, there are reports that describe the experience of each interviewee, during their training, on the subject.

Finally, in the third category, factors that influence the BNC process, all the elements reported by the interviewees that they understood as being important in the BNC process, both facilitating and hindering such communication, were described.

Definition of bad bews

Most respondents (cited as "P" – from "person") understand "bad news" as information related to a bad diagnosis or an unfavorable prognosis for the patient, such as intractable diseases. Others, however, have restricted this definition to only those news that concern the death of a patient. Another frequently cited explanation refers to a situation that has repercussions on the patient's life in relation to any situation that negatively changes his/her life/the lives of the people around him/her.

P2: "(...) outcome, sometimes unfavorable, of the worsening condition, a clinical disease that is getting worse (...), sometimes, when there is a possibility, little therapeutic possibility, when the diagnosis is made." P16: "Give information regarding, for example, cancer, you know, if the patient has, for example, an incurable cancer, he will have palliative treatment. It's more like that."

P19: "I deal with more emergencies, you know, with oncological cases, you know, but bad news, for me, I always read about death, and not about prognosis, but I also think about prognosis."

P1: "(...) it is news that will have some impact on the patient's life, which you know the patient will receive in a hard way."

Some interviewees understand that bad news is related to a possible breach of expectations, which can generate feelings such as frustration, even if it is not perceived by the transmitter as bad news.

P8: "(...) every patient expects a positive response about the medical resource he seeks. Everything that escapes this expectation of the patient becomes bad news, you know, something not expected by the patient.".

P4: "Sometimes, it is very easy for me, but, for the patient, it is a tragedy (...), and, sometimes, a small thing, for the patient, of news that I do not even consider to be bad, I think it's silly."

In another aspect, failing to consider the receiver of the information (patient and/or family), or prioritizing the communicator, the concept of "bad news" would be linked to the act of communicating the news itself. Thus, there is a greater relationship with the difficulty of transmission than with the difficulties related to reception, diverging a little from the ideas raised in the previous definitions.

P3: "(...) in my opinion, the one that you cannot pass on to the patient or family member before thinking about them, so, it is news that, just by having to think about how to say it, it is already bad news."

Influence of professional and individual training in the BNC process

Among the reports of professionals trained in the various medical specialties and, probably, in different universities, the great deficiency of academic training related to BNC is noted, so that there does not seem to have been any preparation to deal with this type of situation, in graduation or in the medical residence. It was even reported the benefit of optional courses that address this theme, offered by universities, which can collaborate for a more complete training.

P4: "Nothing, technical/professional training contributed zero. It contributed by giving me the experience of seeing, living, witnessing, learning by doing. Of technical training, zero."

P1: "My training, like, I consider very good. So, I went to a good college, where we already had contact with patients, like, from a very early age."

P5: " (...) in college, as we give the option of simulation, so, I started reading about the subject and I learned, I learned by teaching. So, I learned to be able to teach how

to communicate bad news, which we do in practice. (...) When you have to teach something, you study so much that you end up learning it very well."

P16: "In college, very little, like (...) and, even in residency, there wasn't, like, a specific class, specific training for that (...)"

Most claim that practical experience, after a period in the profession, helps to develop skills in BNC, giving the opportunity to interact with other experienced professionals (teachers), contributing to acquiring knowledge and skills to give this type of news to patients. Others sought, individually, knowledge on the subject.

P3: "The practice itself, right? We end up learning the hard way, because, in my training, whenever there was some bad

news, I was with some preceptor, I always observed how he spoke, how he called the patient, how he reserved the environment (...)"

P17: "Like in the residency, right, in radiotherapy, you've been seeing this since when you just entered the residency, so, you spend three years living with it, you'll experience it. There are some lectures, some courses, some things that we do and train, right? Just like the other professionals, our professors deal with it too, so we have a lot of discussion on the subject."

P11: "(...) I had no formal training for this. I've looked it up, I've read about it (...)"

Factors that influence the BNC process

The influencing factors in the BNC were the data that most presented diversity in the doctors' speech. Among those reported, the degree of understanding of the patient/family was the most present. A technical difficulty in communication was also mentioned, in making patients/relatives understand. Understanding the severity of the transmitted news was reassuring for the communicator, while not understanding this severity was considered a complicating factor.

P10: "(...) the level of education of the population we serve, which, sometimes, is a very low level. So, sometimes, we have difficulty to make the patient or the family understand the seriousness of the situation."

The patient's reaction to bad news was also reported as an influencing factor in this communication, reassuring the communicator and being an obstacle in this scenario. Finally, the questions that the patient asks during the BNC were also reported as hindering communication.

P1: "The patient's own reaction. That patient who is a little calmer brings much more peace of mind. And, then, I think it comes a lot, like, it depends a lot on the questions that the patient asks us, at the time. That patient who asks questions that we can answer without being so hard on her is easier (...)"

The behavior of the patient's companion/relative at the time of the news was reported more often than the patient's own reaction. One interviewee even reported, as something that causes difficulty, family requests for bad news to be omitted from the patient, implying an internal conflict in reconciling the family's desire with the patient's rights regarding his condition. Two interviewees, additionally, mentioned the importance of previous preparation of patients and their families, both the emotional preparation to receive bad news and the preparation related to the patient's knowledge about their condition, especially when an unfavorable outcome is expected.

P10: "(...) consciously or unconsciously, people sometimes prefer not to see the seriousness and even ask us to omit it. Mainly family asks: 'Oh, don't tell my mother that she has cancer or what she's going to do.'."

P8: "(...) the moment when you will break this news and see the preparation, both of the patient and the family members, to be able to receive this impact, too."

It was also mentioned, as of great importance to facilitate the BNC, the multidisciplinary action. This action was positively cited as important in preparing the patient in relation to his condition and prognostic possibilities, managing the anxieties of the patient and his family, generating less difficulty for the physician in dealing with these factors. In addition, the help of other professionals can facilitate the communicator's preparation for the news, as reported by an interviewee. It is worth mentioning, however, the need for quality in this team. One interviewee reported, as a complicating factor, a previous communication that was poorly performed, thus indicating the need for the auxiliary team to prepare in the communication process.

P6: "Now, the multidisciplinary team helps a lot, because they can work with these anxieties, both with the patient and with us (...)"

P7: "(...) and, if possible, get in touch with the attending physician, beforehand, in order to be better prepared for this news. In the hospital environment, sometimes, someone has already arrived, already given the dry and raw news, you have to get there and notice, see what really happened."

Still related to the emotional factor of communication, the severity of the prognosis was cited by some interviewees as a hindrance to BNC. This difficulty was reported in cases of diagnosis of a serious illness and in cases of change in prognosis for the worse. One respondent said that the change from a curable to an incurable prognosis is more bad news than a severe prognosis from the start.

P17: "(...) a patient that we, sometimes, are considering curative (...) and, then, the disease evolves, or it gets worse, or, for some reason, it becomes incurable, so, like, in this case, it ends up being more difficult than the patient we already see, from the beginning, with that prognosis."

The doctor's relationship with the patient and his family was mentioned as influencing the BNC. However, there were differences in the opinions of respondents

about such influence. One interviewee said that when he starts to get emotionally involved with the patient and his family, communicating bad news becomes more difficult. However, most reports seem to demonstrate the opposite, that a more intimate relationship with the patient and their family facilitates the transmission of bad news.

P12: "(...) and when we get emotionally involved with the patient, then it is not that uncommon, and some patients, in fact, begin to be a big part of our lives. And for them, or for their family, it's harder."

P7: "I think what makes it easier is having a good relationship with the patient; it makes everything easier."

The communicator's caution in the BNC was widely reported as a facilitating factor in communication. Most of the interviewees reported the importance of knowing how to choose the right words to talk to the patient, indicating a relationship between well-performed communication and a better response to the news by the patient. One interviewee described this relationship better, reporting that caution in communication helps the communicator to distance himself emotionally from the patient, facilitating communication, which shows, once again, the importance of the emotional factor in BNC.

P5: "(...) the word that most defines is 'caution'; the care we have to have with the person, the way of speaking, of choosing the right words (...)"

The communication of multiple bad news was highlighted as something very negative by two interviewees. Whether it was communicating the same bad news to different family members, or multiple bad news throughout the day, communicating multiple bad news was reported as a difficult factor.

P12: "Another thing that is very difficult is when, after you say everything and it seems that your preparation for talking about it is over, you have to start again, because a family member arrives who has never accompanied you, has never been there, and wants to know everything , from the start. So, breaking the news multiple times is extremely draining."

Some interviewees also cited their own family influence as something that helped them, for a better BNC. One respondent highlighted the advice received from his father, who is also a doctor, as something that helped him a lot in this regard. Another reported her father's tranquility as something that helped her to be calm as a doctor.

P3: "(...) I have a great teacher, who is my father, who is also a doctor, and who helped me a lot in this regard, you know? So, that advice that no teacher gives you on a daily basis, but that a father gives you."

The patient's age was reported by several interviewees as something that greatly influences the BNC. Reports were consensual that the young age of the patient makes BNC more difficult. One interviewee reported that, after becoming a mother, giving bad news about children became more difficult, linking the emotional character and the relationship with the patient to the act of communicating the bad news.

P20: "Generally, in cases of very young patients, it is a complicated thing, because a child, a young person, is not expected to die, like that, with such a young age."

Finally, the influence of the environment where communication takes place is also highlighted. The reports are corroborated in classifying a private, calm and interference-free environment as something very positive when communicating the news. Likewise, a non-ideal environment, overcrowded and with noise and interference, was reported as hindering this communication. In addition, one interviewee reported that the non-ideal environment for communicating bad news is the result of a rushed medical profession.

P3: "(...) sometimes, lack of time, lack of a more appropriate place, a certain lack of privacy in the outpatient setting. So, this can create a difficulty, in a more humane way (...)"

P18: "Now, without a doubt, what makes it more difficult is the excess number of patients that we have to care for. The volume of cases that we have to deal with, and deal with this huge demand (...)"

DISCUSSION

From the analysis of the interviews, it was possible to arrive at several definitions, complementary to each other, of what would be bad news in the perception of the interviewees. In a communication process, three fundamental elements are needed: the communicator, the receiver and the transmitted information. Following this concept, the definitions of bad news were divided into those referring to the sender of the news, those related to the receiver and those related to the object of communication, that is, the transmitted information[10].

Initially, in relation to the transmitted information, bad news represents any information that brings a negative connotation or meaning. From this, bad news can be stratified into three different types of information: communication of the diagnosis of advanced disease with poor prognosis; communication about complications related to the treatment, such as mutilation, impairment of functions and their consequences in the loss of quality of life; and the communication of exhaustion of current healing resources and preparation for exclusive palliative care[1,2].

Thinking about the recipient of the information, which would be the patient and their family members, bad news is any and all information that implies, directly or indirectly, some negative change in their lives, or something that involves a drastic change in the perspective of the future, in a negative sense, like diabetes mellitus in a teenager, or a major heart disease in an athlete. Following this thought, it is important to point out that this definition

depends on subjective aspects linked to the receptors. The following can be highlighted: their expectations about the future or in relation to the proposed treatment; the possibility of cure and survival; the non-occurrence of complications and their concepts about what is bad or good, and not always bad news for the sender is interpreted as such by the receivers[1,2,11,12].

Finally, analyzing the communicator, the difficulty of the news would be linked to the act of its transmission. Whenever the transmitter sees the need for prior preparation or has feelings such as anxiety and fear to convey information, he is facing bad news.

Faced with the issue of training doctors in relation to BNC, it is possible to see how communication is an indispensable and crucial tool in medical practice, on which all means of exchanging information and establishing the doctor-patient relationship are based. It is also one of the elements of the medical consultation that most generate complaints and dissatisfaction on the part of patients, which highlights the existence of difficulties and precariousness, on the part of the medical professional, for communication.

In addition, professional communicators of these news usually emphasize their BNC skills developed after their academic period[13]. Many medical professionals end up needing prior preparation to mitigate these difficulties in communication and reduce the negative repercussions they may generate. The importance of experience acquired through practice for this type of communication is highlighted, which is constantly being improved, making it an easier task.

The act of communicating bad news needs greater attention, especially in academic training, given its importance for the development of well-performed communication and its preparation, especially in view of the frequent report of a delay in addressing this topic in the curriculum, despite being a common practice of most medical professionals[14].

The vast majority of physicians refer that prior preparation for the BND is extremely important, both for better communication and to reduce the negative repercussions. It is almost a consensus that preparation for this type of situation in medical training is, at least, insufficient[15,16]. There is, therefore, a significant deficiency in addressing how academic and professional training would help physicians to deal with such a situation in their routine. Despite this, studies show that there are no differences in negative emotional repercussions between more experienced and less experienced physicians. The importance of experience, then, seems to be clearer in the effectiveness of communication and in the strategies used by professionals during their practice, such as better choice of environment or selection of patients with better prognosis[15].

In any case, most physicians report a common positive point generated by the BNC, which is the experience gained through practice for this type of communication in the future. The constant practice of BNC seems to help to reduce the emotional repercussions in future communications, in addition to helping the physician in his attitudes during the transmission, ensuring better support for the patient and his family. Such reports demonstrate that the communication process is in constant improvement and that its practice can make the task easier[15].

The literature describes several factors that influence the formulation of the BNC concept. Regarding the transmitter, their facilities and experience in communicating, their fears and concerns and their level of interaction with the patient; in relation to the receiver, the type of patient, their age, their expectations; finally, in relation to information, the individuality of the receivers. All these factors are analyzed, sometimes unconsciously, by the communicator, who arrives at the diagnosis of bad news[17].

The factors that influence the BNC can be divided into factors that influence the technical quality of communication and emotional factors in the communicator's perception, such as perception, meaning the subjective understanding of the communicator established from the stimuli received by the external environment, in this case, by the moment and context of the BNC.

The technical difficulties of the BNC not only hinder the understanding of this news by the patient and their family members, but also directly influence the communicator's perception of the difficulty of delivering that news. That is, there is a direct correlation between the objective factors that influence the quality of communication and the perception of the difficulty of transmitting the news, by the communicator. This correlation makes it possible to directly address these objective factors, seeking to make them ideal, to maximize their positive effects on communication, with the aim of reducing the difficulty in BNC by the communicator.

Corroborating this finding, the literature presents data that also make this parallel, indicating a relationship between the technical conditions that hinder or facilitate communication and the factors resulting from this communication. It was remarkable the positivity extracted from communication when it is done in a standardized and structured way, seeking to reduce, as much as possible, the complicating factors and the independent conditions of the communicator[6,16].

Unlike the factors that objectively influence the technical quality of communication, those related to the communicator's emotional difficulties are unpredictable and difficult to control. What can be established is that the emergence of communication difficulties, in the physician's perception, happens when he is exposed to a negative emotional charge, on the part of the patient or his family members. This difficulty extends beyond the period of communication, influencing the handling of the case after a bad acceptance of the news. This closely correlates the

communication process with the quality of medical practice itself. The doctor's emotional involvement with his patient makes this perception of difficulty even more intense, even creating situations of profound dilemma for the doctor.

It is important, however, to differentiate this emotional involvement from a good doctor-patient relationship. Although they are closely linked, one does not necessarily mean the other. The conflicting reports about the influence of the doctor-patient relationship on the difficulty of BNC show that, even when this relationship is ideal, it can make it difficult or facilitate the transmission of news, in the communicator's perception[18,19].

Bearing in mind the correlation between the doctor's emotional involvement with his patient and the difficulty of communicating the news, it can be inferred that a good doctor-patient relationship is not synonymous with a deep emotional relationship between doctor and patient. The literature reinforces this finding, showing that the positivity of the doctor-patient relationship is related to behavioral factors, such as humble and empathetic attitudes, and not to the creation of deep ties between doctors and their patients. Even empathy is seen, not as something purely affective, but multifactorial, also involving cognitive and behavioral processes[19,6].

The multidisciplinary action, in a holistic way, in approaching the patient, before and after he receives the bad news, is one of the best mechanisms to reduce these emotional factors. When this action is performed ideally and with quality, the patient's emotional bias is prepared, even before he gets in touch with the doctor, reducing the difficulty perceived by the communicator when breaking the news. After the news is given, the multidisciplinary team also acts in the assimilation and management of the news received by the patient, influencing the conduct of their case and, again, facilitating future contacts between doctor and patient[2,20].

Finally, still within the factors that influence the BNC, it is worth noting that there are complicating factors that are immutable and unpredictable, such as the young age of the patient, the severity of the prognosis and the intrinsic factors of the communicator. It should be noted, however, that although these factors are independent of any measure that can be taken, their interpretation and meaning pass through the filter of the communicator's perception. This perception is a factor that can be worked on, especially if done with prior preparation, communication structuring and practice time in BNC. The latter is extremely important, as it comes into contact with bad news during professional training[18,19].

CONCLUSION

It is understood that the definition of bad news depends on the individual perception of each communicator, being influenced by professional and personal training processes. This definition is an element that directly interferes with what the doctor perceives as something that facilitates or hinders the process of communicating these news.

Due to the possibility of minimizing some complicating factors and the application of factors that facilitate the communication process, the use of strategies that optimize this process is allowed and recommended for physicians.

Authors' participation: *Júlio Henrique Pereira Nascimento, Olívia Maria Trindade, Daniel Teixeira Machado, Paulo Otávio Alves Ashidani, Ana Cláudia Moreira Carvalho, Gustavo Nogueira Coelho* - participated in the design of the project, data collection and analysis, writing of the article, critical review of the work and approved the final version. Thus, they declare that they had sufficient participation in the work to assume responsibility for the total content. *Alexandre Ernesto Silva* - collaborated/guided from the project conception, critical review of the work to the approval of the final version. Thus, they declare that they had sufficient participation in the work to assume responsibility for the total content.

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