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Evaluation of health academic academic perceptions about the maintenance of inequities in health communication

Letícia de Oliveira Pinto[1], Claudia Mingrone[1], Giovanna Ferreira Lopes[1], Giovanna Bertolini Chuery[1], Lara Ayrosa Galvão Mixéu[1], Jonas Moraes-Filho[1,2]

[1]Curso de Medicina, Universidade Santo Amaro, São Paulo, Brasil.
[2]Programa de Meestrado e Doutorado em Saúde Única, Universidade Santo Amaro, São Paulo, Brasil.

ABSTRACT

OBJECTIVE

This study aims to evaluate the perception of health students on the maintenance of practices that accentuate health inequities during doctor-patient communication.

METHODS

Cross-sectional observational study approved by the Research Ethics Committee of Universidade Santo Amaro (nº 5,358,167). The results were obtained through the application of electronic questionnaires to students of undergraduate courses in health areas about impressions and knowledge regarding the perception of the topic offered in teaching, adequate care and communication capabilities with patients belonging to social groups vulnerable people, such as LGBT, people living with HIV/AIDS, homeless people and black and elderly populations.

RESULTS

189 responses were obtained, 82.9% of which came from medical students, 7% physiotherapy, 4.5% biomedicine, 3% nursing, 2.1% dentistry and 2% psychology. According to the results of this study, it is possible to observe that, according to the perception of more than 95% of participants, communication is essential for medical care and 83.9% consider it necessary for communication to be appropriate to the individual and collective complexities of populations in scenarios specific. However, 64.1% of participants consider that medical schools do little to prepare future health professionals for the complexities of health demands present in society.

CONCLUSION

Although 95% of participants consider that communication is essential for medical care, only 35.7% of future health professionals believe that they are prepared throughout their studies to provide such care to individuals who are historically vulnerable and subject to various health determinants.

DESCRIPTORS

Health Communication, Humanization, Social Determinants of Health.

Corresponding author:
Jonas Moraes-Filho.
Docente no Programa de Mestrado e Doutorado em Medicina e Bem-estar Animal e Saúde Única, Universidade Santo Amaro. R. Prof. Enéas de Siqueira Neto, 340 - Jardim das Imbuias, São Paulo – SP, Brasil
E-mail: jmfilho@prof.unisa.br
ORCID ID: https://orcid.org/0000-0002-4734-9512

INTRODUCTION

Universal and equal access to actions and services to promote health, prevent illnesses and guarantee the biopsychosocial well-being of all citizens was made possible through article 196 of the 1988 Federal Constitution, which ensures that health is a right for all and duty of the State. This full state of health is achieved through public policies that aim to establish respect for human dignity, through access to information, health care for the body and mind, adequate nutrition, hygiene, basic sanitation, safety and health options quality of life[1].

However, maintaining the right to health is still, for many, just a legal-political and constitutional principle, which results in cluttered rights and systemic inequalities. Despite the historical struggles in favor of equality, it is necessary to defend difference so that equality is feasible in its potential, that is, equity must be provided to include disadvantaged and vulnerable sectors in Society[1, 2].

Specific health scenarios are seen as populations of high joint and individual complexity with important social determinants of health, with people with disabilities as an example; homeless; black; elderly; person living with HIV/Aids (PLHIV/Aids); Lesbian, Gay, Bisexual, Transsexual, Queer, Intersex, Asexual, Pansexual, other sexual orientations, gender identities and expressions (LGBTQIAP+); indigenous people; quilombola communities; riverside communities and the population deprived of liberty who need a different perspective to provide equal treatment[3].

Bearing in mind the complexity of the dimensions that make up the spectrum of human diversity and uniqueize each person or each social group, the health professional must be able to act with social responsibility and commitment to the defense of citizenship, human dignity, integral health of the human being and always having as its transversality in its practice the social determination of the health and disease process[4].

The intersection of these points is intensified when it becomes clear that the relationship between the health service and the patient involves other aspects beyond the physical encounter of these characters and the resolution of the biological complaint, given that illness is experienced in different and subjective ways by individuals, encompassing individual, social and cultural aspects. Therefore, one must take into account individuals' conceptions of illness, the degree of vulnerability they find themselves in the culture in which they are inserted, the understandable transmission of information to the patient and forms of treatment available to result in a health practice entry into the specific scenario in which the user finds himself[3, 5].

Based on individual-centered health care, it is necessary to pay attention to some factors such as: humanization in care and good communication, which generates good relationships with the patient and quality of care. All these factors in practice can be understood as the healthcare professional-patient relationship. It is this relationship that guarantees acceptance, success of any drug therapy, successful intervention and reduction in the number of patients resistant to therapy. Furthermore, each patient is unique and has their own culture and habits, which influence the care provided by the healthcare professional and the continuity of care[1, 3, 6,7].

Therefore, a paradoxical example of the maintenance of inequities in health is the education traditionally offered by undergraduate health courses in the country, which contributes to the maintenance of an unequal system by assuming that the approach must always be similar with everyone. However, this theory applies in a completely different way within the country's health reality, since focusing only on physical aspects of the disease, standardizing the patient and ignoring socio-economic and cultural aspects that patients will bring with them to care, only will bring harm to the individual. The denial of the need for adjustments in the health professional-patient relationship and communication distances the patient from care, leading to rates of late diagnosis and treatment of diseases, poor adherence to treatment, search for inappropriate and/or illegal means to resolve demands in health, maintaining mortality rates from preventable causes, among others[8, 9].

Due to this scenario, bringing together all the peculiarities of the population and the training necessary for health professionals to be able to provide good care, this study aims to evaluate the perception of academics on health courses about the maintenance of practices that accentuate health inequities during communication with the patient.

METHODS

This cross-sectional study was approved by the Research Ethics Committee of Universidade Santo Amaro, opinion number 5,358,167 and data was collected through the signing of the Free and Informed Consent Form by the participants. For data collection, the convenience sample consisted of academics from undergraduate courses in health areas interested in participating in a series of lectures on "Adequacy of Doctor-Patient Communication" who voluntarily responded to the questionnaire sent in the year 2022, virtually, through the Google Forms Platform.

The sample consisted of 189 participants from private universities, aged ≥ 18 years, coming from students studying medicine, physiotherapy, biomedicine, nursing, psychology and dentistry. As an inclusion criterion, participants needed to be over 18 years of age, working in the health sciences field, and agreeing to participate in the study after presenting the Informed Consent Form. Questionnaires from participants who were under 18 years of age, those that contained duplicate or incomplete answers, or that despite being answered, participants had not agreed to participate in the study through the Informed Consent Form were excluded.

The questionnaire began with sociodemographic questions in order to characterize the studied population. The variables analyzed were gender, age, undergraduate course, region of residence. We chose to collect data on the participants' opinions regarding health communication practices in the context of patient care, which contribute to the maintenance of health inequities through a non-validated questionnaire, structured in 5 care scenarios with vulnerable populations (PLHIV/AIDS, LGBTQIAP+, homeless people, black and elderly populations); of which the participant should evaluate on a scale of 0-10 (0 being for those who did not feel prepared, and 10 for those who felt completely prepared) how safe and knowledgeable they felt to carry out the service.

Statistical analysis was performed using SPSS 26 software and all tests used a statistical significance level of 5%. The statistical tests were chosen in accordance with the type of variable involved (qualitative or quantitative) and the adherence to normality of the quantitative variables, with a descriptive analysis being carried out, followed by univariate analysis. Exploratory data analysis was carried out by determining the frequency of respondents and confidence intervals.

RESULTS AND DISCUSSION

189 responses were obtained to the questionnaire. The sample consists of 82.9% (n=155) female and 17.1% (n= 34) male. The median age was 23 years old, with the youngest age being 21 years old and the oldest age being 52 years old. Among the participants, the courses mentioned were: Medicine (n=154), Physiotherapy (n=13), Biomedicine (n= 09), Nursing (n=06), Dentistry (n= 04) and Psychology (n=03).

Of the total number of participants, 180 (95.5%) of them give the highest level of importance to the ability to adapt health professional-patient communication during health care. It is important to mention that studies show that effective interpersonal communication is essential for the physical and psychological health of any person. In this context, for the patient, interpersonal communication involves everything from attitudes and information about symptoms and prognoses, to the prescription of treatment and preventive care[10, 11].

Furthermore, 83.9% of those interviewed consider it completely necessary for communication to be adequate in health care for populations in specific scenarios, such as: LGBTQIAP+, PLHIV/AIDS, homeless people, black population and elderly population . However, for this objective to be achieved, it is necessary to increase knowledge on the part of professionals about the disparities of patients from social minorities, and it is necessary to adhere to the use of inclusive language, without making assumptions about gender, sex, age, possible comorbidities and place of residence by health providers, in order to avoid uncomfortable situations in building a good relationship[12, 13].

Among the participants, 91.4% completely agree with the phrase: "universal access to health is a right for everyone". Equity in public health care ensures that the most vulnerable receive differentiated care, so that they are equal to others. Therefore, it is necessary for the health professional to adapt their form of care and communication to welcome and promote the continuity of health care for the population in a specific scenario[3].

One of the main responsibilities necessary for health professionals is the ability to translate the patient's verbal and non-verbal speech, signs and symptoms to diagnose the disease and offer treatment. In this sense, in the context of medical training, one of the topics of the National Curricular Guidelines for undergraduate Medicine relates to communication in order to generate understanding, autonomy and security for the individual under care[2, 4].

Expanding beyond the medical context, communication in all areas of healthcare is essential. By Cartesian dualism, body and soul are considered two different and independent substances; This idea generated strong influences on Western medical-scientific thought to divide the body into two poles: the physiological and the psychological, each of which is destined for different specialties. The area of physiotherapy per curricular unit is aimed at treating the patient's physical complaints, however, it is also necessary to address that person's expectations of remission, as there is a limitation of care depending on the different pathologies. The ability to communicate in this scenario is essential to have specific cognitive-affective personal approaches to cultural suggestions. The patient's perspectives are centered on expectations and fears based on cultural aspects[16].

If we consider that all culture consists of the meanings that individuals attribute to existence and reality, it is important to recognize that these meanings also extend to psychic life. Within this cultural context, the ways of understanding psychic phenomena may vary, being specific to each culture and may be similar or different in relation to other cultures. In this sense, it is essential to recognize that the field of psychological knowledge and practices is not restricted only to the meanings that psychological science attributes to psychic phenomena, but also encompasses the meanings that different cultures attribute to these phenomena. Thus, it is crucial to highlight the importance of communication between the psychologist and the patient within this cultural context, as this interaction allows for a deeper and more contextualized understanding of the psychological problems and issues faced by the patient[17,18].

With regard to the broad area of biomedicine, communication with the patient is essential for an understanding of the disease process and its evolution. There is a field of biomedicine called Alternative and Complementary Medicine that focuses on health promotion. These measures can be important instruments to actually achieve the absence of the disease. Knowing how to communicate with different populations is extremely important for adapting integrated practices[19].

The nursing team has direct and constant contact with patients, especially during hospitalization. When we understand that power permeates social interactions, it is important to recognize that the hospital environment, dedicated to care, often becomes a scenario where the exercise of power is present. This occurs due to the imposition of medical procedures and technologies that are unknown to the patient. The patient often accepts these impositions in the belief that they are necessary for their recovery, even though they may cause discomfort, violate their physical integrity or go against their will. In this context, effective communication between the nursing team and the patient plays a fundamental role, as it allows the patient to understand the procedures and technologies used in their treatment, promoting a relationship of trust and mutual respect. Furthermore, a lack of adequate communication can contribute to the perpetuation of inequities, as patients who have difficulty understanding information or expressing their needs may receive inadequate care, thereby exacerbating health disparities[20].

Effective communication between dentistry and the patient plays a crucial role in maintaining oral health inequities. When there are gaps in communication, such as technical language that is incomprehensible to the patient or a lack of empathy in listening to their concerns, this can lead to disparities in access to treatment and the quality of dental care. Proper communication can help overcome these barriers, ensuring that all patients understand their treatment options, feel empowered to make informed decisions about their oral health, and are treated with dignity and respect throughout the process. When communication is poor, existing inequities can be exacerbated, thus perpetuating oral health disparities between different population groups[21].

Given that the research participants are students of some health sciences course, only 35.7% of future health professionals believe that they are prepared throughout their studies to provide adequate care to historically vulnerable individuals subject to various health determinants. Regarding the level of knowledge to provide care to specific populations, 43.9% declared to have good knowledge on the subject, 38.4% declared to have regular knowledge on the subject, and 5.6% poor.

In order for more qualified health professionals in communicating with patients to be trained, it is necessary to strengthen the teaching staff, who play an essential role in the training of academics. Teachers play an important role as essential agents in the quality training of students. The lack of pedagogical training, especially for university teachers, becomes an obstacle for professionals to take on the practice of the purest meaning of teaching, according to Tardif: "[..] a subject who has knowledge in terms of know-how arising from his own activity and from which it structures and guides it". The professionalization of teachers goes beyond theoretical knowledge, as it must also involve larger questions about attitudes and values. The total or partial lack of pedagogical training is an important factor associated with student learning insecurity[14, 15].

When asked about the theoretical-practical knowledge necessary to establish good health professional-patient communication in specific scenarios, it was found that 61.3% do not have the knowledge to provide adequate care to a patient belonging to the LGBTQIAP+ population and that 38, 7% have such knowledge; 61.3% do not have the knowledge to provide adequate care to a patient diagnosed with HIV/AIDS and 29.9%

have such knowledge; 70.1% do not have the knowledge to provide adequate care to a patient living on the streets and 30.5% have such knowledge; 53.2% do not have the knowledge to provide adequate care to a patient belonging to the black population and 46.8% of those interviewed have such knowledge; 58.5% of participants do not have the knowledge to provide adequate care to a patient belonging to the elderly population and 41.5% have such knowledge.

The importance of effective communication between the healthcare professional and the patient is guided by some aspects such as: communication is established, from the beginning, between the professional and the patient; adherence to treatment largely depends on the bond established; the patient must be elevated to the position of communicator, not remaining a mere spectator. Therefore, transmitting information is essential in this relationship with the patient, as good communication reduces complaints due to inappropriate practices and concerns, improving adherence to treatments and health recovery both[12].

CONCLUSION

Regarding healthcare professional-patient communication, 83.9% of respondents consider this to be a completely necessary skill. Only 35.7% of future professionals believe that they are prepared throughout their degree to provide adequate care to historically vulnerable individuals and subject to various health determinants. In view of the analyses, it is urgent that future health professionals must understand that vulnerable groups need measures that meet their particularities and peculiarities arising, mainly, as a result of systemic inequalities. Therefore, considering that communication skills are a necessary and indispensable tool, it is necessary to consider improving this practice, aiming to improve the quality of patient care and the provision of health services. This study contributes to future research and the implementation of improvements in academic teaching spaces in the health area.

REFERENCES

1. BRASIL. Constituição (1988). Constituição da República Federativa do Brasil. Brasília, DF: Senado Federal: Centro Gráfico, 1988.
2. Barreto, Mauricio Lima. Desigualdades em Saúde: uma perspectiva global. Ciência & Saúde Coletiva [online]. 2017, v. 22, n. 7 [Acessado 15 Outubro 2022] , pp. 2097-2108. Disponível em: <https://doi.org/10.1590/1413-81232017227.02742017>. ISSN 1678-4561. https://doi.org/10.1590/1413-81232017227.02742017.
3. Ando NM, Amaral Filho RCG. Medicina de família e comunidade em cenários específicos. In: Gusso G, Lopes JMC, organizadores. Tratado de medicina de família e comunidade. Porto Alegre (RS): Artmed; 2012.
4. Brasil. Ministério da Educação. Conselho Nacional de Educação. Câmara de Educação Superior. Resolução n.3, CNE/CES de 20/06/2014. Diário Oficial da União 2014 p. 8-11.
5. Sucupira, Ana Cecília. A importância do ensino da relação médico-paciente e das habilidades de comunicação na formação do profissional de saúde. Interface - Comunicação, Saúde, Educação. 2007; v. 11, n. 23 pp. 624-627. doi: 10.1590/S1414-32832007000300016.
6. Campos CFC, Fígaro R. A Relação Médico-Paciente vista sob o Olhar da Comunicação e Trabalho. Rev Bras Med Fam Comunidade [Internet].2021; 16(43):2352.
7. Caprara, Andrea e Rodrigues, JosianeA relação assimétrica médico-paciente: repensando o vínculo terapêutico. Ciência & Saúde Coletiva [online]. 2004, v. 9, n. 1, pp. 139-146. doi: 10.1590/S1413-81232004000100014
8. Barreto, Mauricio Lima. Desigualdades em Saúde: uma perspectiva global. Ciência & Saúde Coletiva. 2017, v. 22, n. 7. pp. 2097-2108. doi: 10.1590/1413-81232017227.02742017.
9. Ceron, Mariane. Habilidades de comunicação: abordagem centrada na pessoa. 2012. Disponível em:<http://www.unasus.unifesp.br/biblioteca_virtual/esf/2/unidades_conteudos/unidade24/unidade24.pdf>. Acesso em: 10 Set. 2022.
10. Fernandes, João Claudio Lara. A quem interessa a relação médico paciente?. Cadernos de Saúde Pública [online]. 1993, v. 9, n. 1. pp. 21-27. doi: 10.1590/S0102-311X1993000100003.
11. Oliveira, Viviane Ziebell de, e William B. Gomes. "Comunicação médico-paciente e adesão ao tratamento em adolescentes portadores de doenças orgânicas crônicas". Estudos de Psicologia (Natal), vol. 9, dezembro de 2004, p. 459–69. SciELO, https://doi.org/10.1590/S1413-294X2004000300008.
12. Perez, Milena Regina Dos Santos, et al. "Percepção de pacientes sobre a comunicação de médicos clínicos e cirurgiões em hospital universitário". Revista Brasileira de Educação Médica, vol. 45, no 2, 2021, p. e064. DOI.org (Crossref), https://doi.org/10.1590/1981-5271v45.2-20200492.
13. Rossi AL, Lopez EJ. Contextualizing Competence: Language and LGBT-Based Competency in Health Care. J Homosex. 2017; cap. 64(10) pág. 1330-1349. doi: 10.1080/00918369.2017.1321361.
14. Moraes FCG, Ramos P, Giannella TR. Teachers' Knowledge and Health Education: a literature review. Cad. Saúde Colet., 2020;28(3):455-463. https://doi.org/10.1590/1414-462X202028030124
15. Tardif M. Saberes docentes e formação profissional. 13. ed. Petrópolis, RJ: Vozes; 2012.
16. Canto CREM, Simão LM. Relação Fisioterapeuta-Paciente e a Integração Corpo-mente: um Estudo de Caso. PSICOLOGIA CIÊNCIA E PROFISSÃO, 2009, 29 (2), 306-317
17. Massimi M. Psicologia e cultura na perspectiva histórica. PSICOLOGIA CIÊNCIA E PROFISSÃO, 2009, 29 (2), 306-317
18. Ratzinger J. (2007). Fé, verdade, tolerância. (S. H. Ferreira Trad.). São Paulo: Instituto Brasileiro de Filosofia e Ciência R. Lúlio. (Originalmente publicado em 2005).
19. Tesser CD. Práticas complementares, racionalidades médicas e promoção da saúde: contribuições poucos exploradas. Cad. Saúde Pública, Rio de Janeiro, 25(8):1732-1742, ago, 2009
20. Baptista MKS, et.al. O poder na relação enfermeiro-paciente: revisão integrativa. Rev. Bioét. vol.26 no.4 Brasília Out/Dez. 2018
21. Lamy RLRF, et.al. Social Inequities and Oral Health: Integrative Review. Rev. Aten. Saúde, São Caetano do Sul, v. 18, n. 63, p. 82-98, jan./mar., 2020