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COMMUNICATION AS A COMPONENT OF QUALITY IN HOSPITAL SERVICES: A PATIENT-USER PERSPECTIVE

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Abstract: Communication in the healthcare setting is essential to promote interaction with patients throughout the care journey. Always present in the therapeutic setting, its relevance is due to the numerous barriers imposed by information asymmetry and language limitations, aggravated by the complexity of the hospital environment, where the flow of communication is transversal, present in interpersonal relationships, in physical evidence and in the available technological and administrative resources. This study sought to identify, from the patient's perspective, the influence of communication on the assessment of perceived quality. A qualitative, descriptive exploratory study was conducted through documentary and bibliographic analysis and semi-structured interviews. The results showed a strong influence of dialogical communication present in the relationship between healthcare agents and patients, with emphasis on the greater relevance of behavioral issues related to empathy and effective communication, compared to technical issues associated with professional practice, highlighting the importance of improving therapeutic communication and the opportunities for implementing new communication channels that support the communicative practices already present in the hospital context.
Keywords: Health communication; Hospital communication; Health quality.

INTRODUCTION

The relevance of communication in the context of health has already been widely discussed in the literature, in its most varied contexts, forms and objectives. In this sense, this study contributes to the theme by bringing an exclusive perspective of the patient regarding the influence of communication in the hospital environment, allowing a better understanding of it as a component of quality from this angle of care.

Always present in the care activity, conveying conscious and unconscious content, whose meaning is directly related to the context in which it occurs1, communication is not limited to sharing information, it represents understanding the other, it is like a creative act based on the invention of new knowledge[2].

The theme of communication has been explored by health sciences in the search for strategies that strengthen relationships of exchange, information, treatment and dialogue between professionals (health agents) and the population assisted.[3]. Therefore, it is necessary to take into consideration, the numerous barriers imposed by the asymmetry of information, language limitations, level of intellectual development and socio-cultural differences of the various actors in the health service. These barriers are aggravated by the flow of transversal communication in the hospital environment, present not only in interpersonal relationships, but also in physical evidence that somehow interferes with the health status of patients, whether for guidance, prevention and adherence to treatment or continuity of care outside the hospital environment.[4].

From this perspective, it is important to consider the relevant role of the health professional, their communication skills and potential ability to significantly influence patients' assessment of the quality of health services provided.

Several communication models have been experienced in health practices. Models that reinforce several paradigms linked to the imposition of behaviors and the transfer of information, addressing the need to build more horizontal practices where the use of appropriate techniques, tools and channels contribute to the construction of more effective communication, essential for evaluating the services offered by the hospital institution[5]. The most widely used communication paradigm in health practices is Lasswell's hypodermic theory. (1971)[1] which represents a simple and linear structure where it is believed that the mere communicative act (sending the message) properly planned, upon contact with the patient (receiver), will promote exactly the desired effect. However, it is known that this simplistic theory implies ignoring the stage of interpretation of the message by the recipient, leading to failures in the effectiveness of communication and consequently, in care[6].

It is known that communication is a process of social interaction and languages that goes beyond the exchange of information between agents and patients through dialogical communication, especially because in the service environment, given its intangible characteristic, it is necessary to reduce uncertainties and, to this end, it is common for customers (in this context, patients) to look for signs or evidence of service quality in the facilities, people, equipment, communication material, symbols and even prices[7].

The motivation and justification for studying this topic are related to the collective factor that involves the health care process, which occurs through the intervention of various components, including communication components, and at their various points of contact, highlighting the direct influence that personal experiences, beliefs, values and habits experienced by all actors who participate in the care process cause in communication processes in the hospital environment.[8].

GOALS

Based on the premise that the institutional communication pattern adopted in a hospital organization, through its various means, can contribute directly or indirectly to the quality of care provided, just as the communication tools used can support dialogic communication and complement the care activity, this study addresses the theme of communication in the hospitalization process with the following objectives:

GENERAL GOAL

Identify the patient's perception regarding the communication elements used in the hospital organization that can influence the quality of services provided during hospitalization.

SPECIFIC GOALS

a) Know the communication components that influence the perception of the quality of care provided to patients in the hospital environment;

b) Identify which communication elements can be implemented or improved to contribute to improving the patient's experience

METHOD

This is an applied research with a qualitative, descriptive, exploratory approach, using documentary and bibliographical research methods and semi-structured interviews, carried out in a large private hospital in the capital of São Paulo. The participants' discourse was used as a source of information for the analysis of the relational concept between communication and quality in hospital services, focusing only on communication

1. LASSWELL, H. The structure and function of communication in society, 1971

directed to the patient in the care process.

Authorization was obtained from the participating hospital to conduct the research through the signing of the Institutional Authorization Form, as well as approval from the Research Ethics Committee (CEP) of the institution, duly registered with the National Research Ethics Committee (CONEP) linked to the National Health Council (CNS), under number CAAE 47133221.3.0000.5450.

Participants were selected using a simple random sampling model. In the end, 28 patients aged between 18 and 79 years old who had been hospitalized clinically or surgically (except for cases of Covid-19) between January and June 2021 and who had reported some kind of complaint to the ombudsman department during or after said hospitalization period were selected.

The documentary analysis involved the institution's records present in the ombudsman reports for the years 2020 and 2021, the review of which highlighted the recurring presence of reasons related to the various communication elements contained in the provision of services, validating this research proposal.

The interviews followed a script structured in 4 thematic axes, which allowed segmenting and directing the data collection to meet the proposed objectives, as described in Table 1.

Thematic Axes	1	Understanding the theme of "quality"	- theme definition - experience
	2	Positioning and image of the institution	- knowledge - reputation
	3	General service experience mapping	- service - information - infrastructure
	4	Communication strategy	- pattern - channels - materials

Table 1: Structure of the instrument - Interview script

For thematic analysis of the axes, the content analysis technique based on Bardin was applied[9], where the analytical procedure involved the selection of each recording unit identified by reading the interviewees' statements and subsequently ordering them by classification into categories and subcategories.

The data obtained were analyzed based on the description of absolute and relative frequencies belonging to each subcategory. The categories and subcategories were defined based on the axes established in the interview script and the interviewees' statements by reading and classifying the respective recording units and analyzing the occurrences (frequency) and subsequent interpretation of the meanings in each of the axes studied. In the selection of the selections, the context units were grouped by similarity of meaning using complete sentences to better understand the meaning of the speech. For enumeration, the frequency of appearance of each duly grouped recording unit was considered. As for the initial categorization, the semantic criterion (by thematic axis) was used, referencing the origin of the elements with the inclusion of the questions from the semi-structured script. Following the proposed structure, the 4 thematic axes studied were analyzed according to the corresponding categorization.

RESULTS

The majority of the sample was female (79%) and interviewees aged between 60 and 79 years (39%), which is equivalent to the prevalent profile of patients treated at the hospital.

Among the results obtained, it was identified that for most patients, the concept of "quality in health" does not have a clear and concrete definition and is directly related to emotional and affective factors present in the care process, showing itself to be in line with the literature regarding the difficulty of the patient/user of the health service to define

the concept of quality in an objective and direct way. In this sense, it is understood that the issue of subjectivity may be related to the vulnerability and emotional conditions that involve the individual in the search for health care.

In the context of the general evaluation of services, whether positive or negative, assistance services have a significant participation, with emphasis on the "teams" component, related to the performance of the medical and nursing teams with greater weight in the negative evaluations. This data confirms the relevance of the role of healthcare teams throughout the entire care journey and their influence on the patient's quality assessment process.

The results also showed that a low level of knowledge about the healthcare organization does not influence the quality perceived by the patient. It was observed that the lack of a position in the user's mind (reputation) does not affect the perception of the quality of services.

As for aspects related to the hospital's infrastructure, it was concluded that a positive assessment of the topic, indicating great satisfaction on the part of users, suggests that the infrastructure is also capable of positively communicating the institution's attributes, contributing to the perception of overall quality.

> "The quality was very good […] the room is of a very good standard, the bathroom, the hospital facilities in general […] the facilities are very good" (E23)

> "There are a thousand, there is no doubt about that. The operating rooms […] there are a thousand, not ten, there are a thousand […] the structure is first world". (E27)

It was shown that the performance of teams in their communicational manifestations is one of the factors that most influences quality in the general context of hospital unit services. Teams represented respectively by nursing (40%), medical teams (25%), general care (25%) and reception (10%), where it is worth considering that the broad participation of the nursing team in the analysis of this theme may be related to the fact that the patient spends most of the time in the hospitalization process under the care of these professionals.

> "So, what makes the difference in you is people, […] what makes me understand that I was well attended to was the care provided by the nurses." (E4)

> "I think it's the human factor, the human factor combined with the infrastructure. Definitely, the human factor." (E28)

When asked about their relationship with the teams, it was possible to identify that the patient personifies the care using personal adjectives, which attribute positive characteristics to the people and not to the services. Almost half of the respondents mentioned some positive attribute related to the behavior of the professionals and it was possible to observe that the issue of technique or professional capacity is not more relevant than the behavioral issues related to empathy and effective communication.

A positive experience with the care teams may indicate that a more personal and closer relationship with the patients is capable of establishing more efficient communication that can positively influence the perception of the quality of the services as a whole.

Although the majority of patients confirm the influence of communication in their assessment of quality, the minority deals with the topic objectively with regard to possible improvements, pointing to the need to realign communication with families, information on the status of the care and the relationship with the medical teams. In all three approaches it is clear that improving therapeutic communication is necessary, as well as reducing communication barriers. The results

indicate that patients need information, and to this end, it is interesting to implement new communication channels that are capable of transmitting information related to care using technologies that can assist the flow of information between the hospital, the patient and the families, reducing the dependence on dialogic communication through appropriate, safe and efficient tools.

DISCUSSION

COMMUNICATION CHALLENGES IN THE HOSPITAL ENVIRONMENT

In the hospital environment, there is a constant need for teams of professionals, especially nursing professionals, to meet patients' demands for information, whether to learn about diagnostic procedures or therapies to which they will be subjected, to facilitate adaptations to clinical situations, to alleviate anxiety regarding painful procedures, or to modify risky habits or promote adherence to short- and long-term treatments.[10].

In this sense, it is worth highlighting that in all relationships established in the hospital environment, as well as in other health sectors, communication must focus on empathy, where listening and time are elements of attention to the sender, regardless of the affective state and cognitive functioning of the receiver. It is the responsibility of the health agent to make the message effective for the recipient, through the dialogical model of communication and also through non-verbal interactions (eye contact, posture, etc.). Interpersonal communication – verbal and non-verbal – is a fundamental skill to be acquired to enable excellence in care[11]. It is important to avoid one-way practices, the use of inaccessible language, poor listening, or the imposition of orders and denial of the other's perception. [12]

Communication barriers are inherent to any communication process, especially in the hospital environment. It can be said that failures in communication processes originate, most of the time, from the lack of a well-defined internal communication strategy in the organizational communication policy.

In other words, a communication culture needs to be established in the organization, making communication an asset valued by senior management to support relationships with internal and external audiences.

Communication always aims for consensus, common understanding, and is based on an active and peaceful exchange of information between participants. Consensus refers to the possibility of producing understanding through dialogue, through everyday acts that occur in personal relationships. According to the National Humanization Policy (PNH), communication is a strategic competence for management committed to the humanization of care. Dialogue capable of promoting consensus or common understanding is that portrayed in the encounter between two or more subjects, who, even with different capitals, have their speech recognized as valid. In a dialogue, the objective is not the simple and immediate agreement of opinions, but rather the recognition of both speeches, the ability to accept or disagree, since they are based on valid arguments. This same principle applies to all relationships in the hospital environment, health agents and patients, as well as employees and management[13].

For a dialogic encounter to occur, it is essential that there is harmony between sender and receiver through a language that awakens similar senses and meanings for both. It is necessary to break the paradigm that one individual is the holder of knowledge and the other, the being who must be "taught" or "led""[14]. To meet the needs of the hospital environment, it is necessary to establish a communication model in which the relationship ceases to be merely informative

and one-way, and incorporates the bilateral aspects of the process, the equality of conditions and functions established between the interlocutors. In this model, the emphasis is placed on the nature of the relationship between the two poles, erasing or ignoring the other aspects of the process, including the nature of the messages and the meanings produced.[15]. Reducing the asymmetry between the parties and practicing empathy are fundamental to reducing the communication barriers described in table 2 below:

Barrier	Description
Limitation of the sender and/or receiver	When there is no understanding of the message or stimulus emitted due to problems of an organic nature, hearing, memory, attention or reasoning;
Presupposition of understanding	When the sender (person providing guidance) believes that the message has been understood and does not provide further explanations on the subject addressed;
Imposition of value scheme	When there is no respect for the patient's beliefs and values;
Absence of common meaning	When the sender's language is not understood by the patient;
Influence of unconscious mechanisms	When the patient denies his illness, believing himself to be healthy;

Table 2: Communication Barriers in the Healthcare Environment

Source: Adapted from DELL'ACQUA *et al* 1997

PERSPECTIVE FOR BEST PRACTICES IN HEALTH COMMUNICATION

It was possible to identify that the concept of quality defined by the interviewees is based on generic and subjective criteria that do not concern material components such as equipment or infrastructure, but rather the emotional components present in care, linked to the attention and empathy of the teams. For most patients, the elements that define quality are directly related to the performance of the health teams (doctors and nurses), making their participation, both technical and especially relational, highly relevant throughout the care journey, corroborating the idea that the team-patient relationship can be defined as the anchor point for the entire care process.[16]. Considering that the patient's perception of services, whether positive or negative, is formed most of the time based on their experience with relational issues, where the medical and nursing teams assume an even more relevant role in the context of the quality offered. It can be concluded that the individuals who evaluated the hospital positively received a quality service, where quality for them, according to recorded reports, is summarized in the attention provided by the care teams, with greater emphasis on the nursing teams. In this sense, investments in the development of behavioral skills focused on reception and communication can support the practice of care and, consequently, the quality perceived by the patient.

In healthcare, the tools of the communication mix are primarily based on interpersonal relationships, where communication is considered a fundamental clinical skill that must be established efficiently to create a relationship of trust between the patient and the teams in favor of therapeutic and humanized care[17].

The findings of this study reinforce the theory that interpersonal communication skills and the effects produced on the patient can be considered components of a marketing strategy focused on differentiation, which is increasingly sought by healthcare organizations in a highly regulated and competitive market. It is important to highlight that communication within the healthcare system, especially in the hospital context, occurs in a complex environment, involving both favorable and adverse factors, and it is necessary for the actors involved in the care process to develop the capacity for expression,

psychological control and perception of the environment in order to establish an effective communication pattern[18].

It is understood that in a general context, dialogic communication (and its relational elements) is the component of the care journey that most influences the perception of service quality by patients, followed by the infrastructure elements that reinforce the communication of comfort and safety. Thus, it is concluded that the quality of interpersonal relationships in the health context continues to be strategically essential for institutions that seek to have the quality of their services recognized.

Every intervention resulting from clinical care and medical decision encompasses different dimensions, with emphasis on the physical and communicational dimensions, which, when practiced together, make it clear that the quality of care and treatment is not only the result of the application of scientific technical knowledge and material conditions, but also of the use of relational practices (interaction and communication), which was observed in the findings of the present research.[19]

The results confirm that improving relational communication skills on the part of health agents is an essential path in the search for quality, showing that more than technical interventions, the interactions present in therapeutic communication help the patient to overcome the adversities of hospitalization and promote better health outcomes, understanding therapeutic communication as communication that, in addition to informing, calms, welcomes and engages the patient in the process of caring for their health.

Healthcare institutions have taken on the challenge of improving the quality of care and services offered to patients because quality of care has become an essential criterion in evaluating the performance of institutions worldwide[20]. It is important to highlight that patient participation in this quality building process is increasingly evident and necessary.

Finally, it is worth noting that an important finding of this study reflects not only the influence of communication on perceived quality of care, but also, indirectly, its contribution to more effective and long-lasting care, making processes more efficient, optimizing hospitalization time, reducing waste of resources (human and material) and thus promoting the sustainability of healthcare businesses.

FINAL CONSIDERATIONS

During the process of illness and hospitalization, the patient feels fragile, insecure, and afraid. However, it is still common to observe in health practices that care is essentially focused on the disease and not on the individual. Despite being a widely studied topic in Brazil and around the world, the topic of "communication" still seems to be neglected by health institutions, whether in the context of care transition, in the exchange between health teams, and especially in the interaction with the patient throughout the care process. Advances in science and technology increasingly contribute material resources to improve care, expanding the possibilities of more positive health outcomes. However, it is important to highlight that technology also brings the risk of reducing the bonds between health professionals and patients. Bonds that are sustained by the practice of effective communication, where empathy and interest in others are present. There is still a long way to go towards the evolution of human behavior regarding communication aspects in the health field. It is concluded that the construction of solid and trustworthy interpersonal relationships in care practices is strategically essential for the provision of more complete care, the quality of which can be easily perceived by patients.

LIMITATIONS AND FUTURE STUDIES

One of the limitations of this research is that the participating institution belongs to a business group and most of the patients interviewed have a business relationship with the health insurance company that maintains the hospital. This relationship can confuse or lead to misinterpretations and assessments, since participants are unable to separate the operation of the health insurance plan from the specific activities of the hospital, often leading to confusion regarding the responsibility of each party in the care process.

In addition, the fact that the health insurance company provides access to few hospitals can also weaken the participant, who has little power of choice, thus configuring a relationship of dependence with the hospital under study, which can inhibit the participant from responding openly or, even, not motivate him/her to contribute effectively to this type of study.

This study also found a limitation related to the cognitive profile of respondents over the age of 60 (39%), who presented a low understanding of the dimensions studied and, consequently, a significant number of responses that were not pertinent to the questions on the axes analyzed.

The research conducted is qualitative, with a small group of participants, therefore not allowing generalizations. However, the study provides support for the design of other studies that can explore in more details, the issues that were raised here in this document.

To better understand the theme of communication in the hospital environment and justify the direction of improvement actions by institutions with regard to instruments to support dialogic communication, it is recommended that complementary research be conducted with the objective of studying in more detail the influence of each communication component in the construction of quality. Such research can be carried out through a control group experiment, where one group would be subjected to the use of communication technology tools and material resources that support and complement dialogic communication in the transmission of health information and the other group would not, in order to confirm the effectiveness (or not) of the use of new communication tools.

To validate the results found, it is suggested that this study be replicated in other hospital institutions with different profiles for a new collection and analysis of data, independently. Furthermore, it is important to consider reapplication especially at another time, post-pandemic, to ensure that new results are obtained without the influence of the effects of the pandemic on the population's health-related behavior.

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