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Reflecting about assumptions for care in the healthcare education for hypertensive people

REFLETINDO SOBRE PRESSUPOSTOS PARA O CUIDAR/CUIDADO NA EDUCAÇÃO EM SAÚDE DA PESSOA HIPERTENSA

REFLEXIONANDO SOBRE LOS CONCEPTOS DEL CUIDAR/CUIDADO EN LA EDUCACIÓN EN SALUD DEL SUJETO HIPERTENSO

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ABSTRACT

Hypertension has high prevalence and mortality. Preventing and controlling this disease poses a challenge, which implies in considering the educational process as a necessary tool for care. The study had the purpose to reflect on the assumptions for care in the healthcare education of hypertensive people. It was observed that the assumptions for caring, in the process of healthcare education, are based on considering the person instead of the sick body, and in comprehending caring while being capable of investing in the clinic of the individual, favoring spaces for sensitive listening and welcoming, comprehension of suffering, the meaning of falling ill and caring for the self. We expect this reflection to contribute for the implementation and enhancement of new forms of caring in the programs of hypertension, comprehending the human being as someone destined to have freedom, happiness and full satisfaction.

KEY WORDS

Hypertension.
Health education.
Nursing care.

RESUMO

A hipertensão arterial apresenta elevada prevalência e mortalidade, sendo um desafio prevenir e controlar a doença, o que implica em considerar o processo educativo como ferramenta necessária para o cuidado. O estudo teve como objetivo refletir sobre os pressupostos para o cuidado na educação em saúde da pessoa hipertensa. Depreendeu-se que no processo de educação à saúde, os pressupostos para o cuidar assentam-se na consideração da pessoa em lugar do corpo doente e na compreensão do cuidar apto a investir na clínica do indivíduo, privilegiando espaços para a escuta sensível e o acolhimento, para a compreensão do sofrimento, do significado de adoecer e cuidar de si. Esperamos que esta reflexão contribua para implementar e aperfeiçoar novas formas de cuidar nos programas de hipertensão, compreendendo o ser humano como ser destinado à liberdade, felicidade e plena realização.

DESCRITORES

Hipertensão.
Educação em saúde.
Cuidados de enfermagem.

RESUMEN

La hipertensión arterial presenta una elevada prevalencia y mortalidad, siendo un desafío prevenir y controlar la enfermedad, lo que implica en considerar el proceso educativo como una herramienta necesaria para el cuidado. El estudio tuvo como objetivo reflexionar sobre los conceptos relacionados con el cuidado, en la educación en salud, de la persona hipertensa. Se desprendió que en el proceso de educación en salud, los conceptos sobre el cuidar están basados en la consideración de la persona en lugar del cuerpo enfermo y en la comprensión del cuidar apto a invertir en la clínica del individuo, privilegiando espacios para la escucha sensible y el acogimiento, para la comprensión del sufrimiento, del significado de enfermarse y cuidar de sí. Esperamos que esta reflexión contribuya para implementar y perfeccionar nuevas formas de cuidar en los programas de hipertensión, comprendiendo al ser humano como ser destinado a la libertad, felicidad y plena realización.

DESCRIPTORES

Hipertensión.
Educación en salud.
Atención de enfermería.

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INTRODUCTION

Systemic hypertension (SH) is a chronic, non-transmissible disease with multiple expressions, being a relevant public health problem given its social and economic implications, such as: 1) it has a continuously high rate of prevalence and mortality, in the national and international contexts[1]; 2) It is a disease that acts either on its own or is associated with aggravations of several diseases, being multifactorial (associated to modifiable risk factors like smoking, excessive use of alcohol, sedentary lifestyle, obesity, high-calorie food, stress; and non-modifiable risk factors like gender, heredity, age and race)[2]; 3) due to its chronic and incapacitating characteristics, it results in early retirements, long hospital stays, costly treatments, changes in the individual's self-esteem and self-image[2]; 4) Allied to the disciplinary discourse, the hypertensive person has a restrictive condition of life, needing constant monitoring, including medicalization of the food and physical activities and changes in the lifestyle[1]; 5) The level of treatment compliance is not satisfactory, contributing to the morbidity and mortality of the disease, and there are several factors that interfere with compliance, all of them related to the therapy, the healthcare system and the person[2]. This scenario reveals that SH control and prevention are indispensable, and that the multiple risk factors associated with the disease imply changes in the lifestyle.

Primary prevention of SH is fundamental to reduce morbidity and mortality due to cardiovascular diseases. Its main objective is the reduction or modification of the hypertensive disease risk factors by implementing appropriate policies and educational programs that try to avoid or delay the disease[3].

The many programs existing in Brazil to support the person with SH aim to promote awareness of the need for changes in habits that are considered harmful, as well as to maintain these changes as long as possible. The objectives are related to helping the person to understand, know and accept the disease, knowing and recognizing risky behaviors, negotiating and complying with treatment proposals and helping them cope with problems that may hinder its maintenance[4].

In 2001, the federal government began the Hypertension and Diabetes Mellitus Care Reorganization Plan, with the purpose of bonding people with those diseases to the healthcare units, granting them systematic monitoring and treatment by qualifying professionals and reorganizing the services[5].

The general objective of this plan was to establish guidelines and goals for the reorganization of care for people with hypertension and diabetes mellitus in the Single Health System – *Sistema Único de Saúde (SUS)*, by qualifying the professionals in the basic healthcare network, guaranteeing the diagnosis and bonding people afflicted with such chronic diseases to the healthcare units, in order to provide them with treatment and monitoring. These measures were intended to restructure and increase resolutive and quality care for individuals with the aforementioned diseases in the public healthcare network[6]. The greatest challenge in this plan is to maintain hypertensive individuals' capacity to comply with the therapeutic regimen, a fact that is not usually observed in practice due to the high prevalence of disease and low rates of compliance – nearly 40% of hypertensive people abandon treatment[2].

We have experienced the implementation of multidisciplinary healthcare programs for people with non-communicable chronic diseases during our career. The activities of SH-related programs included medical, nursing and dietician appointments, referrals to the psychology service, monthly educational lectures, quarterly walks in parks to encourage physical exercise, search for patients who did not attend these activities and celebration of special dates related to SH control.

Even with all these investments, we observed that people hardly ever had their blood pressure under control. We often received people in critical situations due to complications, with non-compliance to treatment contributing heavily towards it. Therefore, it is evident that the care provided to the professionals deserves consideration, and there are psychosocial and emotional indicators implied in the disease onset and control. Therefore, it is undeniable that blood pressure control is not only limited to the sick body. It is necessary to consider the life experience and subjectivity of the person as indispensable aspects in the processes of falling ill and self-care.

Nearly 40% of hypertensive people abandon treatment.

We know that the condition of being hypertensive determines the need to change habits and to transform the way of being and living, which, in turn, requires active participation of the person in the process of treatment. It is also true that successful changes by the hypertensive person depend on healthcare professionals, who should be prepared with the assumptions and techniques of healthcare education to improve their therapeutic approach[7]. Announcing lifestyle changes as a list of changes to be absorbed, as a measure that regulates action, is a principle that seems to attribute the responsibility of the success or failure in controlling the disease to the patient, not influencing or determining the necessary changes to effectively control it[7]. As such, the healthcare education process needs to contribute to the individual's valuation of the changes in lifestyle.

We hope that this reflection can contribute to the identification and comprehension of some indicators that interfere in treatment compliance, resulting in discussion, proposals and, ideally, the implementation and improvement of new therapeutic approaches in SH programs, in order to delay the complications of the disease by effectively controlling it, attaining valuation of health as a necessity to maintain life.

OBJECTIVE

The objectives of this study were: reflecting on nursing healthcare assumptions for hypertensive people in healthcare education.

NURSING CARE: ASSUMPTIONS FOR HEALTHCARE EDUCATION OF THE HYPERTENSIVE PERSON

As long as there has been life, there has been care. Caring, taking care, is an act of life with the purpose of assuring maintenance and continuous existence[8]. The term caring comes from the latin *cogitare*, meaning to consider, imagine, think, pay attention to, be concerned about[9]. Caring is not simply an act, it is an attitude. Therefore, it covers more than a moment of attention, zeal and unveiling. It represents an attitude of occupation, concern, responsibility and affective involvement with the person receiving care[10].

Conceptually, caring is also defined as the fundamental, systematized practice that is capable of self-guidance. Its wholeness is represented by actions that are present in every moment of the life cycle, in the different manifestations of the process of falling ill, interacting with the human being in its different dimensions, including the psychosocial and spiritual spheres[11].

Caring is also understood as an art, since it is an exercise that is built by the proximity between the desire of caring and the techniques learned, according to the paradigm one believes in, so that it can be performed according to ethics, without myths or dogmas, identifying values and principles that have to be reaffirmed by the professional[12].

In a reflective essay about the topic, caring was defined as:

> [...] healthcare that is immediately interested in the existential meaning of the experience of falling ill, physically or mentally and, as a consequence, also regarding the practices of promotion, protection or recovery of health[13].

Care can be understood as an existential, relational and contextual phenomenon. Existential, because it is part of a being, which is gifted with rationality, cognition, intuition and spirituality – therefore, feelings and sensitivity. Relational, because it can only occur in relation to the other, by shared experiences. And contextual because it assumes variations, intensities, differences in its expressive ways and forms of caring, according to the context it is performed in[14].

For one author[15], one of the goals in nursing care is to relieve human suffering while maintaining dignity. The one providing care should consider the one receiving care in the biological, social, psychological and spiritual dimensions, which in turn are interdependent, derived from the whole as complementary, non-exclusive aspects, and are not supposed to be taken isolatedly[16].

The care deliverer takes on a responsibility, becomes responsible for contributing to the maintenance and perpetuation of the human species. For so, it is always necessary to create a welcoming environment, where care relations can be cultivated[17]. The care relations can thus be considered:

> [...] those who distinguish themselves by the expression of caring behaviors that people share, such as trust, respect, consideration, interest, attention, among others. In a caring environment, people feel well, recognized and accepted as they are; they can express themselves in an authentic way, and are concerned with one another in the sense of updating information, providing and exchanging ideas, offering support and becoming responsible and committing themselves to the maintenance of this caring atmosphere[17].

As seen, when providing care, the beliefs, values and meanings of the situations experienced by the sick person should be considered when interacting with the healthcare practices. This means that every person is unique and has a subjective way of living and falling ill. It is important to establish care as a therapeutic attitude that seeks its existential meaning actively[13].

It is impossible to forget that the disease *means that the whole existence is damaged*[10]. In this regard, one author[10] states: it is not simply a part of the body that is ill, but life itself falls ill in all of its dimensions – regarding oneself (the individual experiences the limits of mortal life), society (the person may become isolated, stop working and need treatment at a healthcare center) and the global meaning of life (crisis in the fundamental trust in life, leading to questioning due to falling ill).

Falling ill is always permeated with subjectivity, constituting a socio-cultural phenomenon in itself, due to the permanent interdependence with the context the person lives in. Therefore, the subjectivity of the person will influence the onset of the disease, its evolution and acceptance of treatment, as well as the process of health recovery[18]. Not only a physical body falls ill, but a human being who has a body, a social and professional life, influencing and being influenced by the society it is part of, as a subject impregnated with beliefs and values[19].

Due to the considerations and conceptions about nursing care expressed until now, it is necessary to reflect about its expression in the relationship established between caregivers and the person with hypertension.

In healthcare focused on hypertensive people, the nurse, as a member of the multiprofessional team, has extremely important tasks, such as: executing the nursing appointment, during which she investigates risk factors and lifestyle habits, measures blood pressure, performs the stratification of individual risks, orients about the disease and the use of medication and its adverse effects, evaluates the reported symptoms and provides orientation about personal and family lifestyle habits. In addition, there is also the moni-

toring of the treatment of people with controlled blood pressure, referral to the physician when necessary, service management, including the search for absent patients, controlling return appointments and scheduled consultations, and the delegation and supervision of activities that are usually done by the nursing auxiliaries or technicians[20].

In hypertension control programs, the nursing appointment is regulated by the Professional Law #7,497/76, article 11, subsection I and Law 94406/77, article 7, subsection *e* of the Nursing Code of Ethics. These laws have made it possible for nurses to take part in multidisciplinary teams with healthcare and educational actions[21].

Caring as an inherent function of the nurse and, in this case, care for the hypertensive individual, is an extremely relevant factor, with the purpose of contributing to prevent, effectively control and delay the complications of the disease.

In view of the specific attributions of the nurse, regulated by the aforementioned guidelines, we consider that a reflection on healthcare assumptions is indispensable, in order to value changes in habits that are seen as risk factors of the disease, by both healthy and hypertensive people. In this sense, it is worth noting that, in view of the relevance of the multiple expressions of hypertension, healthcare professionals have been discussing and investing efforts in the prevention and control of aggravations of the disease.

A significant part of healthcare practices is based on diagnosis and treatment of diseases as defined by scientific knowledge, with body alterations and injuries being prioritized to the detriment of the sick people and their necessities. Based on this biomedical model, there is little space for listening, welcoming, comprehension of suffering, education and integral healthcare[22].

However, although medical literature generally conceives diseases as multifactorial and understands the influence of psychosocial factors in their manifestation, the prevalence of the unidimensionality of hospital-medical interventions still seems to prevail, i.e. the prevalence of the therapy focused on the control of bodily problems[7]. Such an approach, when associated with hypertension, may jeopardize prevention and aggravation control, since:

> [...] the medical action, based on the symptomatic approach, leads to diagnoses that are supported exclusively on aspects of organic concreteness, isolating the organic phenomenon from its context, focusing on the sick part of the body, privileging a causal perspective and tending towards physiological reductionism[1].

The biomedical model, only based on the symptomatic approach and evaluation of diagnostic exams, attempts to treat hypertension based on the sick body. With this model, a large amount of scientific production emerges, trying to identify risk factors and classify and treat hypertension.

We cannot forget that hypertension control implies important behavioral changes, which requires the healthcare team to make efforts in the psychosocial approach to provide care to the hypertensive person. Therefore, overcoming the current model demands different investments in professional education and intervention, aiming at caring for the person instead of the sick body. It assumes the comprehension of different ways of being and living, and the experiences and expectations of a person who lives with a chronic disease by choosing to have treatment or not[7].

The main challenge of healthcare professionals is to be open to approaches that are capable of investing in individualized clinical care, including care for their disease, using welcoming strategies capable of promoting bonding, space for sensitive listening, potentializing personal investments in changing the meaning of falling ill[1]. Bonding is everything that bonds, links or connects; a moral link; a relation[23]. Bonding is the establishment of references that people make in relation to a given team of workers. Due to the bond established by the implemented care, the subject can be strengthened, i.e. its autonomy can be concretized[19].

Welcoming should enable the universality of access to healthcare services, so that everybody who seeks them out can have their necessities heard. This listening should be specific, professional, qualified, whose commitment is to offer the most adequate response, i.e. the solution to the problem, either by referrals, future scheduling, or even immediate solution[24].

Considering the person as a subject of the actions of healthcare professionals implies understanding the relationship established among his life history, his way of being and living and the risk factors for hypertension[7].

How persons think, feel, knowing their beliefs, values and attitudes, as well as the social context behavior is processed in – these are essential factors to be considered in the therapeutic process, aiming at the proposition of an effective educational strategy[7] that will influence the relationship with the disease and healthcare[5]. Besides, despite any effective action to change the attitudes of a person, this will only occur if there is motivation and if the person can count on indispensable supports offered by the social and economic structure[7].

Therefore, acknowledging that several factors influence personal health favorably or harmfully, and also that self-care actions imply hypertension control and responsible actions, requires that healthcare professionals work with subjectivity, understood as follows:

> [...] the world of ideas, meanings and emotions built internally by the subject from his social relations, experiences and biological constitution; it is also the source of its affectionate and behavioral manifestations. It is the way of feeling, thinking, fantasizing, dreaming, loving and doing of everyone[25].

Healthcare is a process that goes well beyond teaching, instructing and training people, especially those with hypertension, to change their lifestyles. It assumes taking a political and ethical stand, supported on values of solidarity and justice, understanding the human being in its essence as someone destined to freedom, happiness and full accomplishment[26].

The educational approach in healthcare education aiming at the valuation of behavioral changes in hypertensive people also assumes that the healthcare team members will be skilled in addressing preventive issues of the disease, using a single language that is also respectful and easy for users to understand[27].

Adequate communication and interaction needs to be established between hypertensive people and healthcare professionals, considering dialogue, interaction and reflection. For so, it is important to know how to listen and try to comprehend the hypertensive person, as well as using language that is accessible and easy to understand[28].

Although healthcare professionals acknowledge that behavioral changes are important to detect, improve and minimize possible healthcare problems, they often do not know how to do it. Using techniques like coercion or the attempt to transfer knowledge is commonplace, with the professionals expecting that, from there on, the patient will react with automatic and immediate actions. Instead of information, threats; instead of education, prohibitions. They cannot make allies with such methods; they simply transfer responsibilities[29].

We know that behavioral changes are not easy to execute, requiring the use of efficient and efficacious strategies by healthcare professionals. Simply informing the meaning and the benefits of the control of risk factors for a disease may not be enough to help people change their ways of being and living. On the contrary, it can be seen as a restriction to their way of living, working and relating with friends and family, making it difficult to comply with the treatment[7].

In practice, what can be observed is a unilateral approach and the utilization of programs that attempt to treat hypertensive persons in the same way, disregarding their individual differences and the fact that each human being has its own opinion and beliefs about the disease and its treatment.

The way healthcare professionals, including nurses, address hypertensive patients is often restricted to asking about blood pressure maintenance in the past few days, if they took medication at the correct times, if they have practiced physical activities regularly and if diet is being complied with. This demonstrates lack of care towards a whole proposal of trust, respect and intentionality for the other, according to the assumptions defined herein about the care to be provided to people with systemic hypertension.

In everyday healthcare practices, it is generally noticed that the physician prescribes anti-hypertensive medications, while it is up to other professionals in the multidisciplinary team to work with non-medication practices, listening to the life history of the person who fell ill, the limits and possibilities of changes in lifestyle, providing healthcare orientations – all of which demand time, competence and listening in order to apply an effective strategy, which will contribute towards control and prevention of aggravations and, therefore, treatment compliance.

When they reflect on treatment compliance, healthcare professionals need to evaluate whether hypertensive persons are interested in changing their lifestyle, if the information they provide is assimilated and valorized, if the values, beliefs and knowledge they have about the prevention and control measures are different from their own and why. They cannot take the difficulties for granted which are found in the adoption of measures that substantially alter the lifestyle habits of hypertensive people. It is important to have a good rapport among the healthcare team in order to provide customized orientation, making it adequate to the lifestyle, personal preferences and purchasing power of a person with SH[30], among other aspects. It should also include risk factors associated with the disease, its chronicity, the absence of symptoms and its complications, such as damage to vital organs, when the tensional levels are not under control, the types of treatment and the importance of continuity, in order to be effective. It cannot be forgotten that compliance with treatment consists of a complex behavioral process that can be strongly influenced by the environment, by the healthcare professionals and by healthcare itself[31], by the perception and strategies of coping with adversities, the problems of life and support networks[32].

In everyday healthcare practices, it is generally noticed that the physician prescribes anti-hypertensive medications, while it is up to other professionals in the multidisciplinary team to work with non-medication practices.

Observational studies have shown that most people with a hypertension diagnosis show low compliance with the treatment, and many do not even return to the regular medical appointments. The amount of controlled hypertensive patients varies from 4 to 12%, depending on the criteria used[33]. Among people undergoing pharmacological treatment, however, the percentage of controlled patients reaches 20 to 50%[34]. It is worth noting that, in addition to the usual medical treatment compliance difficulties, such as economic difficulties and access to healthcare services, the adverse effects of the medication and the inadequacy of the physician-patient relationship, there are other factors that are characteristic of hypertension – including the inexistence of symptoms in the first 15 to 20 years and the chronicity of the disease[33].

Other variables, such as personal and sociodemographic characteristics of hypertensive patients, their knowledge

of the disease and treatment, values, beliefs, experiences, expectations and family support are also implied in complying with treatment, and need to be considered in the process of healthcare education, when actions for hypertensive people are proposed[35].

In a multivariate analysis performed with 782 (82.7%) hypertensive individuals, including all variables under study, three were independently associated with higher probability of abandoning the treatment: smoking, education and hypertension diagnosis of five years of less. Increased age (over 60 years old) represented a reduction in the risk of abandoning medical monitoring. The person who smokes seems to be less concerned about health promotion. Likewise, people with a recent hypertension diagnosis, probably due to being previously healthy and asymptomatic, do not follow the medical recommendations adequately. Low education indicates a low socio-economic profile[33].

One study with black people also showed a tendency to believe less in benefits regarding preventive measures and hypertension control in lower-income classes, for young adults and people living without a partner. The support offered by family members is considered to facilitate the individual in the context of the disease and treatment[35]. In another study[37], illiterate males younger than 40 years old were more likely to abandon treatment. Another investigation revealed that non-white, young and widowed men did now know important aspects of the disease, and that higher stress levels were associated with unfavorable biological and social variables[35].

Therefore, we understand that caring includes investigating, determining and intervening in factors associated to the abandonment of healthcare team monitoring. For the groups at risk, priority and specific measures should be directed at favoring compliance. The participation of the person in the process of self-care and the world should be valued, as well as the comprehension that this participation implies interaction, relation, mutual transformation, co-dependence and co-evolution, seen as several viewpoints limited by our own existence, especially regarding care provided to people with chronic diseases like hypertension[1].

As such, in order to prevent and control hypertension, the primordial aspects noted are the analysis of beliefs related to the susceptibility and severity of the disease, the benefits and barriers for treatment compliance, as well as the adoption of a healthcare proposal that goes beyond action focused on the sick body. The efficacy of treatment consists not only in using medication and instituting measures that regulate action, but in considering the person in its wholeness. In view of these statements, we agree that it is fundamental to develop comprehensive plans aimed at preventing complications and promoting the discovery of the best way to live and live well, with quality. Achieving the participation of the individual in these plans may mean the difference between treatment success and failure[38].

Providing care to hypertensive people goes beyond simply reducing their blood pressure levels, since it also demands investments to reduce the risks of the cardiovascular disease; involving the person in the control of obesity, sedentarism, dyslipidemias, excessive ingestion of alcoholic beverages, as well as in the abandonment of smoking and everyday stress management[39]. Overall, it means making efforts in the healthcare education process, aiming to contribute to improvements in the quality of life of the population.

Efficient communication between the healthcare professionals and the individual, being prepared to listen, speak and interpret, as well as interest beyond technical-scientific issues in the established relationship may offer better conditions to acknowledge the importance of changing lifestyle habits and, therefore, progress more adequately towards better results in treatment compliance.

Therefore, the following proposal should be considered:

> […] education should show and illustrate the multifaceted Destiny of the human being: the destiny of the human species, individual destiny, social destiny, historical destiny, all of them entwined and inseparable. Therefore, one of the essential vocations of future education will be the examination and study of human complexity. That would lead to the acquisition of knowledge, and therefore awareness of the common condition of all human beings, and the rich and necessary diversity of people, peoples, cultures and our roots as citizens of the Earth[40].

FINAL CONSIDERATIONS

Preventing and controlling hypertension implies considering the educational process as a necessary tool for healthcare. In the healthcare education process, the assumptions for care are supported on the consideration of the person instead of the sick body and the comprehension of care that is capable of investing in individual clinical care, privileging spaces for sensitive listening and welcoming, comprehension of suffering, the meaning of falling ill and self care. For nurses to contribute to hypertension control and prevention, they need to go beyond conveying information and classifying individuals in risk groups. Thus, they need to assume and consider that the subject thinks, feels, acts, knows and believe that the social context behavior is processed in will certainly influence the valuation of healthcare by hypertensive individuals.

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