

\* Original Article

## Health communication in tertiary care: exploratory study on the information retained by the patient\*

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### **Abstract**

This study aims to evaluate patient's knowledge about his disease and therapy after six months of outpatient follow-up, with health education activities in an extension project. The delineation was longitudinal and experimental. At each monthly visit by the patient to the ambulatory, students provided, recurrently, the information about his chronic disease, as well as its treatment, applying a health educational process during appointments and individually. When conducting the survey, a standard questionnaire was used in order to evaluate the information retained by patient, applied when assistance begun (in the service) and six months after health education project implementation. There was expansion of information about diagnosis (was extended), which were congruent with reality, as well as about used (the) medications (in use). 33.3% of those who reported knowledge of used drugs' name at the beginning of follow up, turn out 65,5%. 12.5% of those aware of drugs' side effects have become 41,7%. One may conclude that, in the short term, the benefits of the *Continuum* Extension Project have increased the information obtained by patients. More than drawing conclusions, this study raises the issue regarding the need of embracing educational actions programs, focused on the patient, (with the aim of) aiming at increasing his knowledge about his own treatment and, consequently, the possibilities of therapy adherence.

**Key-words:** health communication; doctor-patient relationship; hospital ambulatory care; continuity of patient care

### **Introduction**

One of the important changes in health care in recent times was the one that recognized the right of patients to information about their health problem (BÉRGAMO, 2005; MERCADO-MARTINÉZ, 1999). This theme unfolds itself in topics of current relevance, such as the humanization of care, the need for patient participation in their therapy and the importance of communication processes in health. However, the presence of the communicative dimension in the educational act has not been getting sufficient attention from researchers (REIS, 2010).

Health communication concerns the study and use of communication strategies to inform and influence individual and communities decisions that enhance health (BRASIL, 2006).

We must remember that "the patient also learns," especially if the doctor-patient relationship incorporates aspects of the so called "anthropological model of the disease", which allows the physician to include fundamental aspects of the socio-cultural area in the patient's life (VIGIL, 2000).

In such case, the Health Communication is currently considered a practice intrinsic to the care program at all levels of health care, since it allows the organization of individual and collective strategies for coping with problems in the health-disease process. Information, education and communication are the basis for changing the patient's behavior, constituting a factor of clinical and social relevance.

This process has been termed "functional literacy in health" and, according to the American Medical Association (AMA), is the ability to obtain, process and understand basic health information necessary to make appropriate decisions and to support the correct following of therapeutic instructions (NOGUEIRA-MARTINS, 2010).

The *Continuum* Project of extension, linked to the Scholarship Program of Extension / Federal University of Paraíba (UFPB), focuses on the continuity of care, to reduce the high rate of new admissions of patients with chronic diseases such as hypertension, *mellitus* diabetes and chronic kidney disease, diseases that have high prevalence among patients hospitalized in the infirmaries of clinical medicine of the Hospital Universitário Lauro Wanderley (HULW). In this project were applied actions of Health Communication through the continuity of ambulatory care and processes of popular education for patients discharged from the hospital.

The objective of this study was to evaluate the knowledge held by the patient about his disease and treatment after six months of ambulatory follow-up with communication actions in the aforesaid extension project.

## METHODS

The study design was longitudinal, of uncontrolled intervention, with pre and post information measures about the disease and treatment (CAMPANA, 2001). The sample was chosen for convenience, once it intended to capture the behavior of patients enrolled in Project *Continuum* of extension in relation to treatment adherence in the context of educational action conducted by graduated students of UFPB Medical school in the ambulatory of infirmary patients discharged from the medical clinic of HULW.

Thus, the inclusion criteria were: be followed-up by the aforesaid extension project; be aged 18 or more years, be at least in the second appointment at the day of the interview, and accept to participate in the study. Patients with disabilities that prevented communication, in clinical conditions that dissuaded their participation in the study or lived far from the work, were excluded.

The place where the study was held was the Hospitalization Outpatient of Medical Clinic (HULW, UFPB). The extension activities of the aforesaid project were developed through post-hospitalization clinical follow-up in infirmaries outpatient of HULW medical clinic and health education of patients followed. The ambulatory care had a monthly basis. The main operational objectives were educational guidance on non-drug treatment and control of drug treatment adherence. Clinical monitoring aimed the glycemic, blood pressure and symptomatic control.

This set of actions was conducted by a team of doctors and undergraduate medical students of UFPB extension. The educational orientations and interviews were conducted by students. The orientation to the patients assisted in the ambulatory was individual, approaching their disease and care they should have for its proper control, according to the procedure recommended by Green and Kreuter in the clinical setting. (CAMPANA, 2001). This is defined by the combination of educational support that leads to health with actions related to individuals.

Thus, in each visit of the patient to the ambulatory, we sought provide in a systematic way, information and communication about their disease and treatment. The extension undergraduate medical students clarified on measures of non-pharmacological treatment such as diet, exercise, weight reduction, anti-smoking and alcohol consumption campaigns, and foot care in case of

diabetics; and for pharmacological treatment, it was clarified the importance of maintaining compliance with the regular use of the prescribed drugs.

For the face to face interviews and collection of other data, we used two instruments: a semi-structured and standardized questionnaire (**Chart 1**) developed by the authors to evaluate the retention of information by the patient, and a form of clinical and demographic data. This questionnaire with questions about the patient's knowledge about their main disease and treatment was applied in the initial care in hospitalization outpatients and six months after implementation of the extension project of health education. The data collection instrument was subjected to pre-test.

**Chart 1** - Questionnaire on patient knowledge about their disease applied at the beginning and after six months of outpatient follow up

Questionnaire - Questions
1 - Do you know the name of the disease that caused your recent hospitalization?
2 - What is the diagnosis that the patient reports?
3 - Do you know what the names of the medicines that you will be taking at home?
4 - If the third response was positive, what are the names of medications according to the patient?
5 - Do you know what side effects these medicines may have?
6 - What are the side effects according to the patient?
7 - Do you know what precautions were recommended by the doctor to follow at home? If so, which are they?

The study was submitted to the analysis of the Committee of Ethics in Research of HULW/UFPB. It was explained to the participants the objectives and nature of the research and the interviews began after they signed the consent form. The superintendency of HULW authorized the study performance at the institution and its subsequent dissemination in scientific journal with information about the hospital.

## RESULTS

The welfare activities of the project *Continuum* of extension were carried out between June and December 2009, with the inclusion of 32 patients recently hospitalized in the clinic infirmaries of the Hospital Universitário Lauro Wanderley (HULW). Twenty-four of these were followed-up on a monthly basis, because eight patients lived in distant cities, not allowing their monitoring.

In the socio-demographic characterization of the attended patients, it was found that the average age of patients followed-up ranged from 18 to 77 years (average of  $51.8 \pm 15$ ); 17 (70.8%) were male; 10 (41.7%) were white, 9 (37.5%) mixed and 5 (20.8%) blacks; 16 (66.7%) were married, 17 (70.8%) from the city of Joao Pessoa and metropolitan area, with  $5.0 \pm 4.2$  years of education (basic education in 65% of cases, and 20% illiterate) and monthly income of up to one minimum wage in 70.8% of cases.

In the evaluation of primary diagnoses, renal, cardiovascular and endocrine diseases were most frequent. Fifteen (62.5%) patients attended were hypertensive, and 42% of these had concomitant hypertension and *mellitus* diabetes. The frequencies of major chronic diseases are shown in **Table 1**.

**Table 1** - Frequencies of hypertension, diabetes mellitus and chronic kidney disease in patients attended by the Project Continuum of extension (n=24)

<b>Chronic Disease</b>	<b>f</b>	<b>%</b>
Hypertension	15	62,5
Chronic kidney disease	14	58,3
<i>Diabetes mellitus</i>	8	33,3
Hypertension + <i>diabetes mellitus</i>	7	29,2

The above categories are not mutually exclusive.

All patients had comorbidities, and 40% had more than five active problems. The observation of the events recorded at the end of the project indicated that 16 patients (66.7%) did not miss any of the appointments. Eight patients failed to attend the scheduled appointments: five of them missed once, returning after we requested their attendance at the clinic by phone. Two patients missed twice due to problems of transport to the hospital and one missed three times, no longer returning to the clinic, and with whom it was not possible to maintain contact due to change of address and phone number.

During the six month follow-up monthly visits were made, but some of the patients had fewer visits due to their later inclusion in the project. For this reason, the number of visits ranged from two to five, with an average of 3.4 visits.

Patient responses to the questionnaire on the information held at the beginning of monitoring in the extension project and after six months of continued care showed a significant increase in knowledge about diagnosis and medication treatment (**Tables 2 and 3**).

**Table 2** -Knowledge of patients about their disease and treatment in the beginning of outpatient treatment after hospitalization (n=24)

<b>Information held by the patient</b>	<b>f</b>	<b>%</b>
They knew about non-pharmacological treatment	20	83,3
They knew the diagnosis	18	75
Correct diagnosis	11	45,8
They knew the names of the medicines	8	33,3
Correct names of the medicines	6	25
They knew about the side effects	3	12,5
Side effects coincide with actual ones	1	4,2

**Table 3** -Knowledge of patients about their disease and treatment after six months of outpatient follow-up post-hospitalization (n=24)

Information held by the patient	f	%
They knew about non-pharmacological treatment	20	83,3
They knew the diagnosis	19	79,1
Correct diagnosis	16	66,6
They knew the names of the medicines	15	65,5
Correct names of the medicines	11	45,8
They knew about the side effects	10	41,7
Side effects coincide with actual ones	5	20,8

No changes were observed in patients' knowledge about non-medication treatment. There was also little change in responses on the knowledge of the diagnosis on the responses obtained before the intervention, but there was an increase in the percentage of diagnoses congruent with their real ones. However, other items suffered changes in the responses: the 33.3% who reported knowing the names of drugs in use at the beginning of the monitoring increased to 65.5%; 12.5% who knew the side effects of drugs increased to 41.7%. There was an increase of correct answers related to medications used and their respective side effects.

There was no difference in retention of information due to age, health problem presented or number of diagnoses .

## DISCUSSION

Users of the *Continuum* Project had a high coexistence of hypertension and diabetes *mellitus*, an association that raises their morbidity, alongside to the need for continuous monitoring and actions of Health Education

The data obtained are similar to the results of other studies that addressed this matter, although they focused methodologically different the communication made to patient about their disease and treatment. Some researchers analyzed the items of knowledge independently (GREEN; KREUTER, 1991; FLETCHER, S., FLETCHER, R.; THOMAS, 1979). Others used scores to summarize the discussed items, (OLIVARES; ESPINOSA, 1996; AZEVEDO, 1987), while others used a global concept of knowledge which involves understanding the disease and treatment (VARGAS; DOMEQ; MAUREIRA, 1991; DEWULF, 2006).

This should occur because the concept of communication on the drug used includes various items that are not sufficiently equivalent in the representation of this variable. Thus, it is necessary to distinguish the importance of each item analyzed according to the patient's and drug therapy characteristics (VASCONCELOS, 2009; ASCIONE; KIRSCHT; SHIMP, 1986).

Similar studies performed in Brazil are of observational design. In a study performed in an outpatient university hospital in Fortaleza, Ceara, it was verified the existence of a sufficient level of information retained by patients on the drugs in use according to medical prescription (ASCIONE; KIRSCHT; SHIMP, 1986). In this study, the success rate for the item name of the drug was 69%, much higher than the one found in this study before the educational intervention, only comparing its results after the action.

Also in the study mentioned above, it was verified that the information retained on side effects were observed in only 20% and only 16% corresponded to frequent and/or severe side effects of the drugs in use, confirming the data found in this study. However, it was observed that the knowledge on those events increased from 12.5% to 41.7% after the educational intervention of patients. Moreover, this investigation was developed only for the purpose of checking the level of awareness of outpatients with regard to the therapeutic indication, name, dose, frequency of administration, duration of treatment, and side effects and, therefore, there was no educational actions of observational study (ASCIONE; KIRSCHT; SHIMP, 1986).

The lack of information regarding the side effects observed may be related to the low value given to that item of information, both by those who provide the prescription end drug, as for those using it (REIS, 2010). The possibility of side effects caused by the drug is often omitted by the prescriber, perhaps for fear that negative information about the drug affects patient acceptance, or even the occurrence of a nocebo effect due to the communication.

Also in the city of Fortaleza, Ceará, but in population-based study concerning the evaluation of the patient-physician communication during the prescriptive conduct, it was observed that the doctor advised the majority of patients to take the drug prescribed (92.5%) and adequately perform the treatment (70.6%), but omitted, in most cases, information about the possible side effects (SILVA; SCHENKEL; MENGUE, 2000). However, this study was limited in collecting information only on the last medical appointment, not acknowledging how many times the patient attended the clinic and if there was continuity with the health professional who attended him.

This research problem was also evaluated in the context of the Family Health Program (PSF) in Bahia, where it was found that communication about their health problem was not deepened by the doctor, omitting relevant aspects of the disease and treatment of patients attended (ARRAIAS; BARRETO; COELHO, 2007). Also in a study conducted in Pelotas, Rio Grande do Sul, on outpatient care for hypertensive patients, doctors did not recommend patients to make exercises, stop smoking and lose weight. (FRANCO, 2002). Therefore, although essential to compliance with the treatment regimen, the guidelines on how to take the drug do not follow the recommendations of the World Health Organization for the good medical prescription (PICCINI; VICTORIA, 1997).

Levinson and Chaumeton studied the medical communication to patients about their diagnosis and treatment in an outpatient clinic of primary care and not tertiary, as addressed in this study (OMS, 2001). Other quantitative studies have addressed the issue of information in patients with severe diseases focusing on bioethical aspects. (LEVINSON; CHAUMETON, 1999; GULINELLI, et al, 2004). Other studies found are works of qualitative nature that focus on the treatment of specific diseases with outpatients (OLIVEIRA, V.; OLIVEIRA, M.; GOMES, 2004; BARRÓN-RIVERA et al, 1998).

In the context of a hospitalization, it was addressed in a study the degree of knowledge of the patient discharged on their treatment at the Hospital das Clínicas of the University of São Paulo, noting that this knowledge depends on the education level of the patient, but does not depend on the age, type of care unit, length of hospital stay and number of prescribed drugs, ( BARRÓN-RIVERA et al, 1998), confirming the findings of a study conducted in the wards of the Hospital of the Universidade Federal da Paraíba ( DEWULF, 2006). In both studies it was found that patients still have doubts about the treatment prescribed and its continuity at the time of discharge.

Also in João Pessoa, Paraíba, Santos et al. observed that 27% of inpatients in HULW/UFPB complained about the lack of information provided by the medical staff on the precautions to be followed after their discharge. Analyzing this fact, the authors argue that this variable is often responsible for the patient's return to the hospital because of recurrence of disease caused by the lack of therapeutic orientation (STAPE, 1979). The mentioned authors claim that according to the responses of interviewed patients, doctors in HULW are "very reserved and do not inform patients about the treatment." Also according to Santos et al., "(...)these professionals (doctors) are generally not prepared to be health educators" (p.60).

In this respect, the problem of lack of patient orientation is its main dissatisfaction. Hence the warning that the physician needs to recognize that claim and realize that their dialogue with the patient is of vital importance (SANTOS; ANDRADE; MAGALHÃES, 1997). put the issue of physician-patient relationship in an educational context. It is understood that the educational issue refers not only to patients, but also to the health professionals (CAPRARA; FRANCO, 1999).

The education of the patient and their families by the health team is essential because it is known that the main cause of poor adherence to treatment resulted from the lack of patient education (DEWULF, 2006; LÓPEZ, 1997; SOUSA-MUÑOZ; RAMALHO; BORGES, 2008). Studies show that patients with hospitalized with chronic diseases or who are not outpatients after hospitalization receive an average of six different drugs, reaching 20 in prolonged hospitalization (LÓPEZ, 1997).

It is estimated that approximately 50% of patients who use drugs do not follow the treatment prescribed by the doctor. (SOUSA-MUÑOZ; RAMALHO; BORGES, 2008). Although it is possible to postulate many social, psychological and economic reasons to this fact, the problems with the following of treatment may be caused in part, by insufficient information on the medicine prescribed.

In general, the provision of appropriate information to patients about medicines may not be considered an easy task for physicians (REIS, 2010). It is known that often the doctor does not have enough time to give detailed information of a prescribed treatment, yet in the context of an often prolonged hospitalization in a tertiary hospital, the impossibility resulted from lack of time it is not justified (MOREIRA, 2008).

The verbal information provided by the physician may also be insufficient due to the fact that the patient himself prioritizes the information received about the disease and diagnosis, paying less attention to information on the drug prescribed, especially patients of low socio-economic level. In addition, the patient may not understand the verbal information, not accept it or even forget

some of it after medical advice. In this respect, both the verbal information given by the physician as written information are important and complementary in patient's education. The provision of written information should constitute an effective mean to support verbal instructions provided to patients on medicines.

It is observed, therefore, the importance of professional training and health personnel, in particular, with counseling techniques in intervention of promotion, protection and support to patients with chronic disease. It is essential that health professionals who deal with these patients develop specific counseling skills. This results from the issue of what communication skills has been identified as one of the essential clinical skills for all health care providers, either primary care or tertiary care. (LIMA, 2001; CANABARRO; HAHN, 2009).

The focus of this paper is on tertiary care, where it is attended a large number of patients with chronic diseases of high complexity. Although the Plan of Care for Hypertension and Diabetes are embedded in primary care, they "do not meet the impending demands, as they are fragmented" (p. 119) The dimension of care requires the integration of actions for health promotion, disease prevention, treatment and rehabilitation, also including the effectiveness, the organization of activities, models of service management and training of professionals serving the health care system (ROSA, 2009). Moreover, assistance and health education should be performed during the outpatient visit, without the patient waiting for the moment of encounter of group interventions on a particular date and time to receive the guidelines.

During the last decades, there has been a great development and a growing shift the theoretical and methodological approaches in this field of study, with the contribution of studies of contemporaries Anthropology of Health and Social Sciences. It is noted, however, that these reflections are not being translated into concrete educational interventions. In this regard, it is worth noting the development of theoretical frameworks available to educators and other researchers, as opposed to the application of these elements in practicing and making of concrete (REIS, 2010).

With regard to actions performed in the customer service of *Continuum* Project of extension, hypertensive, diabetic and nephropathy patients, have expanded their relationship with the team during the follow-up after hospitalization. The fact that there have been frequent appointments does not necessarily indicated greater severity of the manifestations and, in contrast of what managers of health systems admit, the high use does not happened due to misuse (BRASIL, 2006). In this study, the frequency of appointments was determined by the need for implementation of educational actions of the project.

The National Commission on Social Determinants of Health states that the effects of educational level appear on the ability to understand health information (REIS, 2010). Here it should be added that the results found in this study revealed that in addition to those factors mentioned above, and despite unfavorable levels of education (20% of illiterate patients) continuous educational orientation seems to have an effect on the patient's knowledge about their health problems, considering their self-report.

It is concluded that much of the information provided during the educational activity has been assimilated by the project participants. Therefore, the assistance benefits derived through the implementation of the Project Continuum of extension were in the short term, an improvement of information of patients about their health problem. We can see the need to continue this extension activity with the closure of the research.

This work, rather than to draw up conclusions, raises the issue of the need of adopting basic programs of educational actions for the patient to increase their knowledge about the treatment itself and, consequently, their chances of adherence to therapy.

## Competing Interests

The authors declare that they have no competing interests.

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