

# *Facilitative Attitudes in Clinical Practice: Strategies for Adhering to Aids Treatment*

## Atitudes Facilitadoras na Prática Clínica: Estratégias de Adesão ao Tratamento da Aids

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### ABSTRACT

Health services have invested in antiretroviral therapy and identifying barriers to adherence is essential for the quality of treatment and for the life of the patient. The present study, conducted at a leading center for HIV/Aids in Natal, Brazil, identified from the perspective of the patients, relational attitudes of professionals that could be characterized as facilitative for the quality of care, humanization of actions and adherence to treatment. The data were collected through semi-structured interviews of 34 patients and analyzed by ALCESTE software, which classified the textual discourses into five classes: *Care received at the facility*, *Positive and negative aspects of the facility*, *Professional care*, *Perception of the care* and *Doubts about the treatment*. Results point to dissatisfaction with the infrastructure of the facility, lack of quality health care, privacy and dialogue with the professional, all of which cause stress. Sensitive listening can be achieved by rebuilding subjectivities and the dialogic relation, as alternatives to reduce inequalities in the professional-patient relation, must also be established, enabling professionals to reconsider fundamentally technical concepts and attitudes centered only on the biomedical model.

**KEYWORDS:** Health Care, Professional-Patient Relation, Humanized Care, HIV/Aids Therapy.

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## RESUMO

No serviço de saúde investir na terapia antiretroviral e identificar as barreiras de adesão torna-se essencial à qualidade do tratamento e da vida do paciente. Assim, o presente estudo com abordagem qualitativa, realizado em um centro de referência em HIV/Aids em Natal/RN, buscou identificar na perspectiva dos pacientes, atitudes relacionais dos profissionais que se configurassem condições facilitadoras para a qualidade do atendimento, humanização das ações e adesão ao tratamento. Os dados foram coletados através de entrevista semi-estruturada com 34 pacientes, e analisados pelo Programa ALCESTE que classificou os discursos das entrevistas em cinco classes: *Atendimento recebido no serviço, Aspectos positivos e negativos do serviço, Atendimento do profissional, Percepção do atendimento e Dúvidas sobre o tratamento*. Resultados apontam insatisfação com questões estruturais do serviço, falta de qualidade na atenção e nas relações do cuidado profissional com a privacidade e escuta, sendo motivo gerador de stress. Emerge a necessidade da busca da reconstrução das subjetividades para a escuta sensível, da relação dialógica como alternativa de redução das desigualdades na relação profissional-paciente, criando possibilidades dos profissionais reverem conceitos e atitudes fundamentalmente técnicos, centrado apenas no modelo biomédico.

**PALAVRAS-CHAVE:** Assistência à Saúde. Relação Profissional-Paciente. Humanização da Assistência. Terapia HIV/Aids.

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## INTRODUCTION

The Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) have presented a challenge to science since their inception and concern for public health systems throughout the world. In Brazil strategies to control and treat the disease have been continuous. In 1996, with the introduction of antiretroviral (ARV) treatment, a combination of drugs with different actions, commonly called "cocktail", or HAART (highly active antiretroviral therapy), there has been a drop in mortality, fewer hospitalizations and opportunistic complications, improved prognosis, and increased survival, reflecting in benefits for the quality of life of patients.<sup>1, 2</sup>

For this syndrome, adherence to medication is an essential factor for treatment quality. Patient response depends on the care and attention received in the health services, on the action and attitude of professionals about attending to their needs, doubts and anxieties, and identifying and resolving difficult personal problems. Being attentive

to patients enables the development of strategies that reduce damage, and thinking of treatment in a shared way by assessing their clinical situation in the perspective of the real possibilities. The tension and unrest experienced causes a state of alarm that opens them to learning the subtle elements of interacting with the professional.<sup>1,3,4,5</sup> Cultural difficulties must be perceived because they may interfere in the assimilation of information. A climate favorable to verbal expressiveness must be created to find technical, personal or material strategies that meet the needs of the patient.<sup>6</sup>

Other authors<sup>7,8,9</sup> reiterate the emotional, educational and informative needs of patients when reflecting on the illness in this context; this requires effective care of their well-being using communicative understanding that restores their integrity and considers them as a participative individual in the health/illness process. The professional and the health team must change their traditional clinical attitude, reduce the perspective of the disease<sup>10</sup> to inter-subjectivity, and based on dialogue and careful listening of the patient, build

individualized therapeutic projects within the understanding of expectations, fears, and desires, resulting in a broader clinical practice.

There is a precariousness and disrespect in the care provided by health services, and restoring humanity is to oppose the violence, lack of dialogue, denial of others and structural deterioration that have been characterizing access to services. Furthermore, discrimination itself has been stigmatizing the Aids carrier.<sup>11</sup> The user-professional interaction is an important factor in the care process, since it reveals anxieties and fears that trained professionals can relieve.

Identifying what affects the mental health of those who live with Aids contributes greatly to interventions that lead to an adaptation to reality, given that patients under treatment who do not improve appreciably tend to become disappointed and unmotivated. This, in turn, increases anxiety and leads to depression, which hinders adherence, worsens quality of life and influences their state of health.<sup>13</sup>

Therefore, the quality of care in health services is considered a fundamental factor, and in this sense, the individual and subjective perception of users as protagonists of the health system, must be a relevant aspect in the organization, restructuring and execution of these services.

Starting with this premise, our objective was to discover, based on user perception, their needs and feelings about professional care and identify attitudes that facilitate the quality of care, humanization of actions and adherence to treatment at a leading government Aids/HIV ambulatory facility.

## METHODOLOGY

This study was conducted at the Serviço Ambulatorial Especializado (SAE) (Specialized Ambulatory Care) in an infectious disease hospital belonging to the State Secretariat of Public Health of Rio Grande do Norte in Natal, Brazil. It is a leading ambulatory facility in biopsychosocial care,

preventive actions, follow-up and integrated clinical treatment provided by a multi-professional team, in addition to being a center for university teaching and research.

This is a qualitative, descriptive, exploratory study. A qualitative approach was used because it answered questions that could not be quantified, but rather described from the perceptions of the subject. A semi-structured interview was used to facilitate data gathering; this favored communicative interaction and disclosure on the part of the subject. Participant observation was used to complement information on the health facility, such as its functioning, physical structure, routine, procedures, behaviors and ways of interaction.<sup>14</sup>

The data were collected from 34 individuals between January and April of 2005. Inclusion criteria were: age of majority, registration at the health facility and acceptance to voluntarily take part in the study by signing a free and informed consent form, after being made aware of the objectives of the research. The recorded interviews were carried out before and after the patients were seen by SAE professionals. They lasted an average of 70 minutes and were later transcribed. The sample was satisfactory in terms of response saturation.

Descriptive analyses were performed for the socio-demographic characteristics of the subjects. A computerized analysis of the textual content of the interviews was done using ALCESTE 4.5 (Analyse Lexicale par Contexte d'un Ensemble de Segments de Teste)<sup>15</sup> software. It is a methodology of quantitative analysis of qualitative data that investigates the distribution of vocabulary in written communication text and transcribed oral text. The program segments the texts into initial context units (ICU), represented here by the "corpus" of the 34 interviews, then reformats and divides this text into line segments called elementary context units (ECU), grouping the semantic roots, defining them by classes and considering the function of the word within a context.<sup>16,17</sup> ALCESTE computes a line of words for each class that is characteristic of this class.<sup>18</sup> The strength of the association between each

word and its class is expressed by a value of chi-squared ( $X^2$ ); the larger the value of  $X^2$  the more important the word for the statistical formulation of the class. The list of words is the basic source for interpreting the classes.

This project was approved by the Research Ethics Committee of the Universidade Federal do Rio Grande do Norte (no. 84/2004) and followed guidelines established by Resolution 196/96 of the Conselho Nacional de Saúde (National Health Council) on studies with human beings.

## RESULTS

**Table 1** shows relative sex parity of the participants. The number of women in the 19-30 age group was significantly higher, but members of both sexes were contaminated at the height of their productive and reproductive life (19-40), which corroborate other studies on the unpreparedness of individuals with respect to care, prevention and the use of condoms.<sup>19,20,21</sup> Most of the subjects do not have fixed partners and live with their nuclear family (parents, siblings). Low schooling is observed, mainly in women, where most are found to be unemployed with no defined profession. They dedicate themselves to domestic activities, caring for their own children and those of others, or work as seamstresses or house cleaners, often only in exchange for shelter and food. Half of the men have semi-qualified jobs or are self-employed. A total of 32.56% of the 34 subjects interviewed receive INSS (National Institute of Social Security) retirement or disability benefits. A total of 84.72% live in the capital, while the rest are from the interior of the state, from other states or from other countries.

When considering the corpus of the discursive material of the 34 individuals, ALCESTE analysis defined the Classification of Descending Hierarchy (CDH), which determined 5 classes, as shown in the dendrogram of the distribution of lexical classes (**Fig.1**). Classes were named containing words belonging to each of the successive partition stages; values of frequency and  $X^2$  were also

included, according to the profile of the lexical classes identified (**Fig.2**) and illustrated with the subjects' discourses. What follows are the most typical statements from which each class originated. The symbol # indicates the words relevant to the class.

Class 1, **Care received at SAE**, corresponds to the 88 ICUs, that is, 27.24% of the material analyzed. It is correlated to classes 2 and 3. The lexical traces characteristic of this class characterize SAE as the place where the subjects face the disease. It a generator of expectations, where routine appointments are a source of anxiety, where the disease is confronted, but also represents the possibility of continued well being, of living. There are concerns about the procedures prescribed and curiosity about the results.

*“44 9 # I hope that # I am well... that # I am well #looked after. # I hope that my # CD4 and viral load #are better, that they have #gone up, otherwise I'm going to go crazy. “*

*12 12 I suffered a lot to get where I am, it was very hard... and the rich get help.... I #came for a #routine #check up and see my #CD4 and viral load...*

Through the discourses it is also possible to learn the meaning of individual experiences, such as concerns about the long time between appointments, a delay that could very well cause a decrease in CD4 and viral load.

*109 24 the #appointment was #good, he #said that my #CD4 and viral load are #good and #prescribed #new #exams and #asked me to #return #here in four months. I think this is #bad; a #return #appointment takes a long time.*

Class 2, **Positive and negative aspects of SAE**, represents 75 ICUs (23.22%). There is dissatisfaction with the comfort and available space of the facility.

350 21 ... what bothers me is the how run-down the place is, it's stressful

The subjects considered contact with the attendants positive, but, in addition to inadequate space, they complain about the lack of privacy and time during consultation, which was also shown in class 1. The participation of students without the subjects' consent during the consultation seems to intensify self-vulnerability and distrust.

372 28 a #positive point... the people are #attentive, the #care #could be better if #there were more infectologists and #less time between appointments... #negative points are the #lack of #privacy during the consultation, confidential #information is spread around.

346 14 ...this space... is small.... There is no #privacy; the appointment is short, there aren't enough #rooms, we're running into one another.... There are a lot of students; nobody asks our permission... we're guinea pigs, what else can be expected from a #public #service!

Class 3, **Professional care**, comprises 29 ICUs (8.98%). It is related to class2 and refers to the patients' experiences with the way they are received by the practitioner. We see impasses in the relation when we analyze the needs felt by the patients and those expressed by the professional. The words opportunity and unburden oneself were the most frequently cited in this class and identified by their  $X^2$  value (**Figure 2**). They are exemplified by the following discourses:

136 10 it's #difficult to get in touch with the doctor.... The demand is great... he's always busy.

The patients are worried about the quality of care and the relation established with the professional; there are expectations about how they should be received.

133 36 ...there aren't many #opportunities here to #talk to the doctor about #personal

#matters, we can't #unburden ourselves ... there is no #space to #listen to us... the doctor should hear us more, know about our life, but they don't take part...

161 12 the professionals have #limited #time, they want to know about our CD4 and viral load, #headache, blood pressure etc...

Class 4, **Perception of professional care**, contains 43 ICUs that correspond to 13.32% of the interviews. The contents of this class refer to the aspects that individuals perceive in the professional who cares for them, mainly the medical practitioner. Words of association and frequency emerged that were significant. This class has the highest statistical association, that is, the highest  $X^2$  (**Figure 2**), when compared to the other classes. The words value, observe, look, attention, among others, were identified and represent fundamental aspects of health care perceived by the subjects.

216 28 when you #observe or ask, in their #look #we # perceive a lot more than the #words.

228 23 the doctor treats us in a direct #way; I #noticed that her #expression is cold, dry; she doesn't seem to be in tune with #us... When the #care is good, I #come back, understanding us helps and motivates #us...

227 29 I observe the #way the #professional treats us, if he #enjoys what he's doing , if he looks #us in the eye, if he is sure of what he's doing and #understands what we're #saying, if he knows how to #listen; the #way he #expresses himself is #important.

By observing, the subjects accumulate knowledge, perceive and learn the professional's way of being and of acting, which allows the creation of bonds of trust. By valuing the way of speaking, receiving,

listening and understanding, the subject accumulate meanings that are built within empathic relations.

Class 5, **Doubts about treatment** contained 88 ICUs (27.24%). The thematic content of this class represents the health-disease process and is correlated to all the previous classes. It is as significant as class 1 and refers to the dimensions of the disease, life and death, and is associated with confrontations, clarifications, doubts and expectations made concrete by the understanding of information. The words of greatest association were follow, treatment, question, have, doubts and are significant in the context of the reports and leave no doubts about the treatment.

332 21 *the search for better quality of #life is what #makes me #follow the #treatment, I #follow it to the letter... when I don't #understand, I #ask until I have no more #doubts; I #ask my doctor.*

269 21 *the #disease manifested itself for about two #years, first with the appearance of hepatitis, then diabetes and urinary infection. Today, what #makes me #follow the #treatment is that, as I #became #aware of the infirmity, I started to talk; my anxiety decreased and I now #know the #importance of #following it.*

For the subjects below, adherence to treatment does not seem to be necessary, but rather something dependent on a daily routine, which also leads to other justifications, such as resistant behaviors.

322 36 *I don't #have any #doubts .... There are #drugs with side #effects and I #want to know what these #effects are; I always #ask. I #have #difficulty in #following treatment because I forget; I'm #doing things at home and when I remember it's already past the #time... when the #drug #affects me, I don't #take it.*

26 *I #have difficulty in #taking the #drugs; I forget; they taste bad; I've always had this #problem.*

This discourse clearly shows the need for communication and attention for understanding and adhering to treatment.

300 16 *#clarity and #conviction on the #part #of the #professional is #fundamental for treatment; if there's no #confidence in the #professionals' instructions, if they don't pay attention to the #patient, it's impossible to follow any treatment.*

Participative observation during the data collection period at SAE showed a facility with precarious infrastructure and inadequate service. There is a lack of both visual and verbal information about treatment: "It's important to have informative posters that are more visible to the general public" (373 30). There is no teamwork to meet patient needs and relieve anxieties. Difficulties in interrelations with other sectors of the hospital were observed: "the problems usually have to do with the #lack of integration #of the other #sectors of the #hospital with SAE (358 26)". Care is limited to routine examinations and the handing out of condoms. On the other hand, medication is readily available and not generally lacking, which is a source of security for the users of the service: "I haven't # missed my medication so far; this #makes me feel better" (367 23).

## DISCUSSION

This study was carried out at a leading center for HIV/Aids. The information obtained reflects aspects and details with significant content on the existence and experience of the subjects of this center. Thus, the considerations are pertinent in the discussion of the results found.

For these patients the disease is seen as a conflicting way of living in the world. Good care through an open dialogue is a frequently expressed desire. For human beings to exist they must be well, and disease causes an imbalance in the continuity of this existence, given that individuals face the

possibility of death, which leads them to lose their meaning of life. Patients need to confront the disease in order to defeat death and feel alive. And this is possible when they talk and are listened to, for if they face the real problem, they stop denying their disease, start to experience genuine feelings and assimilate concrete information and make more responsible choices.<sup>3,22</sup> The attitude of listening in this case must provide means for patients to express their needs, answer their doubts, meet their expectations, give emotional support and not be merely a source of information.

When the subjects talk about SAE, they do so by recounting experiences of needs ignored or overlooked by the professionals. A health action model that goes against the reality of the user, that is, seems to negate the perception of these needs through the routine daily practice of the professional. The neglect of the facility, with no comfort and inadequate space, is another aspect that is repeatedly seen in the public health system. The feeling of well-being is replaced by a feeling of unrest, triggered by the environment.<sup>12</sup>

The SAE, as a teaching institution, allows the participation of students during medical consultations without prior patient consent. This causes feelings of conflict, discomfort and frustration and increases anxiety levels, which could compromise the adherence and evolution of the treatment. This lack of privacy in the patient-professional relation, which should be built with care, mutual understanding and intimacy, transforms confidentiality into a relationship shared with others and creates barriers that are intensified not only by physical discomfort, but also by the non-perception of patient needs. They feel intimidated by the impersonal and unethical behavior of the professionals, who fail to consider their presence as an autonomous being.<sup>23</sup>

One frequent finding in the discourses is the complaint about the long interval between medical consultations. Another is the short time available for the professional to provide the patient with a more attentive, careful and thorough examination. The

actions are more directed towards the clinical techniques associated with AIDS. The way a patient is treated has become dissociated from the quality of care and the organization of health services. The professional has increasingly resorted to a routine of examinations, becoming a simple supplier of information. Costa<sup>8</sup> writes that there should not be predominance of the professionals logic or of the administrative system in health services, but rather the desires and anxieties of the user should take precedence. It is fundamental to consider some aspects of the subjects of this study, such as socioeconomic level and schooling, given that more than 50% of the men and women are unemployed, have no fixed partner (> 70%) and are contaminated at the height of their productive and reproductive life (19-40 years). Subjects who feel underprivileged and deprived see in SAE the possibility of encounters, care, and unburdening. The facility often becomes a place of comfort, a fact justified by the social experience of discrimination, fear, abandonment, prejudice, exclusion and low self-esteem, all of which interfere and impede the search for help. Total listening time in this study is the most important factor for understanding AIDS as a very complex health problem that requires collaboration and co-responsibility between the professional and the patient.

Studies<sup>8,9,4</sup> show that dialogue, individual attention, and the empathic relation in the care process humanize the relationship allowing intimacy and trust, transforming the space into one of sociability, solidarity, cooperation and mutual support, enabling the understanding and adherence to treatment. Effective care in a dialogic understanding of communicative interaction overcomes individualism. The integrality of actions recovers and contextualizes the institution and integrates the members of the team into a network of caregivers.

It is important to point out that conflicts and anxieties not elaborated on by the patients, emerge as tensions that impact the daily routine of the professionals, transforming them into bureaucrat

technicians obliged to fulfill public administration norms related to work demands and to those of the team.<sup>24</sup> In summary, the implantation in health services of “productivity” logic has been quantifying to the detriment of quality. Care based on the traditional quantifying model has led to incapacity in relations, contaminating perception and transforming it into statistical data.<sup>25</sup> Campos<sup>26</sup> and Ayres<sup>7</sup> write that multi-specialties have been fragmenting the performance of the health professional, which, instead of stimulating facilitative bonds in interventions, have been disintegrating the actions of caregiving, resulting in high social cost implications.

There is a need to know the perception of patients, and the reality of the discourses points to their difficulty in communicating and interacting with the medical practitioner. The look, attention, facial expression, manner of speaking and responsiveness are aspects hoped for in contact with the professional and meanings that the subjects build within a context, in the search for interaction. This finding is significant and corroborates other studies<sup>3,9,27</sup> on the importance of professional congruity in the capacity to perceive, to listen, to communicate and to put themselves in the patient’s situation in a coherent way. Facilitative attitudes for clinical practice that adapt life experience to awareness is a process that must be communicative, resulting in understanding and growth for the patient and adherence to the treatment. These are essential skills in health care.

Another aspect that must be considered in this study were references to non-adherence due to interference in daily and social activities. The patients know about the importance of taking medication, but are not committed to the treatment; there is information, but no awareness. These difficulties seem also to be associated with the need for keeping the secret “no one #knows, only my #wife, I have no one to talk to, to #unburden myself to... there isn’t much concern here about #personal #matters (123 24). This corroborates studies by Vitoria<sup>4</sup> and Vasconcelos<sup>5</sup> who report that reduced adherence is a result of interference in patient

activities or lifestyle, treatment side effects, the impossibility of sharing the secret for fear of losing friends, self-esteem and social support. They add that professional-patient co-responsibility in the treatment process must be shared, that individualized attention must include the patients’ history in order to understand their needs and resistances in a mutual discovery that will enable the integration of the relation through a therapeutic alliance when forming the bonds of trust.

Responsible and committed choices on the part of the patient will only occur through interactive dialogue with the professional, in which verbal contents and subjective facts felt and expressed can be elaborated. It seems that, in addition to professional behavior, the way in which the professional relates to the patient’s experience will influence outcome. Costa<sup>8</sup> also approaches *treating* as *caring for*, where medical care involves speaking with patients without coercion, without imposing measures or prescribed behaviors, but rather acting with caution, with understanding and dialogue in a process of trust.

## CONCLUSION

The study shows the existential needs of the users of SAE that must be discussed and investigated in a clinical setting. Considering the relevance of the emerging needs, we believe that they may constitute a significant learning process and lead to a strengthening of relations and of the treatment, thus raising the quality of life and promoting the health of HIV/Aids carriers, as well as humanizing actions in treatment and in care. The search for reformulating subjectivities and the sensitive listening in dialogic capacity emerge as alternatives for reducing inequalities in the professional-patient relation, enabling the redefining and rebuilding of health care and of the meaning of life.<sup>8</sup>

From the perspective of the patient, care and treatment is characterized by the impersonality of the clinical technique before the real listening. The professionals are separated from interactive

relations of understanding and listening. Adopting group strategies to support the manifestation of self expression is a facilitative factor in elaborating and adapting to the disease.

Needs and desires emerge for a listening to conflicts, doubts and expectations that are not attended to. The patients observe the attention, the interest and the concern of the professional, but on the other hand perceive that this concern is usually more directed to routine aspects of the disease, reading the results of examinations and prescribing medication. The short consultations leave no time to discuss personal matters.

The daily routine of health services has transformed individuals into being part of the process and not the center of attention, and understanding and identifying facilitative attitudes enables the reformulation of the *art of caregiving* in daily health actions. One relevant finding of this study is the need to develop a new approach to the routine patient, one of relations already formed, of bonds already established that do not necessarily mean a condition for effective interventions, if these links have not maintained through attention, care, and authentic and comprehensive listening.

Finally, non-adherence or interruption<sup>5</sup> of antiretroviral treatment may be related to difficulties in affective relations concerning treatment support management, which leads us to conclude that quality of the doctor-patient relation as well as that of the multi-professional team are fundamental for treatment.

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Contribution with the Project development, performing research, data analysis and writing the article.

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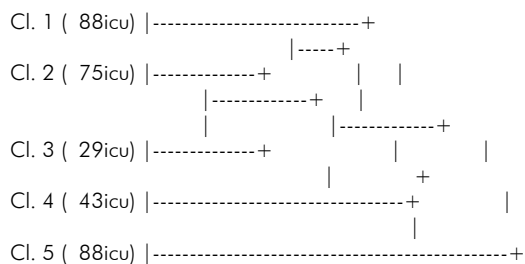
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**TABLE 1 – SOCIODEMOGRAPHIC CHARACTERISTICS OF THE STUDY SUBJECTS**

(N = 34) NATAL, BRAZIL.

	Men (n=16)		Women (n=18)	
	Nº	%	Nº	%
<b>Age</b>				
19 - 30 years	05	21.25	09	50
31 - 40 years	07	43.75	06	33.33
41 - 50 years	02	12.50	02	11.11
56 - 60 years	02	12.50	0	0
61 - 70 years	0	0	01	5.55
<b>Marital state</b>				
Fixed Partner	04	25	05	27.77
Without Partner	12	75	13	72.22
<b>Level of schooling</b>				
Elementary School Dropout	02	12.50	08	44.44
Elementary School Graduate	05	21.25	04	22.22
High School Dropout	01	6.25	01	5.55
High School Graduate	07	43.75	04	22.22
University Dropout	01	6.25	01	5.55
<b>Occupation</b>				
Employed	08	50	02	11.11
Unemployed	03	18.75	14	77.77
Pension recipients	05	21.25	02	11.11
<b>Origin</b>				
Capital	09	12.50	13	72.22
Interior of the state	05	21.25	04	22.22
Other state	02	12.50	01	5.55
Other country (Ital/Fran)	02	12.50	0	0

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**FIGURE 1. DENDROGRAM OF THE DISTRIBUTION OF LEXICAL CLASSES OF DESCENDING HIERARCHICAL CLASSIFICATION (DHC) OF THE CORPUS ANALYSIS OF THE 34 INTERVIEWS WITH PATIENTS FROM THE SAE. NATAL, BRAZIL, 2005.**

Class 1 Care received at SAE 88 ICU – 27.24% Words of greatest association			Class 2 Positive and negative aspects o SAE 75 ICU – 23.22% Words of greatest association			Class 3 Professional care 29 ICU – 8.98% Words of greatest association			Class 4 Perception of professional care 43 ICU – 13.32% Words of greatest association			Class 5 Doubts about treatment 88 ICU – 27.24% Words of greatest association		
Word	Freq	X <sup>2</sup>	Word	Freq	X <sup>2</sup>	Word	Freq	X <sup>2</sup>	Word	Freq	X <sup>2</sup>	Word	Freq	X <sup>2</sup>
Examination	22	58.46	Positive	26	67.09	Opportunity	7	72.74	Valorize	19	123.28	Follow	32	85.73
Doctor (female)	22	28.82	Negative	23	59.70	Unburden	8	72.34	I observe	13	88.20	Treatment	37	70.65
Said	19	27.64	Lack	17	41.59	Group	5	41.36	Look	18	76.61	I question	21	55.41
Doctor (male)	14	27.49	Can	17	38.69	Speak	16	19.89	Attention	24	63.67	I have	49	52.27
Conversation	28	26.05	Pleases	10	29.27	Space	7	16.30	Pay attention	12	60.62	Doubts	30	49.97
Result	13	21.94	Aspect	8	27.13	Listen	5	13.30	Value	5	33.07	I follow	14	39.08
Asked	7	19.11	Structure	9	25.81	People	13	12.10	See	12	30.24	I seek	20	35.21
CD4 and viral load	7	19.11	I see	13	25.67	Know	10	10.18	Attentive	5	25.97	Take	14	34.66
Name	8	17.75	User	7	23.66				Confidence	5	25.97	Health	13	28.02
Attended	28	16.71	Public	8	22.39				Expression	5	25.97	Live	11	26.09
I hope	16	15.23	Facility	11	22.16				Manner	5	25.97	Difficulty	18	25.53
Infectologist	7	15.03	Hospital	15	17.29				Professional	20	21.49	Guidance	8	21.91
Felt	7	15.03	Care	26	16.72				Fundamental	8	19.63	Comprehension	8	21.91
Pediatrics	6	12.34	Dissatisfies	9	16.08				Understand	9	18.55	I do	7	15.02
Expectation	7	11.93	Should	9	16.08				I respect	6	14.54	Die	8	14.49
Calm	8	11.88	Place	6	12.34				Comprehension	5	14.34	Drink	5	13.56
												I ask	16	10.27

**FIGURE 2.** PROFILE OF THE CLASSES IDENTIFIED USING ALCESTE ANALYSIS. DESCENDING HIERARCHICAL CLASSIFICATION BY ORDER OF FREQUENCY OF THE TEXTUAL MATERIAL OF INTERVIEWS WITH SAE PATIENTS (N = 34). NATAL, BRAZIL, 2005.