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COMMUNICATION OF BAD NEWS IN PEDIATRIC EMERGENCIES: EXPERIENCES OF PROFESSIONALS IN THE PRE-HOSPITAL CONTEXT

COMUNICAÇÃO DE MÁS NOTÍCIAS EM EMERGÊNCIAS PEDIÁTRICAS: EXPERIÊNCIAS DOS PROFISSIONAIS NO CONTEXTO PRÉ-HOSPITALAR

COMUNICACIÓN DE MALAS NOTICIAS EN URGENCIAS PEDIÁTRICAS: EXPERIENCIAS DE PROFESIONALES EN EL CONTEXTO PREHOSPITALARIO

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Objective: to understand how health professionals working in the pre-hospital experience the communication of bad news to the family in the pediatric emergency, as well as to propose a communication protocol based on these experiences. Method: qualitative research with theoretical-methodological support based on Symbolic Interactionism and Inductive Thematic Analysis, through semi-structured interviews, in the 2nd semester of 2019. Results: the professionals experienced the difficult communication process under the influence of the hostile environment. They set out actions to try to care for and receive the family. Family care generated reflections and a desire to provide adequate care. After the analysis of these experiences, the *Protocolo Acolher* was proposed. Final considerations: health professionals working in the pre-hospital feel unprepared and extremely uncomfortable before communicating bad news. The protocol developed can collaborate in directing pre-hospital care professionals and help them in the process of communicating bad news.

Descriptors: Health Communication. Emergencies. Emergency Responders. Family Nursing. Pediatric Nursing.

Objetivo: compreender como os profissionais de saúde que atuam no pré-hospitalar vivenciam a comunicação de más notícias à família na emergência pediátrica, bem como propor um protocolo de comunicação baseado nessas experiências. Método: pesquisa qualitativa com sustentação teórico-metodológica baseada no Interacionismo Simbólico e na Análise Temática Indutiva, mediante entrevistas semiestruturadas, no 2º semestre de 2019. Resultados: os profissionais vivenciaram o difícil processo de comunicação sob a influência do ambiente hostil. Eles estabeleceram ações para tentar cuidar e acolher a família. O cuidado com a família gerou reflexões e desejo de oferecer um atendimento adequado. Após a análise dessas experiências, foi proposto o Protocolo Acolher. Considerações finais: os profissionais de saúde que atuam no pré-hospitalar sentem-se pouco preparados e extremamente desconfortáveis

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diante da comunicação de más notícias. O protocolo desenvolvido pode colaborar no direcionamento aos profissionais do Atendimento Pré-Hospitalar e ajudá-los no processo de comunicação de más notícias.

Descritores: Comunicação em Saúde. Emergências. Socorristas. Enfermagem Familiar. Enfermagem Pediátrica.

Objetivo: comprender cómo los profesionales sanitarios que trabajan en el prehospitalario experimentan la comunicación de malas noticias a la familia en la emergencia pediátrica, así como proponer un protocolo de comunicación basado en estas experiencias. Método: investigación cualitativa con soporte teórico-metodológico basado en el Interaccionismo Simbólico y el Análisis Temático Inductivo, a través de entrevistas semiestructuradas, en el 2º semestre de 2019. Resultados: los profesionales experimentaron el difícil proceso de comunicación bajo la influencia del ambiente hostil. Establecen acciones para tratar de cuidar y acoger a la familia. El cuidado familiar generó reflexiones y un deseo de brindar una atención adecuada. Tras el análisis de estas experiencias, se propuso el Protocolo de Bienvenida. Consideraciones finales: los profesionales de la salud que trabajan en el prehospitalario se sienten poco preparados y extremadamente incómodos ante la comunicación de malas noticias. El protocolo desarrollado puede colaborar en la dirección de los profesionales de la atención prehospitalaria y ayudarles en el proceso de comunicación de malas noticias.

Descriptores: Comunicación en Salud. Urgencias Médicas. Socorristas. Enfermería de la Familia. Enfermería Pediátrica.

Introduction

Children present vulnerabilities inherent to their life cycle and are subject to the potential lifelong consequences of unduly treated health conditions. Thus, children need access to safe and quality emergency care, especially in the pre-hospital. Numerous challenges need to be transposed in the pre-hospital pediatric emergency, including the lack of training and experience of professionals in the conduct of these conditions[1].

Accidents and violence are among the main external causes of morbidity and mortality among children and adolescents in Brazil, constituting an important public health issue for the whole society. Falls, foreign body aspiration, traffic accidents and hit-and-run accidents, intoxication, burns, drowning and homicides are the main occurrences that reflect this problem[2-3].

In order to reduce the mortality rate, hospital stay and the consequences caused by the lack of early care, in 2002, the Ministry of Health (MH) implemented the *Serviço de Atendimento Móvel de Urgência* (SAMU) in the pre-hospital context. The SAMU team is composed of physicians, nurses, nursing technicians and drivers/first-aiders[4].

Pre-Hospital Care (PHC) involves actions whose focus is to positively influence the reduction of morbidity and mortality rates, respecting current protocols and always aiming at a better evolutionary prognosis[5]. Children have unique needs, which can be intensified when the disease is severe or puts their lives at risk, which can occur especially in the environment outside the hospital. Extra-hospital care for children requires high quality, appropriate resources, trained support staff and effective emergency care[6].

The characteristics of the scene in PHC, such as type of accident, severity, number of people involved and age of victims, influence the interaction established between the professional and the family. Child care often requires specific technical and behavioral skills[5,7]. Professionals can express low levels of comfort in the treatment of critically ill children in the pre-hospital context due to specific demands, such as medication dosage, airway management and communication barriers[8].

In this context, these professionals are expected to have to deal with the high demand of bad news communication. Coping with some situations can become a difficult task for the professional, something that cannot be delegated to other team members, and is restricted to those immediately involved with the service.

Bad news can be defined as information that involves a drastic and negative change in someone's life and that alters his/her perspective of the future. Health professionals experience this situation on a daily basis. The bad news not only impacts those who receive it, but also those who inform it, which can cause emotional discomfort and suffering. Moreover, professionals are not

always prepared in their education for this important challenge[9-10].

The relationship between families and professionals can intensify or minimize suffering during communication, which is influenced by previous experiences, beliefs and expectations about the present and the future. Professionals are responsible for adopting a reflective approach to understand the differences and complexities of patients and their families, providing resources that facilitate the development of these relationships. Moreover, it is also necessary to consider their own personal experiences, meanings and subjectivity in the communication process[9,11].

Training courses for SAMU professionals are generally focused on the pathophysiological and technical aspects of health care, offering little space for them to develop communication, reception and empathy skills[12].

In order to guide health professionals in the communication of bad news, since the 1970s, protocols have been developed and implemented in the hospital context[13], including the so-called SPIKES. In Brazil, there is the *PACIENTE* protocol, based on SPIKES, adapted to the Brazilian reality and proposed as a tool to direct communication[14].

Although widely used, these protocols have a limited scope when considering PHC, revealing gaps in the direction of professionals working in those services. Thus, knowing the experience of receiving families of children in emergency situations can contribute to the elaboration of a protocol that meets this demand.

In this sense, the questions that led this research were: How do health professionals experience the process of communicating bad news in the context of pediatric emergency? What are the issues considered important by health professionals when reporting bad news?

Based on the research questions, the objective of the study was: to understand how health professionals working in the pre-hospital experience the communication of bad news to the family in the pediatric emergency room, and to propose a communication protocol based on these experiences.

Method

Qualitative research with theoretical-methodological support in Symbolic Interactionism[15] and Inductive Thematic Analysis[16], performed in the pre-hospital service through semi-structured interviews. The study was conducted following the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ)[17].

The scenario was a PHC service in the Southeast region of Brazil, which operates 24 hours a day, focused on dealing with traumatic and clinical emergencies. In this service, an average of 130 visits per day are performed, totaling about 1,500 monthly services of basic and advanced life support actions[18].

Physicians and nurses who worked in the emergency service in the PHC modality participated in the research and met the criterion of having at least six months of experience at the time of data collection. Professionals on vacation or sick leave were excluded from the sample. Data collection was approved by the Research Ethics Committee (REC) of *Hospital Israelita Albert Einstein* (SP) under Opinion n. 3.262.865/2019 and authorized by the service coordinator.

Data collection occurred in the second semester of 2019, after the training of the first author conducted by the other authors. The professionals were informed about the voluntary participation and the purposes of the research. The selection was made by convenience and those who agreed to participate in the research signed the Informed Consent Form (ICF). The interviewer previously knew the PHC professionals, and there was no refusal to participate in the study.

The professionals were interviewed in person and individually, during their work shifts, in a reserved place and scheduled time, in a single approach. The interviews began with the guiding question: "Could you tell me about a situation in which you provided care to a child and subsequently had to communicate bad news to the family?" Other issues were introduced to broaden the understanding of the phenomenon.

The interviews, which lasted between 20 and 30 minutes, were recorded and fully transcribed. There was no interruption. The inclusion of new participants was interrupted when the conceptions or meanings attributed allowed an understanding of the context.

For data analysis, inductive thematic analysis was used, a method that reports the experience, meanings and reality of the participants. Thus, the themes identified are strongly linked to the data themselves. The analysis followed the steps: transcription, reading and rereading of the data; systematic and initial coding of the data; grouping of codes into potential themes with further refinement and appointment to clarify the main subject[16]. The coding process was carried out by the first author under the supervision of the other authors.

Results

The study included 4 physicians and 3 male nurses, aged between 35 and 46 years, working in PHC between 3 and 15 years. Each participant received the letter "N", followed by Arabic numeral, in order to preserve their confidentiality.

The analysis of the interviews allowed understanding the meanings attributed by PHC professionals to the communication of bad news and how these meanings permeate their interactions and actions in the context of pediatric emergency. In the interviews, three themes stood out: Dealing with uncomfortable and complex kinematics, Communicating the bad news to the family: caring, receiving and overcoming and Rescuing the ideal care for the family.

Dealing with uncomfortable and complex kinematics

Communicating bad news to the family was an uncomfortable situation for emergency team members, especially because the victim was a child. The professional's symbolic interpretation, perceiving the scenario as chaotic, when faced with the care of a child in serious condition or even with his/her death, affected his/her sense of balance and emotional control. The interaction with the family was permeated by feelings of anguish, failure and non-conformity with the situation. The team had to dedicate themselves first to taking care of the injured child, but could not fail to meet the parents or relatives, explaining to them, calmly and patiently, what was happening to the child. The lack of time, the unknown and the absence of external support symbolized this scene, for the professional, as the most challenging and complex.

> *The information we had was that there was an unconscious adult at the scene, an unconscious child with approximately two to three years old and three more conscious victims there. It was a collision, followed by ejection. The mother was nursing this baby, who was actually a month and a half old, and they both passed away. So perhaps the biggest trauma was not, in fact, the service, but giving this information to the father who was virtually unharmed, so passing on the information that he lost a son and his wife at the same time, was really a challenge. I did not have a great service experience and it was hard in my head to think of a strategy on how to approach this in a quiet way. But I reflected that this is impossible, communicating bad news to a family member is something that will always cause discomfort.* (N3).

The characteristics of the scene, such as the type of accident, the number of people involved and the age of the victims, influenced the professionals' perception of the professionals. The reactions that the family members presented during and after the care were also uncomfortable and impacting. In addition, they provoked reflections in the professionals. When deciding to interrupt care, after evaluation and thorough efforts, the professionals came across the family's requests not to give up saving the child's life, even when they knew that death had already happened. The lack of an adequate place to communicate the bad news was another crucial aspect of the service, as it happened at the very place of occurrence.

> *It was very difficult to give them the news, because the family witnessed all the care provided by the staff, because they did not leave the residence, they did not want to leave, no matter how much we asked. They witnessed all the care actions and it was very difficult to give them the news later. The mother and other people asked us to continue the assistance, and the doctor explained that it was no longer possible due to the weather, due to the brain injury caused* [...] *the guilt... they blamed themselves for what happened back then.* (N7).

The child's death made the team touched and could be aggravated by the cause and circumstances of the occurrence. The professionals felt incapable and unprepared before this condition. It is worth mentioning the anguish of the team that performed all the appropriate procedures for a favorable result and, even so, was not successful. In this situation, feelings such as helplessness, sadness and the feeling of what could have been done invaded the minds of professionals. However, even before all the anguish, they had to fulfill their role by communicating the family in the most empathetic and welcoming way possible.

> [When describing the scene] *Running tear from everyone there at the scene. And he wanted to know about his daughter: "I want to know about my daughter, what happened to my daughter, what happened to my daughter?" Everyone said she was hurt, that it was bad, they did not give the real news... Even afraid of this displacement of the father. And then I came and I said, "Sir, unfortunately your daughter has passed away." I have always been of that attitude because every word you speak creates an expectation, a hope.* (N4).

Communicating the bad news to the family: caring, receiving and overcoming

For professionals, the fact of unveiling an effective strategy of communicating bad news could generate less suffering for the family, but they did not feel qualified for this difficult responsibility. Moreover, they did not feel supported to withstand pressure and wear due to the information and emotions caused by these conditions.

Each occurrence, in its peculiarity, required the professionals to adapt communication strategies, permeated by verbal and nonverbal interactive dynamics. Some professionals tried to be brief and precise, adopt a technical posture, trying not to create false hopes. Others chose to perform reception through empathy, establishing a fast bond and cultivating positive beliefs, despite the situation. Some professionals, before communicating the news, suffer when thinking about the impact caused on the family, revealing the reflective process with their self, having the news as an object and symbol of manipulation.

In the impossibility of reversing the child's clinical picture, symbolically, each word used in communication with the family was thought and carefully chosen. The professionals were aware that this news would break the expectation of those people, triggering a feeling of guilt, denial and despair.

The professionals used other strategies such as: identifying if there was someone from the extended family on site and asking for help to support the parents or trying to understand if the family was aware of the severity of the child's clinical condition, before reporting the bad news.

> *When it involves children, the situation is a little more complicated because it is usually an unexpected death, a traumatic death, an acute loss. Therefore, it is clear that, usually, one of the family members already knows the severity, already knows that it is a risky situation. Talking to him first and then calling the other family members is a strategy that eventually works, but eventually does not work as well. The way you talk, your voice tone, your body posture and knowing how to look the person in the eye and say what happened, saying that often they are not guilty, makes a difference!* (N2).

In the perception and interpretation of the professionals, the absence of technical and emotional support to receive the family in this context, especially in the case of the child's death, was a factor that made the situation more critical. They cared about the family after the news. On the other hand, the daily life permeated by a complex care routine required these professionals to develop strategies to repress their own feelings. They sought to protect themselves from negative emotions, fulfill care actions and overcome discomfort.

> *It is a more complex service in emotional matters, it makes your emotions crazy, especially after we become a father. It complicates things. But at the time of care, I would not even say it is coldness; it is a block perhaps, that we receive to protect even our emotions, not to suffer from the issues of the mind at that time.* (N1).

Rescuing the ideal care for the family

There is a knowledge and support gap that hindered the performance of the PHC professional in relation to communication and reception in the scenario of bad news. The professionals' reports reinforced their perception that they were not

properly trained to act in these situations or did not receive sufficient support to assist the family.

> *There is unpreparedness of the professional to communicate bad news, because he does not learn it anywhere. No pre-hospital course has a chapter on how to communicate bad news. There is no such thing* [...]*, no one tells you: "Look, when you communicate a situation you must act like this!" No, you do not. So each applies in their own way. It may be bad, it may be good, but everyone has their own individuality to communicate bad news and that actually has to change! It is something that becomes very heavy also for the collaborator, and he, not knowing how to handle it, becomes much heavier for the family.* (N2).

After the end of the occurrence, the latent feeling was of impotence. Again, in reflective interactions of the professional's mind, he analyzed his interactions with the family, with the child and with the care itself. Concerns arose about what would have been the ideal care, thus rescuing what was positive and what could be improved. The professionals questioned the lack of resources to meet the needs of the family during and immediately after death, as well as psychological support to workers.

> *The professional who works in the pre-hospital is called cold, a person who does not have much love, those things ... Quite the contrary. If we did not have love, we would not be here, we would not be able to deal with this situation the way we work. We even have an excess of love, only that it is hidden behind a situation or posture that is necessary not to err, to make anyone suffer... So if this is not love, I do not know what it is.* (N2).

Before a child's death, there was a constant exercise of returning to the house at the end of the work shift and forgetting the scene, thus mitigating the traumas brought to personal life. However, in the routine of complex care, and because of the meaning that these visits assumed in the professional's life, they adopted strategies, such as trying to repress their own feelings, change their posture and, in some way, protect themselves against negative emotions, in order to be able to maintain their tasks.

> *A child always brings a post-care reflection. As I said, at the time of care we receive a certain blockage, we get firm to give information, to follow all the suffering of the family, but after the service, when we are at the base, we begin to reflect that little life and then it is... We end up commenting to everyone: "Wow! Such a child messed with us."* (N1).

The reflection and analysis of the experiences narrated by the professionals, consolidated with the support of the literature, helped to propose a protocol of communication of bad news in the pre-hospital context, based on the mnemonics *ACOLHER*. The *ACOLHER* Protocol aims to help PHC professionals in the process of communicating bad news and supporting their actions.

Chart 1 – Communication of bad news in pre-hospital care: *ACOLHER* Protocol[19]

Acronym	Description
A	**Scene evaluation (*Avaliação da cena*):** consider trauma kinematics in terms of the number of victims, age, type of accident, as well as the severity of the victims.
C	**Communicate clearly and efficiently:** understand what the family already knows, do not give false hope, seek support people who can better receive the news and collaborate with communication.
O	**Listener (*Ouvinte*):** identify and analyze who is the family member who will receive the news.
L	**Legitimizing suffering:** invest time, show compassion, adjust your words, as communicating bad news requires experience and observation.
H	**Humanization:** put yourself in the family's shoes, act ethically, respect and receive the emotions of others.
E	**Establish a bond of trust with the family:** recognize the limits of professional performance in reversing the occurrence, be honest, truthful and honest.
R	**Reassessing, reflecting and reorganizing (3 Rs):** Reassess the scene: make sure everyone involved in the incident was dealt with properly and effectively. Reflect: whether the service was adequate, whether empathy and welcoming remained at all stages of the occurrence. Reorganization: the team needs to maintain resilience in stabilization, recovery and reconfiguration in the face of the impactful experience.

Source: Created by the authors.

Discussion

The study advanced by exploring the meanings attributed by PHC professionals reflected in life and death situations, scarcity of time, the unexpected and the unpredictable. This strongly interferes with the way the professional defines the situation, which requires communication skills in an intensely challenging scenario.

The research highlights the chaotic scenario in which the experience of communicating bad news during a pediatric emergency by the symbolic interpretation of the professionals involved in such care takes place. The professionals revealed factors that impacted communication, such as dealing with the unknown and hostile environment, lack of connection with the family, limited time, conditions inherent to the accident and need for rapid decision-making/action.

Emergency environments are focused on priority care to physiological conditions resulting from the clinical worsening of the patient or from accidents, a situation marked by the clinical severity of the patient or victim[20]. This environment has common barriers, such as lack of privacy, competing priorities, time pressure and a limited number of team members[21].

The child's family plays a key role in the care scenario, but it generates insecurity and is an additional challenge for the team in this context. The reactions of relatives are unique, sometimes unexpected and impregnated with a lot of emotion, which impacts the way doctors and nurses dedicate themselves to their care, especially in emergency and urgent situations.

Professionals are compassionate by the anguish of the victims' families and feel charged by them for problem-solving conduct for that situation[20]. The presence of the family member may disturb the team, due to the possibility of distraction, and hinder the professional in their conduct, which can trigger discomfort and stress[22]. Professionals have positive and negative beliefs about the presence of the family, such as being able to observe efforts to save the child, provide important information and provide safety to the child.

In emergency services, some professionals believe they do not have time to pay attention to families. They reinforce that the scenes of care can be understood by families as uncomfortable, impactful or disturbing. They believe that teams should protect families from negative memories[22]. However, in the context of PHC, the professional does not have this option and, even before challenging care, cannot limit the presence of the family. It is a condition imposed by the context in which the call occurs.

Thus, what is expected of the professional in emergency situation, that is, that can save the child's life, is a social product. The professional's self-assessment in relation to their skills is strongly associated with the positive result and their ability to solve challenging situations. Care for children who are victims of accidents was considered a deeper and more challenging situation, increasing self-criticism and, possibly, their emotional and psychological tension[7].

The meaning attributed to the episodic memories of previous care actions is transformed into the present through actions to try to mitigate the anguish of the family and not cause more traumas.

Studies have emphasized that, before death, professionals adopt a more distant and cold posture, aiming to disguise sadness and discomfort, in addition to feelings such as guilt and failure[20,23]. Excluding or barring the family in the face of invasive and emergency procedures is an almost symbolic act, shared with most emergency professionals, justified by the lack of physical resources, the severity of the patient, the philosophy of care and the lack of training[20]. Contrary to this attitude, it is recommended that difficult communications should not be postponed, but terms that are understandable and appropriate to the understanding of the family should be applied, which allows a better understanding of the evolution of the case[22].

On the other hand, some professionals who participated in this study sought to put themselves in the other's place, understanding that empathy is essential. By interpreting that this is a desperate situation for the family, they try to establish a

quick bond and cultivate positive beliefs in order to mitigate distress. From the relational point of view, it is important that the professional exercise empathy in the emergency sectors, seeking to understand the anxieties surrounding this care[20]. Effective communication, problem-solving in relation to health issues and the possibility of being with the family member are perceived as actions of good care[24].

The present study corroborates that the pressures associated with the workload of the team end up generating interpersonal concerns. Meeting an occurrence and dealing with a child who has suffered a serious accident or evolved to death are situations that trigger stress, physical and emotional exhaustion, especially when the child's relatives do not accept the event and end up blaming themselves or even blaming the professional for the fact that the child has not been saved[25].

Personal reflections and the desire for adequate and welcoming care to families were revealed through communication strategies to relieve the exacerbated stress and anguish that affect these professionals. Similar to other studies, the factors that influence the negative aspects of care are the lack of policy and structure, a support team that receives family members in the emergency room, a feeling of isolation, as well as the absence of training and support to deal with this context, especially with the consequences generated throughout their professional trajectories[22].

The communication process is subject to situational and cultural influences. The concern with emotional issues in the in-hospital context, unlike the pre-hospital context, is better established when there is a greater bond with the patient and his/her family members, and when there are already validated protocols regarding the communication of bad news.

Among the main recommendations to professionals highlighted in the relevant literature are: preparing ahead of communication[14]; review the patient's name and case before communicating[13]; present themselves and indicate their role in patient care[13]; choosing a reserved place[12]; having a receptive attitude towards the family[20]; understand what they (relatives) already know[13-14]; reassess what happened during their care actions[13]; incorporate the sociocultural context of the patient[25]; maintain an ethical, empathic and interpersonal relationship[14,25]; promote follow-up of the multidisciplinary team[12]; having the presence of a significant family member[12-13]; answer questions, welcome and listen to the family in a less traumatic and more humanized way[13,25].

The proposition of the *ACOLHER* Protocol was carried out with the objective of assisting and supporting the actions of professionals working in the pre-hospital context. In this environment, more than communicating the bad news, the first-aider needs to welcome the family. The skills, safety and empathy of the professional will serve as the basis for interaction with the family, which, similar to emergency care, can be fast (in a short time), but should never be brief (i.e., superficial or without knowledge).

As limitations of the study, it can be seen that the professionals interviewed were restricted to a single context. Moreover, their experiences were essentially in emergency in the pre-hospital. It should also be considered that none of the professionals had specific training for performance in pediatrics. It is noteworthy that, for being a qualitative research, the analyzed data should not be generalized, as they reflect the reality of a specific interactional context.

The evidence of this study contributes to fill important gaps regarding the communication of bad news in pediatrics, specifically in the situation of PHC. The challenges and anxieties of the professionals that emerged in the data can direct strategies for content insertion and development of communication skills, from academic training to professional training and qualifications in their places of operation.

Final considerations

The professionals who worked in the context of PHC felt unprepared and extremely uncomfortable to communicate the bad news.

The place where they received the child's family was the same chaotic scenario where the accident happened, in which time is crucial for care and limits the bonds. Even before these difficulties, the interviewees were concerned and bothered by the gaps they experienced, such as the absence of psychological support and communication training.

It is worth reinforcing that, for these professionals, understanding pathophysiology is important, knowing how to prioritize care as well, but putting oneself in the other's place, being honest and ethical when communicating with the family, allows them to feel that they are playing their role comprehensively.

Collaborations:

1 – conception, design, analysis and interpretation of data: Daniele Cristina Evangelista Cintra and Mariana Lucas da Rocha Cunha;

2 – writing of the article and relevant critical review of the intellectual content: Daniele Cristina Evangelista Cintra, Patrícia Moreira Dias and Mariana Lucas da Rocha Cunha;

3 – final approval of the version to be published: Daniele Cristina Evangelista Cintra, Patrícia Moreira Dias and Mariana Lucas da Rocha Cunha.

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