Care provided to patients with hypertension and health technologies for treatment*

A PRODUÇÃO DO CUIDADO A USUÁRIOS COM HIPERTENSÃO ARTERIAL E AS TECNOLOGIAS EM SAÚDE

PACIENTES EN USO DE QUIMIOTERÁPICOS: DEPRESIÓN Y ADHESIÓN AL TRATAMIENTO

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ABSTRACT

The objective of this study was to analyze the use of relational technology in the care provided to patients with arterial hypertension. This is a qualitative study, conducted in eight Family Health Units from Jequié-Bahia, Brazil. The study subjects were policy makers, health professionals and patients, totaling sixteen informants. Semi-structured interviews, systematic observation and documental analysis were performed in 2012. The data were submitted to thematic content analysis. The results indicated that the professionals, especially the nurses and community health workers, make use of light technologies in the search for comprehensive care. On the other hand, some professionals have demonstrated biology-based practice, with an emphasis on rules and procedures. There is a need to change professional-patient interactions, considering the uniqueness and autonomy of the patient and family in the construction of new forms of care.

DESCRIPTORS

Hypertension
Nursing care
Family health
Professional-patient relations
Comprehensive health care

RESUMO

Objetivou-se com este trabalho analisar a utilização da tecnologia das relações na produção do cuidado a usuários com hipertensão arterial. Trata-se de estudo qualitativo, realizado em oito Unidades de Saúde da Família de Jequié-BA. Os sujeitos do estudo foram formuladores da política, profissionais de saúde e usuários, totalizando dezesseis informantes. Em 2010, realizou-se entrevista semiestruturada, observação sistemática e análise documental. Para apreciação dos dados utilizou-se análise de conteúdo temática. Os resultados evidenciaram que os profissionais, sobretudo enfermeiros e agentes comunitários de saúde, utilizam tecnologias leves na busca da integralidade. Por outro lado, alguns profissionais demonstraram prática biologicista, com ênfase em normas e procedimentos. Conclui-se que há necessidade de mudança na interação entre trabalhador e usuário, considerando-se a singularidade e a autonomia do usuário e família na construção de novas formas de cuidado.

DESCRITORES

Hipertensão
Cuidados de enfermagem
Saúde da família
Relações profissional-paciente
Assistência integral à saúde

RESUMEN

Se objetivó analizar la utilización de la tecnología de las relaciones en la producción de cuidado a pacientes con hipertensión arterial. Estudio cualitativo, realizado en ocho Unidades de Salud de la Familia de Jequié-BA. Los sujetos de estudio fueron formuladores de la política, profesionales de salud y pacientes, totalizando dieciséis informantes. En 2010 se realizó entrevista semiestructurada, observación sistemática y análisis documental. Para analizar los datos, se utilizó análisis de contenido temático. Los resultados expresaron que los profesionales, sobre todo enfermeros y agentes comunitarios de salud, utilizaron tecnologías leves en búsqueda de la integralidad. Por otro lado, algunos profesionales demostraron práctica biologicista, con énfasis en normas y procedimientos. Se concluye en que existe necesidad de cambio en la interacción trabajador y paciente, considerándose la singularidad y la autonomía del paciente y familia en la construcción de nuevas formas de cuidado.

DESCRIPTORES

Hipertensión
Atención de enfermería
Salud de la familia
Relaciones profesional-paciente
Atención integral de salud

* Taken from the dissertation "Processo de trabalho das equipes de Saúde da Família na produção do cuidado aos usuários com hipertensão arterial", State University of Southwest Bahia, 2010.

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INTRODUCTION

High blood pressure (HBP) is seen as a major public health problem because it is a chronic disease, multifactorial and carries with it a high risk for cardiovascular disease. The number of HBP patients is increasing. In Brazil, there are approximately 17 million people with HBP, and 35% of them are over 40 years old[1].

HBP requires preventative actions and early diagnosis through the work of a multidisciplinary team, in which the nurse taking care of the HBP patient may contribute to both prevention and early diagnosis, thus preventing the disease and delaying its complications[2].

We believe that health professionals who develop care for HBP patients should seek a role that goes beyond the biological and prescribed aspects of this disease, driving changes in the production of health care, with a view toward consolidating actions that enforce the principles of a Unified Health System (SUS), and ensuring integrated and human care.

In this context, the work process of the Family Health Teams (FHT) for HBP patients that aims at integrating care from the perspective of the co-responsibility of employees, users and their families, presents itself as a strategy to overcome fragmented health practices, which are currently dominated by strict procedures, equipment use and the reproduction of pre-established norms for the care itself, which often do not meet the needs of the health needs of the users.

...health professionals who develop care for HBP patients should seek a role that goes beyond the biological and prescribed aspects of this disease...

Therefore, the interaction between different caregivers becomes essential for the construction of collective action planning, more careful monitoring of the population health status and encouraging the involvement of family and different social segments that are directly or indirectly associated with the treatment of HBP.

Thus, it is essential that the care produced by health professionals is grounded by listening, welcoming, ethics, dialogue, autonomy, respect, freedom, citizenship and creativity in order to promote change in their practices[3].

The existence of professionals seeking to ensure the creation of effective links between health care workers and users, as well as the establishment of relationships of sharing and trust, will contribute significantly to the co-responsibility of users and families in health care[4]. Thus, the first action necessary includes sensitive listening to the care needs of users[5], allied to user embracement, with an aim toward consolidating integral care in the family and community context.

This perspective highlights how health care is being shaped and consumed in the process of use while highlighting the logic undertaken by the health care workers through the use of health technologies that the worker chooses, with the understanding that they meet the health needs of the population.

Light health care technologies, or relational technologies, are those that presuppose a bond, patient embracement, sensitive listening, and other such interactions. Technologies classified as light-hard are those that involve well-structured knowledge necessary for health care work, such as clinical medicine and epidemiology. Hard technologies are the equipment, norms and organizational structures[6].

We believe that the use of technologies in health is paramount to solving health situations that lead users to seek health units. However, the rational consideration and appropriate use of light, light-hard and hard technologies is needed to ensure that the relationship between the professional and patient is not centered in procedures, standards and requirements.

Thus, the expectation is that the use of light technologies should receive the most emphasis in care, serving as a enhancing device to the working logic that valorizes the individuality of the subjects involved in the work process[6].

With this research, we intend to sensitize health professionals and trainers of health human resources to the debate about the use of relational technologies in the care of HBP patients and providing these health professionals and trainers with the resources necessary for reflection about the organization of the work process, with a goal toward improving the quality of their produced health care.

This study aims to analyze the use of relational technology in the care of users with high blood pressure.

METHODS

A qualitative study, conducted in the Family Health Units in the municipality of Jequié-Bahia, Brazil, had theoretical grounding based on the health technologies classification and emphasizing relational technology as an essential care device.

This is a portion of a dissertation, comprising sixteen subjects who belong to three groups. Group 1 consists of three policymakers. Group 2 consists of nine health professionals, and Group 3 consists of four users.

The criteria for subject selection in group 1 (policymakers) was based on identifying representatives of the municipal health management who worked with HBP-related policies. Group 2 (health professionals) inclusion involved professional health care workers in an FHT that

were involved with action directed at HBP patients. This group included nurses, doctors, dentists, dental assistants (DAs), and auxiliary nursing and community health agents (CHAs). In turn, group 3 (users) was established as including users diagnosed with hypertension, in addition to being registered in and belonging to the FHU for a minimum of one year.

At the time of the survey, the municipality had 18 Family Health Units, which led us to organize some criteria to define the units that would that would be used in this study, namely the following: a complete minimum team, following Ministry of Health guidelines; a team with a minimum of 6 months of experience; units with 80 to 100% of the families enrolled and followed; and units with only one team. Eight units were selected. Six are located in urban areas and two in rural areas.

The study was approved by the Research Ethics Committee of the State University of Southwest Bahia under protocol number 163/2009. All subjects signed a consent form.

Data collection took place from March to May 2010 using semi-structured interview techniques, systematic observation and document analysis. The policymaker interviews were held in the Municipal Health Department. The user and health professional interviews were conducted in the Family Health Units. Each interview lasted approximately 25 minutes.

Ten observations sessions were conducted, five of which occurred in the physical space of the Family Health Units and five in households of the coverage area. The observations made in the Family Health Units required an average of two hours, and the home visits observations required 40 minutes on average.

The analysis of the Municipal Health Plan of Jequié 2006-2009[a] and of the Annual Reports Management of Jequié 2007 and 2008 was directed toward HBP patient-related matters.

After the recordings were listened to, they were made into transcripts and exhaustively read.

For the interview analysis, the interpretation of the statements were made using the technique of content analysis, thematic modality, and systematized with three steps[7]. The first step was the pre-analysis, in which the study objectives and selected documents to be analyzed were outlined. Then, there was a brief reading of the collected material in order to establish the *corpus*, namely, an attempt of organizing the material. In the second step, we explored the empirical material through exhaustive reading. During this procedure, the text was edited, the data were coded, and the recording units were identified. Then, classification and data aggregation was conducted. The third step consisted of examining the obtained results and their interpretations in order to identify convergences, divergences and unusual data.

Finally, the nuclei of meaning were identified and aggregated into two themes: the bond in the delivery of care and the (re) construction of care delivery, including embracement and integrality.

The testimonies of the respondents and the group represented were identified by a letter followed by a number, for example, respondent 1 (E1), group 1 (G1), and so on.

RESULTS

The testimonials of respondents and health professionals revealed the existence of a bond between health professionals and users:

> (...) It is impossible not to have a relationship because it has been almost five years together. We create this, not only with HBP patient but with his family as well (...) (E9G2).

> (...) I think the bond exists (...) I have no doubt that it exists (...) We can be close to our users, and I believe there is a good channel of communication between the community and the unit (...) (E14G2).

> (...) all patients have a very good relationship between the community and health unit, and this is contributing much with the work that has been developed precisely for this bond, for this understanding between unity and communities (E16G2).

> (...) The bond existing here between health unit and the community is pretty intense (...) (E17G2).

Respondents also indicated that the CHAs and the nurses have had a significant role in care delivery to users with hypertension:

> (...) the nurse that follows the case, because it is previous checked by the doctor, but then is the nurse who follows these people (...) (E15G2).

> (...)the team notices that they have a good bond, mainly with the community agent, with all clients of micro-area, they usually come not only with medication, but the medical history, the outburst of these patients (...) because it is in everyday life, so they tend to talk more with the community agent (...) (E17G2).

> (...) she (nurse) comes back to my home to determine if I'm taking the medicine properly (...) (E22G3).

> (...) The community agent from there always comes to our home to see how we are (E23G3).

Such statements highlight that both the bond and dialogue are strong elements in the relationship between nurses, CHAs and users and enhance the working process of the FHT through a relationship permeated by the ability to express individual concerns.

[a] Printed Documents of the Municipal Secretary of Health of Jequié-Bahia, available for consultation only on site.

For policymakers, nurses are seen as professionals who have a relevant role providing assistance as well as managing the municipal health net:

> (...) nurses most often really embrace the work (...) (E1G1).

> (...) We were able to bring to the Department (Municipal Health Secretary) (...) two nurses with extensive experience in Public Health (...) and we can see how the Department was lacking these professionals and how much we have gained and will gain in the future because these professionals are acting effectively (...) (E3G1).

The technical and scientific knowledge of nurses, in conjunction with the use of relational technologies, provides a comprehensive performance in the course of daily work and, thus, contributes to the management of care and the services produced by the health team.

The testimony of health professionals has shown that embracement is part of the working process of the FHT:

> (...) certainly embracement (...) we try the most to embrace the patient if he has any doubts (...) we do not let him go without a response, just a 'dry' and ready no, we try not to let so (...) and it can cause the patient to always feels feel embraced (...) (E18G2).

The health care team is also discussed and noticed by HBP patients:

> (...) he (doctor) kept me here in the room almost an hour (...) I felt that he was more worried than me because my blood pressure was about 20 (...) he is an excellent doctor, he is a lovely person, he receives us with such politeness(...) (E24G3).

> (...) they work well (...) I feel embraced; they never let me go without receiving me. (...) (E25G3).

However, the testimony of respondent 22, a patient, indicated a lack of acceptance by the professionals working in the FHT:

> (...) it has to be a doctor who enjoys working, who receives the patient with politeness, with love, with affection, who stops to listen. He cannot just come out and say that the patient has nothing (...) If the patient comes to a doctor it is because he has a problem (...) When he seeks a professional, as is my case, I was not feeling well and this really (...) (crying) hurt me a lot. Now I'm not attended here in the care unit (...) (crying) I have difficulty finding a doctor because I am far from any practice, I have to leave my neighborhood and go to another neighborhood looking for a service from a healthcare professional, it is unfortunate (...) (E22G3).

The respondent highlights the disappointment at not being accepted by the professional when he was vulnerable, leading him to seek another health unity. He was explicit that he needs to be treated with respect and attention.

From this perspective, intervention is necessary to ensure that professionals possess sensitivity and an ethical and political commitment to act as an agent of change in different contexts of health units, as explained by a policymaker:

> (...)It does not help that I make a beautiful and wonderful qualification and (...) I do not have good will, I do not have love for what I do (...) (E2G1).

The testimony of respondent 11, a health professional, contradicted his statement that "he sees the patient as a whole" and confirms a purely biological view where the patient is seen just as a body stricken by an illness, moving away from the broader concept of health, which includes the way life is lived in a given historical, social and cultural context:

> (...) Today we see the patient as a whole, but we see, at the moment, he's here with that disease (hypertension) (...) that he gets here with other problems (...)for the service issue, one will be seen restricted to that specific problem (...) (E11G2).

Respondents 13 and 19, both of whom are health professionals, highlight the divergent aspects of the testimony of respondent 11 when they note the integral nature of taking the entirety of the patient's situation into account when caring for hypertension:

> (...) I have to look at it all, don't I? (...) I'll do an evaluation, I'll talk to him, I'll try to make him more comfortable (...) While I'm attending, I talk a lot with the patient; they end up outburst (...) We have to talk to him because our program is this: listening, embracing the patient (...) We are always in this position of embracing the patient, having a qualified listening (...) because the individual cannot have only the arm, leg or only the mouth checked (...) (E13G2).

> (...) I think we have to take care of hypertensive not only on the pathology, to take care of his pressure, balance the pressure of him, isn't it? But we have to take care of a person as a whole, how is the food, the everyday, the experience, his social relationship, his psychological state (...) (E19G2).

Such testimony emphasized that the professional cannot separate the care of a person into parts of the body or even just focus on only the single illness that made the person seek help from a health unit. This testimony highlights the importance of light technologies, as well as their relation to comprehensive care and the consideration of the complexity of the patient's biopsychosocial existence.

DISCUSSION

The Bond in the Production of Care

The predominance of light technologies, such as embracing the patient and sensitive listening, in the work process enhances the bond between professionals and users, allowing openness that facilitates the creative delivery of care that takes into account the individual patient situation. This predominance also allows the health care

professional to overcome the distance caused by the overwhelming presence of hard and light-hard technologies[6].

The bond contributes to the integration between users and the health unit, beginning when professionals meet the users and become aware of their health needs. Thus, this drives patient adherence to the health service and improves the maintenance of patient health care, reducing injuries[8].

This study indicates that the establishment of this bond provides a connection between professionals and users, family and the community through communication and relationships. This connection contributes to the health team work process.

Building a communicative relationship presupposes the possibility of forming a bond between professionals, users and families, focusing on the individual patient experience in order to highlight and improve humanized care. Under such a system, there is an increase in the autonomy of hypertensive patients to make decisions about their own lives[9].

The formation of bonds becomes especially significant when health professionals show interest in users by warmly listening to their concerns. This enhances participation in the care delivered by the health team and leads the patient to believe that his rights as a citizen are ensured and respected[8.10].

Thus, nurses and all members of the FHT should revise their practices in order to encourage patient and family participation in the process of treating HBP. This includes being open about professional conduct and understanding the implications of relational technology utilization.

By using these technologies, the nurses who work in the FHT are able to adjust their actions to better meet the health needs of users. This ability will also allow them to act as social caregivers. [11]

Community health agents already play a fundamental role in forming a bond between the community and health professionals in that they establish an exchange of information and an interaction between these two groups. The health professionals team believes that the community health agent is more successful in communications with nurses because they are responsible for overseeing the work of the agents and are closer to the agents in their everyday actions[12].

During the observations made in this study, it was confirmed, in accordance with the literature, that nurses and community health agents demonstrate greater interaction[12] in the planning, execution and evaluation of actions focused on the care of HBP patients.

However, it is important to not hold health workers solely accountable for the results of the health care delivered because the delivery of care is the result of an equation that involves the patient, the health care worker and the health service[13].

The challenge is to create a teamwork process involving all its members, with discussion spaces for decision making[12], so that there is no work overload, dissatisfaction, or disengagement of the professionals who are part of the team[14]. This situation can lead to uncoordinated actions delivered by the team and create barriers to comprehensive care.

It is necessary to recognize the character often present in the delivery of care, where professionals seem restricted by pre-established rules and users find themselves obliged to listen and try to reproduce guidelines that often do not fit their needs, aspirations or even their ability to meet these requirements. Facing reality, as it presents itself, leads to reflecting on the manner in which the delivery of health care actions really portrays what the patient is seeking in each meeting with the health care professional.

In regard to how bond formation has been reflected in official documents, the Municipal Health Plan of Jequié (2006-2009) and the 2007 Annual Management Report of Jequié emphasize the city's responsibility to ensure the formation of a bond between the health teams and the community, from an expanded professional's view, with an emphasis on valuing human life and the right to citizenship.

We believe that the establishment of a bond also significantly contributes to a better understanding of living conditions and the health of the population. The bond generates commitments and co-responsibility between the different socially involved actors, users, families and professionals in a common process of work and care.

Given the above, we argue that health professionals should adopt an embracing and listening attitude towards users in order to establish a climate of trust and mutual respect, so that the meeting between the professional and the patient becomes an opportunity improve life and social transformation.

The (re) construction of care delivery: embrace and comprehensiveness

The embrace is understood as the posture and practice that is present in the work process of health teams that facilitates the building of a relationship of trust and commitment among users, families and professionals, as well as the promotion of a culture of solidarity and legitimacy of the SUS[15].

Embracing means more than treating users well, it implies an attitude of respect, interest and responsibility for their health problems and needs, with a commitment grounded in the bond between professionals and users. It is a relationship in which the professional is responsible for the user in such a way that it emphasizes the importance of the user in his human and historical essence.

In this study, it was observed that embracement brings benefits to the delivery of care by enabling closer ties between professionals and users through dialogue and the attempt to facilitate the resolution of claims brought by users.

Accordingly, embracement has the potential to enhance change in the delivery of care by acting as a necessary device for the organization of the work process of the health team and by reinforcing the bond between users and health professionals[16].

Often users seek a health care professional to express their angst, share their concerns, fears, expectations, and to find involvement with their suffering. At the same time, this act can make the patient more aware of his condition as he becomes the protagonist of his own history.

Sensitive listening is expected to increase the professional accountability required when dealing with the suffering of others by considering their uniqueness, embracing them from the moment they enter the health unit, and engaging in seeking solutions to their needs and the problems identified.

It is undeniable that care delivered by health professionals to hypertensive patients cannot be restricted to only dealing with the ill body. Indeed, the individual experience of each individual is indispensable[2]. However, a focus only on the biological aspects of the disease is often the reality of health care.

This fact characterizes the challenge that relational technologies can translate into new paths towards changes in the FHT work process via searching for a break with the purely biological view and including health actions that ensure comprehensive care.

It is imperative that, in discussing the delivery of care, the user realizes that their demands are accepted by professionals, which may trigger multiple methods of solving the problem presented and thereafter lead to the user and the FHT jointly building better ways to care for the user's health[17].

Therefore, new ways of conducting and delivering comprehensive care should underlie the strategic role that each health care professional has when doing his or her job with a remarkable enhancement of focus on the individuality of users, enabling interpersonal relationships to have a structural character in the actions developed by the health team.

Such changes in the work process of the FHT presuppose efforts to build a new health care approach to overcome the paradigm of the biological view of health care as the legitimate view while developing respect for the user and his individual experiences[18].

Therefore, being a member of the FHT necessitates an ethical commitment to human life in its biopsychosocial complexity, and thus, health care workers need to overcome the mechanical and fragmented way of delivery care and understand that health care is infused with humanitarian values, solidarity and citizenship.

From this perspective, the comprehensive view emerges as a principle of continuously organizing the work process and increasing the chances of accommodating the health needs of a population that can only be performed from the perspective of dialogue between different subjects[19].

The effectiveness of comprehensive care infuses the embrace of all different health services that compose the network of care[20] for HBP patients. That is, embracement and comprehensiveness can be seen through the perspective of the interpersonal relationship, construction in the intercessor space and the network of health care.

In this sense, the nurse stands out as a professional who has a direct or indirect influence on the SUS management process in regard to the organization and delivery of health services, demonstrating his competence as a manager of care and services by presenting the multidisciplinary knowledge and technical skills associated with humanizing actions[21-22].

The different visions that guide the effective practices of care with hypertensive patients are also confirmed in the official documents of the city. The Municipal Health Plan of Jequié attempts to ensure comprehensive care through the reordering of promotion, prevention, treatment and rehabilitation actions from an expanded vision of care. However, the Annual Reports Management of Jequié, in regards to the population diagnosed with HBP, present a list of activities that restricts care to the biological aspects, with emphasis on light, light-hard and hard technologies.

The findings lead us to consider comprehensiveness and ask questions about the reductionism found in caring for hypertensive patients because, in our observations, we realized that the policies, procedures and guidelines about prescribed drug use were so prioritized that sometimes there was not an opportunity for the health care professional to sensitively listen to the user, confirming the predominance of hard and light-hard technologies in the delivery of care. This challenges professionals to take on a humanizing and embracing attitude, which could improve care delivery.

CONCLUSION

We believe that the objective of this study was achieved by revealing the existing interfaces of the delivery of care to users with hypertension from the perspective of policymakers, FHT professionals and health care users.

In this study, we identified that some professionals appreciate and make use of relational technologies such as acceptance, bond formation, and interaction. In some FHTs, however, the biological vision still prevails in care delivery, with an emphasis on procedures, standards and the use of medications.

The delivery of care to hypertensive users was examined in the context of embracement and bond formation in the search for comprehensive care. The involvement of the family and community of the users and the sharing of experiences, knowledge, expectations, and feelings, along with the valuing of their uniqueness and autonomy, are relevant toward developing new standards of care delivery.

Therefore, it is expected that the care delivered by FHT professionals should possess a broader view of health, so that, in their daily practices, comprehensive care can become a more achievable goal. We emphasize that there is still work to be performed to deliver care to hypertensive users that is delivered from a perspective of the comprehensive appreciation of life and not solely disease focused.

We also note that it is not sufficient to only make a formal commitment to providing comprehensive care in the Municipal Health Plan. It is necessary to make efforts in the search for strategies to support the teams, enabling them to learn how they have been working, and to analyze the results achieved, which will guide their actions towards the purposes of the SUS, namely, health as a right.

Finally, we hope that this study will help to strengthen the ethical commitment and solidarity of everyone involved with the delivery of care to hypertensive users, in the certainty that they, as citizens, have the right to experience health as an inalienable right that is inherent to the human condition.

We believe that this study has contributed to the knowledge of nursing, highlighting the role of nurses in city management and in the care of people with hypertension. This study has shown that care led by relational technology has a greater power to overcome the practices centered in biology-focused care logic, which may advance the ethical dimension of care. It should be noted that this study emphasizes the importance of the care network in providing care for patients with hypertension, with consideration of embracement and comprehensiveness, while pointing to elements for further studies.

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