03 - COMMUNICATIONAL ASPECTS IN HEALTH CARE

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INTRODUCTION

The field of professional-patient relations has been a source of conflict in health services. These represent complex relations, with the expectations of the user, on one side, of a welcoming environment, confidence in the care, interactive and sympathetic dialogue and on the other, the impersonal and hurried relations of the professional, whose communication is usually technical and informative (BRASIL, 2003; FARIA, 1996; CARVALHO; COSTA, 2006). With technological advances human contact and interactive and communicative bonds have been restricted, compromising the subjective nature of health relations, since technical actions by themselves are insufficient. The patient is often transformed by and because of technical choices, without emphasizing the understanding and influence of communication in the relation process. The disease is considered but the individual who is circumstantially ill is forgotten (SCHRAIBER, 1996; KIPPER, SIQUEIRA, 2002).

Medical professionals are criticized mainly for not approaching the patient, not opening a dialogue at the consultation. It is known that they are trained to be skeptical, tending to minimize the phenomena of subjectivity at the encounter ; they are not educated to hear the concealed or intrapsychic dimension of pain and suffering. They receive an intense technical load, but not the skills of interaction. There are limitations concerning the perception of practices as if they can only be predicted, quantified, interpreted. The unique, intrapsychic, human dimension is at the mercy of the objects of professional action. When professionals deal with to disease, pain and suffering, one perceives a void of sensitivity and interactive and communicative expressiveness, fragilizing the encounter, hampering the creation of bonds that lead to understanding patients and their current world (CASTEL, 1999; FARIA, 1996; GONÇALVES, 1997; NOGUEIRA-MARTINS, 1996).

In interpersonal communication, language is a means of interaction, of exchanges, of transmitting individual or collective meanings in which emotions flow, characterizing encounters of subjectivities, a communicational social medium and at the same time a medium of interaction. Recognizing as subjects, those with whom they interact and create the opportunity of intersubjective exchanges through the concrete practice of interrelation, are provocative elements of consciousness that affect both the professional and patient (BERGER, 1996; SCHUTZ, 1979; AUGRAS, 1996).

The act of communicating is above all a dialogue, an existential encounter, an encounter of men mediated by the context to give it meaning, therefore not exhausting itself in the me-you relation. For the interrelation to be fertile in this process, one must believe in the existence of attitudes of care and trust, with exchanged feelings, thoughts and interpretations. Dialogue as the dynamism of communications seeks authenticity. (FREIRE, 1980).

Individuals faced with a situation of conflict/threat suffer a failure in communication, because they break off communication with themselves and as a result, compromise communication with others. For this reason, communication established between the professionals and patients is fundamental to understanding the latter in its entirety, an understanding that must be constructed with them, for in a dialogic relation, the unhealthy Being can reflect and evaluate, understand existence and evolve. It is in the encounter between professional and patient that the humanity of the relation is defined, which will consolidate a successful therapy (ROGERS, 1977; SADALA, 2000).

METHOD

The study was performed at the *Serviço de Assistência Especializada (SAE) em HIV/Aids*, (Specialized Assistance Service in HIV/AIDS) a state institution providing clinical and psychosocial care to patients in Natal, Brazil. Approved by the UFRN Research Ethics Committee (84/2004), in accordance with resolution 196/96 of the *Conselho Nacional de Saude*, (National Health Council) the study aimed at understanding the communicational aspects present at the encounter of the professional with the HIV/Aids patient.

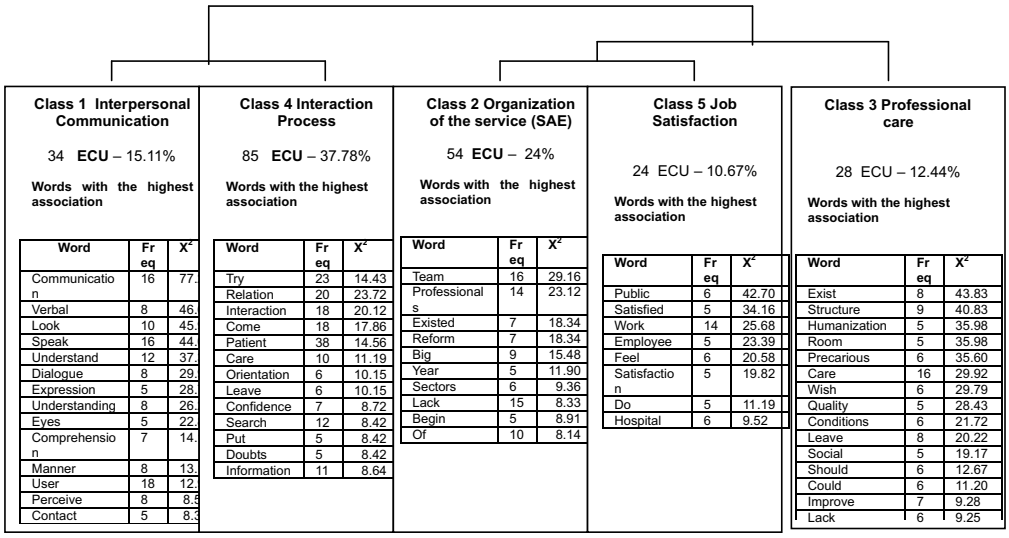
A qualitative methodology with interviews was used to enable a social approach at the encounter with the patients, in order for them to reveal themselves by freely expressing their opinions (BAUER et al., 2002; MINAYO, 2000). Semi-structured interviews were recorded, transcribed and conducted with 22 professionals: 8 physicians, 1 nurse, 1 dentist, 1 psychologist, 1 pharmacist, 1 social assistant, 1 nutritionist, 7 nursing technicians and 1 laboratory technician.

For content analysis of the interview data, ALCESTE 4.5 Analyse Lexicale par Contexte d´um Ensemble de Segments de Teste, Software Program (REINERT, 1990) was used. The program performs a quantitative analysis of linguistic data, distributes vocabulary, the frequency of textual theme content and the characteristics associated to the theme, carrying out a lexical co-occurrence analysis of all the information inserted. The analysis is performed in four stages: In the first, all the “corpus” of the analysis is read, the material is prepared, and the initial context units (ICU) are recognized. The text is divided into smaller segments or elementary context units (ECU). In the second, the ECUs are classified according to word similarity, using frequency matrices in two classes. In the third, the program performs a complementary calculation for each class, verifying the connection between the classes by vocabulary and representativity within the context evaluated. In the fourth stage, the previous classification is justified, providing the ECUs with more characteristics, contextualizing the occurrence of the most significant vocabulary of the classes.

RESULTS AND DISCUSSION

According to the sociodemographic profile of the 22 subjects, females represented 77.27% of the total; the 45 to 50 year age group 68.18%, married 59.09%, university educated 63.63%, physicians 36%, nursing technicians 31.81%, and 40.90% had worked at SAE for over 10 years. All the professionals have specific formation in the health area, considerable experience and maturity.

The “corpus” of twenty-two ICUs (interviews) were analyzed. The analysis of the results of descending hierarchy classification divided the textual material of the discourses into five classes (categories), according to Figure 1.



Class 1 Interpersonal Communication

34 **ECU** – 15.11%

Words with the highest association

Word	Freq	X^2
Communication	16	77.
Verbal	8	46.
Look	10	45.
Speak	16	44.
Understand	12	37.
Dialogue	8	29.
Expression	5	28.
Understanding	8	26.
Eyes	5	22.
Comprehension	7	14.
Manner	8	13.
User	18	12.
Perceive	8	8.5
Contact	5	8.3

Class 4 Interaction Process

85 **ECU** – 37.78%

Words with the highest association

Word	Freq	X^2
Try	23	14.43
Relation	20	23.72
Interaction	18	20.12
Come	18	17.86
Patient	38	14.56
Care	10	11.19
Orientation	6	10.15
Leave	6	10.15
Confidence	7	8.72
Search	12	8.42
Put	5	8.42
Doubts	5	8.42
Information	11	8.64

Class 2 Organization of the service (SAE)

54 **ECU** – 24%

Words with the highest association

Word	Freq	X^2
Team	16	29.16
Professionals	14	23.12
Existed	7	18.34
Reform	7	18.34
Big	9	15.48
Year	5	11.90
Sectors	6	9.36
Lack	15	8.33
Begin	5	8.91
Of	10	8.14

Class 5 Job Satisfaction

24 ECU – 10.67%

Words with the highest association

Word	Freq	X^2
Public	6	42.70
Satisfied	5	34.16
Work	14	25.68
Employee	5	23.39
Feel	6	20.58
Satisfaction	5	19.82
Do	5	11.19
Hospital	6	9.52

Class 3 Professional care

28 ECU – 12.44%

Words with the highest association

Word	Freq	X^2
Exist	8	43.83
Structure	9	40.83
Humanization	5	35.98
Room	5	35.98
Precarious	6	35.60
Care	16	29.92
Wish	6	29.79
Quality	5	28.43
Conditions	6	21.72
Leave	8	20.22
Social	5	19.17
Should	6	12.67
Could	6	11.20
Improve	7	9.28
Lack	6	9.25

Figure 1. Dendrogram with the respective content of the classes as determined by the ALCESTE Program

As can be observed (Figure 1) in the analysis, class 1 was represented by 34 ECUs analyzed, class 2 by 54, class 3 by 28, class 4 by 85 and class 5 by 24. The distribution of discoursive material into classes enabled the attribution of the following categories (themes) that function as their descriptors: Class 1 Interpersonal Communication, class 2 Organization of the services, 3 Professional care, 4 Interaction process, 5 Satisfaction with the service.

These results show the classes of highest statistical association, that is, the highest chi- squared (x^2) and the ECUs that contributed to their formation and synthesized their characteristics. The discoursive material was divided into two blocks initially, then into three subdivisions and finally into two more. In the first grouping , classes one and four had common characteristics, differentiating themselves from classes two, five and three. Although originating in the initial two-block segmentation of the ECUs , their own characteristics and meanings permeated , justifying the separation into classes. As can be observed, the same occurred with classes two,five and three, but one can perceive that class three presents a divergent direction in relation to the block meaning that created classes two and five. Classes one and four, formed by the first grouping, is the most significant class, according to the frequency and occurrence of responses to the central object of the study. Understanding the interaction and communication process included a total of 119 ECUs, that is, 52.89% of the interviews analyzed. Words with frequency of occurrence greater or equal to five were considered in each class.

Interpersonal communication

The dentists and the pharmacist contributed significantly to the formation of class1. The words with the greatest association were: *user, communication, speak, understand, look*, which demonstrates care in the interpersonal relation. This aspect can be better illustrated when highlighting other words such as *dialogue, understanding, comprehension, verbal, perceive, manner.* In order to have understanding with the patient, it is necessary to perceive, see and comprehend, enabling contact and a verbal dialogue. The relevance of this fact can be observed in the third stage of the program, which shows representative ECUs generated by this class: *" Communication is making yourself understood and understanding what the other is saying, whether by spoken or written words, a look, or an expression. A message that has to be transmitted and understood with the patient. This communication is individualized. "* (Pharmacist). As this professional reports, the message has to be revised and understood with the patient, a communication that must be individualized, since it depends on what patients bring to the encounter and consequently on how they understand.

Freire (1979) writes that communication implies an exchange, a reciprocity between active subjects, a moment when one of the subjects, for example the patient, needs to be perceived by the professional within his/her individual meaning, since communication as a dialogue brings individuals together, a fact which presumes participation. *"Communication is when we talk to others and understand what they are feeling; here, at this institution we have to talk, communicate with the patients. So that they understand everything, we have to make things clear; their health depends upon it. "* (Nursing technician A) In this report, communication involves feeling; it emerges as the speaking of one for the understanding of the other and demonstrates a relation of commitment and responsibility with the life of the patient, a suitable communication that, according to Pereira Azevedo (2005) removes the fear of treatment.

The interaction process

Class four, which relates to the previous, had a predominant contribution by the nutritionist. The interaction process was most associated with the words: *patient, search, relation, interaction, come, information, care.* There is a perception that the patient comes in search of information, a relation of care and that the professional seeks this relation at the encounter. This aspect is clear when presented with other words elicited such as *trust, orientation, leave, put, doubts.* Patients need to have confidence, to believe in the relation in order to go outside of themselves and put their doubts forward.

A personal involvement of these professionals is verified when we analyze the high frequency of the words: *try, interaction, patient. " I try to attend well. I see interaction as understanding the needs of others "* (Nutritionist)

" My work is gratifying when it corresponds to what is important, whether it is following the treatment or the care that the family provides for the patient. There is good interaction when we see a friendly relation with acceptance and confidence in the treatment (Pediatrician) In this report the professional demonstrates that a good interaction is related to the commitment of the patient to the treatment. A technical approach is perceived, from the point of view of interaction aimed at adherence to treatment, as reported by Faria (1996). It is a clinical relation model that does not open dialogic space for human, social and subjective relations. More emphasis is given to diagnostic than to communicative skills.

"Interaction occurs when there is confidence, when patients return, when there is credibility, they return, if we do not attend to their needs they change doctors. Professionals may be technically good, but if there is no interaction they change; an interpersonal relation is not enough, there has to be interaction; listening is still a factor that attracts." (Nurse)

In the second grouping, classes two and five are similar because they are related to the outpatient service (SAE) as a place of daily activities, actions, and interrelations, implicating in performance, where satisfaction or dissatisfaction can be verified.

Organization of the service

When analyzing class two, the words of highest frequency association were: *team, lack, professionals, of*. Counting on the significant contribution of the nursing technicians for this class, the professionals attribute the greatest difficulties in the organization of the service to the lack of professionals on the team, as exemplified by the following discourse: *" The quality of care would be better if the number of professionals were increased and if there was a coordinator to better organize SAE and integrate the team."* (Nursing technician D) *" SAE started out well, but there was a break in team cohesion, leaving much to be desired; demand is great; there is an expectation of improvement."* (Physician P) In addition to the lack of professionals, there is also a lack of coordination that seems to cause a demoralization in the team and probably *"There is a lack of communication between the sectors, caused by the absence of meetings, which generates misunderstanding and compromises the good functioning of the services provided; there is a lack of structure."* (Nursing technician F) *"We try to provide a coherent practice but there is a lack of team integration, not enough listening to patient needs or enough dialogue; things do not appear to function here."* (Nursing technician C)

Job satisfaction

The nurse contributed most to the elaboration of this class, which is directly related to the previous and in principle this can be verified by the following report: *" I am satisfied with the work, but the salary leaves much to be desired; there is no coordination , no interdisciplinary actions or team discussions. There is no assessment of protocols; there is no prevention policy and equipment is lacking. "* (Nurse) Further verified by the discourse*"The public hospital is like a lawless territory."* (Nursing technician E) We perceive no commitment whatsoever to organizational questions. When analyzing the words of highest frequency association: *work, public, hospital, feel, satisfied, satisfaction, employee, do*, we see, on the part of the public employees , satisfaction with the work they perform, but, on the other hand the organization of SAE is deficient; there is a lack of good working conditions *" administratively speaking, there are no policy models, no computerized system, no preventive policies. Individualized care is good, but the collective is lacking, which is important for prevention".* (Psychologist) There is insufficient coordination and team discussion and this alone characterizes the disorganization and fragmentation of the activities, causing satisfaction to be individualized, disintegrated from the group, which compromises the "collective eye" in actions related to the patient; there is no joint commitment; each one does their own part and the patient is a fragmented piece of this individualized action. *" I've worked here at SAE for some time; I see poor perspectives; an employee cannot move up in the public service; there is indifference, a lack of incentive."* (Ophthalmologist)

Professional care

Class three was produced mainly by the social assistant and the psychologist. The words of most frequent association were: *care, structure, exist, leave, improve, treatment, lack, wish, precarious, could, conditions, should, humanization, room, quality, social*. We can perceive the recognition of deficiencies that interfere in care and are reflected in the treatment. The structure that exists leaves much to be desired, the space is precarious, there is an insufficient number of rooms; this is illustrated in the following: *" It used to be better here, SAE used to be a high-quality institution. . The structure is terrible, there is a lack of privacy, of rooms"* (Psychologist)

Could, should, words meaning " could be", in a more perceptive vision; as Sadala (2000) writes, the conditional tense is used, indicating a distancing in time and space, a "could be" that is not, as in the report that follows: *" The social work is fundamental for them; my hope is that they establish a follow-up service ; today it is deficient; the ideal would be to have continuous humanized care for a better quality of life."* (Social Assistant). *"The care provided at SAE today leaves much to be desired. Prevention is not focused on as it should, Our public health is precarious; treatment is only curative; there is no investment in prevention"* (Dentist).

The discoursive production of these professionals clearly reflects a necessity, since SAEb is not organized, nor does there seem to be perspective for improvement from the current structure. The aspirations of " could and should " be, bring ideal possibilities to fulfill " expectations that are created" , a discourse waiting for something to occur in order to improve. The non-effectiveness of action can be perceived, an action model centered on the disease and not the patient, on the individual and not the collective, on the curative and not the preventive, a situation that compromises interactive relations in the communication process.

FINAL CONSIDERATIONS AND CONCLUSION

To elaborate this study was to reflect on apparently common constructs, already experienced and debated, but it roused our attention to the comparison of the vicissitudes of a field in continual transformation, that of human relations. In the health area these relations need to be cared for and managed in order to construct authentic, humanized and high-quality communicative relations. Listening to the interviewed subjects redirected our opinions concerning these individuals; a necessary encounter, a significant learning experience, looking at the uniqueness of each one as to their understanding and desires. Possibilities arose for constructing new pathways, new forms of congruent and significant action. After all, dealing with human health is understanding the human being. Despite the difficulties, everyone is interested in developing relational skills, in order to manage difficulties, which implies, in addition to the ability to communicate, fundamental for interaction, the capacity of a intersubjective relation with the unhealthy Being. However, technical relations are perceived, directed toward disease and treatment, in detriment to interactive and communicative comprehension and understanding. These are questions to be rethought in professional health actions, mainly those of the physician, in the context of prevention and treatment of the patient with HIV/Aids, a disease considered to be a serious public health problem.

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ABSTRACT

Interpersonal communication is a human means of interaction, exchange and transmission of meanings. Starting from this principle, this study aimed at understanding communicational aspects involved in the interaction between the professional and the patient with HIV/Aids at a state health service in Natal, Brazil. It is a qualitative study, performed by interviewing 22 professionals. The textual data of the interviews were analyzed by ALCESTE software. Analysis points to a predominantly female profile, age group between 40 and 50 years, married, university-educated, a larger number of physicians and a mean length of service of 10 years. The textual material was divided into five thematic classes for analysis. The professionals considered verbal communication fundamental for the patient to understand information and orientations, thus adhering to the treatment. Interaction is conceived as a more technical-communicative skill than a subjective ability. The health service activities are directed toward individualized actions, with an emphasis on treatment. Medicalization is the daily focus. The professionals refer to the disorganization of the service, a place without coordination or interdisciplinary actions. Communication occurs as the instrumentalization of the technical, reflecting a service centered on the curative, on medical attention, and on the individual, deprived of communicative interaction. Each thematic class had the significant contribution of discourses representative of all the professional categories, with the exception of the physician. By way of concluding “representative discourse” is associated to a remarkable and significant positioning to constructing the context. Questions are raised to encourage the rethinking of the communicative and interactive practices of professionals in the health area, mainly those of the physician related to care, since clinical knowledge comes from the communicative practice of listening to the discourse of the Other.

KEYWORDS: Communication. Interaction. Professional-patient.

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KEYWORDS: Communication. Interaction. Professional-patient.

LES ASPECTS COMMUNICATIES DANS L´ATTENTION E DANS LES SOINS EN SANTÉ
RESUMÉ

La communication interpersonnelle apparait comme un moyen humain d´interaction, de changements, transmission de significations. En partant de ce principe, l´étude a l´objectif de comprendre les aspects comunicatifs compris dans l´interaction du professionnel avec le patient hiv/sida, dans un service de référence publique en hiv/aids, Natal - RN. L´étude qualitatif a été réalisé par des entrevues avec 22 professionnels. Les donnés textuels des entrevues ont été analysés par le software ALCESTE. L´analyse montre le profil prédominant féminin, âge entre 40 - 50 ans, mariés, formation supérieure, un plus grand numéro de médicins, temps de service moyen de dix ans. Le matériel textuel a été divisé en cinq classes thématiques d´analyse. Les professionnels trouvent la communication verbale fondamentale pour la compréhension des orientations et des informations, pour que le patient puisse adhérer au traitement. L´interaction est aperçue comme une habilité plus technique communicative que subjective. Les activités en service envisagent les actions individualisées, surtout le traitement. Le point de vue médical est quotidien. Les professionnels parlent de la manque d´organisation du service, l´endroit sans coordination, les actions interdisciplinaires; la cohérence est un essai. La communication apparait comme un instrument de la technique, et montre une organisation centrée sur la thérapeutique, sur la consultation médicale, sur l´individu, avec la réduction de l´interaction communicative. Chaque classe thématique a eu une contribution très significative d´opinions représentatives de toutes les catégories professionnelles, sauf les médecins. "l´opinion représentative" est associée à une position marquante et significative pour la construction du contexte. Les points à penser sont les pratiques communicatives et interactives de professionnels de la santé, surtout le médecin, dans les relations de soin, en sachant que le vrai savoir clinique vient de la pratique communicative, de l´écoute de l´autre, dans l´interaction.

MOTS – CLÉS: Communication. Interaction. Professionnel – patient.

ASPECTOS COMUNICACIONALES EN LA ATENCIÓN Y EN EL CUIDADO A LA SALUD
RESUMEN

El objetivo de este trabajo fue comprender la presencia de algunos aspectos comunicacionales existentes en la interacción del profesional con el usuario portador del VIH/SIDA en un servicio de referencia estadual en VIH/SIDA, Natal-RN. Estudio cualitativo, realizado por medio de entrevistas a 22 profesionales cuyo análisis de los datos textuales por el *software* ALCESTE apuntó un perfil predominantemente femenino, entre 40 y 50 años, casados, formación superior, mayor número de médicos y media de 10 años de tiempo de servicio. El material textual fue dividido en cinco clases temáticas de análisis. Los profesionales consideran la comunicación verbal fundamental para el usuario entender las informaciones y orientaciones que le ayudarán a adherirse al tratamiento. La interacción se concibe como una habilidad más técnica comunicativa de que subjetiva. Las actividades del servicio son acciones individualizadas, con énfasis en el tratamiento. La medicalización es el foco de atención. Los profesionales se refieren a la desorganización del servicio, sin acciones ínterdisciplinares, donde la coherencia es una tentativa. La comunicación ocurre como instrumentalización de la técnica, reflejando una organización de servicio más centrada en lo curativo, en el atendimiento médico, en lo individual con reducción de la interacción comunicativa. Cada clase temática tuvo la contribución de hablas representativas de todas las categorías profesionales, menos la médica. Como conclusión, "habla representativa" está asociada a un posicionamiento significativo para la construcción del contexto. Deben ser repensadas las prácticas comunicativas e interactivas de los profesionales de la salud, principalmente del médico, en las relaciones de cuidado durante el atendimiento una vez que la sabiduría clínica proviene de la práctica comunicativa de la escucha del decir del otro en la interacción.

PALABRAS CLAVE: Comunicación. Interacción. Profesional-usuario

ASPECTOS COMUNICACIONAIS NA ATENÇÃO E NO CUIDADO EM SAÚDE
RESUMO

A comunicação interpessoal configura como um meio humano de interação, de trocas, transmissão de significados. Partindo desse princípio o estudo objetivou compreender aspectos comunicacionais envolvidos na interação do profissional com o usuário portador do HIV/Aids de um serviço de referencia estadual em HIV/Aids, Natal-RN. Estudo qualitativo, realizado através de entrevistas com 22 profissionais. Os dados textuais das entrevistas foram analisados pelo *software* ALCESTE. A análise aponta perfil predominantemente feminino, faixa etária 40-50 anos, casados, formação superior, maior número de médicos, tempo de serviço em média 10 anos. O material textual foi dividido em cinco classes temáticas de análise. Os profissionais consideram a comunicação verbal fundamental para o usuário entender as informações e orientações para aderirem ao tratamento. A interação é concebida como uma habilidade mais técnica comunicativa do que subjetiva. As atividades em serviço são voltadas para ações individualizadas, com ênfase no tratamento. A medicalização é o foco do cotidiano. Profissionais referem à desorganização do serviço, o lugar sem coordenação, ações interdisciplinares, a coerência é uma tentativa. A comunicação ocorre como instrumentalização da técnica, refletindo a organização do serviço mais centrado no curativo, no atendimento médico, no individual com redução da interação comunicativa. Cada classe temática teve a contribuição bastante significativa de falas representativas de todas as categorias profissionais, à exceção do médico. A guisa de conclusão "fala representativa" está associado a um posicionamento marcante e significativo à construção do contexto. Questões para repensar práticas comunicativas e interativas dos profissionais da área da saúde, principalmente do médico, nas relações de cuidado no atendimento, uma vez que a sabedoria clínica vem da prática comunicativa da escuta do dizer do outro na interação.

PALAVRAS-CHAVE: Comunicação. Interação. Profissional-usuário