The Qualitative Report

Volume 9 | Number 4 Article 7

12-1-2004

# The Relationship between Health Professionals and the Elderly Patient Facing Drug Prescription: A Qualitative Approach

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## Recommended APA Citation

Lefevre, F., Teixeira, J. J., Lefevre, A. M., Cardozo de Castro, L. L., & Witt de Pinho Spínola, A. (2004). The Relationship between Health Professionals and the Elderly Patient Facing Drug Prescription: A Qualitative Approach. *The Qualitative Report*, *9*(4), 706-731. https://doi.org/10.46743/2160-3715/2004.1910

# The Relationship between Health Professionals and the Elderly Patient Facing Drug Prescription: A Qualitative Approach

## Abstract

Aiming at identifying the relationship between the elderly patient facing drug prescription and health professionals, an exploratory and descriptive study of a qualitative cut was carried out using semi-structured interviews. To this end, the Collective Subject Discourse analysis technique was employed. Thirty elderly patients living in the urban area of Maring (Paran State, Brazil) were sampled. They were interviewed from February 25 to March 22, 1998 and selected from the Co-participatory pharmacy database of the Department of Pharmacy and Pharmacology, Universidade Estadual de Maring . The finding supplied eleven central Collective Subject ideas, with different discourses. The rich material provided by the study allows better understanding of the factual reality of the elderly facing drug prescription and their relationship with health professionals.

## Keywords

Drug Prescription, Health Professionals, Elderly, Relationship, and Qualitative Methodology



## Acknowledgements

The authors would like to express their thanks to the Foundation for Research Support in the State of São Paulo (FAPESP) , Brazil, for all the support and incentive provided for this research, according to processes nos. 97/08836-6 and 98/01020-3; to Dr. Lygia Iversson Buch, for her precious suggestions and revision.

*The Qualtiative Report* Voulme 9 Number 4 December 2004 706-731
http://www.nova.edu/ssss/QR/QR9-4/lefevre.pdf

# The Relationship between Health Professionals and the Elderly Patient Facing Drug Prescription: A Qualitative Approach.

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*Aiming at identifying the relationship between the elderly patient facing drug prescription and health professionals, an exploratory and descriptive study of a qualitative cut was carried out using semi-structured interviews. To this end, the Collective Subject Discourse analysis technique was employed. Thirty elderly patients living in the urban area of Maringá (Paraná State, Brazil) were sampled. They were interviewed from February 25 to March 22, 1998 and selected from the Co-participatory pharmacy database of the Department of Pharmacy and Pharmacology, Universidade Estadual de Maringá. The finding supplied eleven central Collective Subject ideas, with different discourses. The rich material provided by the study allows better understanding of the factual reality of the elderly facing drug prescription and their relationship with health professionals. Key Words: Drug Prescription, Health Professionals, Elderly, Relationship, and Qualitative Methodology*

## Introduction

Aging in a healthy way is a great challenge for human beings. During this process, a series of non-infectious chronic diseases develop. The search for long-term hospital beds increase. There is a quantitative growth in drug consumption and, as a consequence, the side effects and negative aspects related to the pharmacokinetics and pharmacodynamics of the aged. The elderly are already the largest users of pharmaceuticals, receiving 30-35% of all written prescriptions (Baum, Kennedy, & Forbes, 1984; Okuno et al., 1999; Piraino, 1995). The heavy drug expenses of this age

group are not only strongly related to its absolute growth, but also to its inappropriate use of medications. The latter has come to be a public health concern on account of its prevalence and potential impact on patient autonomy (Damestoy, Collin, & Lalande, 1999).

According to Williams, Weinman, and Dale (1998), there is an increasing concern for comprehending the relation the elderly patient holds with the drug therapy prescribed. The relationship between doctor and patient has been shown to be an important factor in patient satisfaction. At the same time, Britten, Stevenson, Barry, Barber, and Bradley (2000) reinforce the idea that the patients' participation should be assured in the consultation, alerting to the important adverse consequences resultant from the lack of it. One would surely be closer to achieving a better result if both the process of producing/processing information about medical drugs and the interaction among prescriber, dispenser, and patient had been previously attained (Pepe & Castro, 2000).

Taking into account the complexity of pharmacological therapy and its implications, both the decision-making process and the administration of drug therapy should be a collaborative interdisciplinary series of actions carried out among physicians, pharmacists, patients, and a variety of other professionals with relevant health care experience (Webb, 1995). Information concerning drug therapy should be provided in a clear way so that the whole process might be totally understood by the patient and his caretaker. These ideas reinforce the arguments favoring a kind of negotiation that should be established between physician and patient in an effort to get the latter to understand the reasons why each therapy should be followed. This negotiation could benefit both sides, in so far as it could lead to a mutual agreement on the treatment to be administered (Verbeek-Heida, 1993).

The elderly and younger people have different degrees of understanding in respect of drug therapy. Therefore, it is necessary to search for indications in the meaning of their discourse that would lead to the planning of interdisciplinary programs; which would contemplate, in a sensible way, this difficult public health question. The objective of the present study was to identify the elderly patient/health professional relationship concerning drug prescription.

## Patients and Methods

An exploratory and descriptive study was developed. Qualitative methodology was used to carry out an in depth search for the essence of the language of the interviewees. For Murphy, Dingwall, Greatbatch, Parker, and Watson (1998), the reason underlying this choice concerns the fact that qualitative research may be useful in illuminating the factors which sustain professional practices that have been shown to be ineffective, inappropriate or harmful in healthcare settings.

The intentional sample consisted of 30 patients selected from the Co-participatory Pharmacy database of the Department of Pharmacy and Pharmacology, Universidade Estadual de Maringá, Maringá, Paraná State, Brazil. The Co-participatory Pharmacy serves the needy that require medicines, but cannot pay for them. It is run by professors responsible for the Pharmacy department internship program and their students. Site choice was due to the quality of the pharmaceutical assistance work that is developed by the professionals who act in this establishment. Patients receive medicine only via

medical prescription. All medicines have been donated (most are free samples). A record of all patients who use the service is kept to accompany their cases. The objective is to maintain the optimum benefit of the therapeutics and, consequently, vigilance and pharmacological accompaniment.

The population consisted of male and female patients at least 60 years old who were under medical treatment and had been using more than one medicine for at least 1 year. The justification for this is familiarity with the medicine and contact with health professionals. According to Lefèvre (1989), this is important because the medicine is part of the daily life of these patients.

Risk criteria were used to justify the choice of patients (i.e., those possessing a medically diagnosed disease and using more than one medically prescribed medicine). After selection, the subjects were contacted by telephone or in person and the relevance of the research was explained. After contacting the patients and getting their agreement to participate in the research, an interview was scheduled.

The interviews were developed in the residence of the participants and applied by the researchers (trained in pharmaceutical sciences) themselves. Data collection using semi-structured interviews was carried out from February 25 to March 23, 1998. The discourses were recorded on a micro-tape recorder using 60-minute magnetic tapes.

## Ethical Considerations

The moment that preceded each interview was very casual in the sense of allowing maximum freedom and integration between the researcher and the researched. Before the starting of each interview, the objective of the study was made very clear. Soon afterward, the candidates had the terms of the free consent agreement explained and were asked about their desire to participate in the research. Not one (interviewed individually) refused. Even so, they were informed that their non-participation in the study would not harm them or their access to medical services.

The participants were told that the information that they supplied would not affect in any way their relationship with the health services (i.e., the physician or other professional, continuity of consultations, carrying out of treatment, surgery, new exams, acquisition of medicines, or any other type of treatment). At the same time, total freedom was given to the interviewees in the sense that they could interrupt the interview at any moment without prejudicing themselves. This occurred right before the interviews. It was emphasized that the interview answers would only be used for this research. Total secrecy and anonymity was guaranteed to the subjects who agreed to participate in this study. The criteria used obeyed resolution 196/96 of National Health Council regarding research involving human beings.

All personal data ought to be secured or concealed and made public only behind a shield of anonymity. Professional etiquette uniformly concurs that no one deserves harm or embarrassment as a result of insensitive research practices (Christians, 2000, p. 139). Ethical issues are present in any kind of research. Much discussion of the ethics of qualitative research focuses upon the appropriateness of applying ethical codes that originated in biomedicine to social scientific research in particular (Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998).

Orb, Eisenhauver, and Wynaden (2001) assert that the research process creates tension between the aims of research to make generalizations for the good of others and the rights of participants to maintain their privacy. Ethics pertains to doing good and avoiding harm. Harm can be prevented or reduced through the application of appropriate ethical principles. Thus, the protection of human subjects or participants in any research study is imperative. In addition, Batchelor and Brigs (1994) describe that the deficiency of the researchers in dealing with ethical questions has resulted in researchers who are unprepared to deal with the unpredictable nature of qualitative researches.

## Data Analysis

The collective subject discourse analysis technique (Simioni, Lefèvre, & Pereira, 1997; Lefèvre & Lefèvre, 2000) was employed for data handling, using three methodological figures: the *Central Idea*, the *Key Expressions,* and the *Collective Subject Discourse.* According to the proponents of this methodology, the *Central Idea* (CI) is a synthesis of the subjects' explicit discursive content. Therefore, it is found in the statements, denials, and doubts concerning factual reality, as well as in the value judgments related to the institutional reality or social context in which the subjects are involved. The *Key Expressions* (KE) refer to the selected excerpts taken from the discourses that illustrate the CI. The literalness of the statement should be recovered here. This search is fundamental because through it the reader is able to judge the pertinence or non-pertinence of the way found to discursively translate the CI. For the authors, the KE are a kind of an "empirical-discursive evidence" of the "truths" the CI contains.

The *Collective Subject Discourse* (CSD) analysis is a methodological strategy that aims at providing more clarity to a given social representation. It is a discursive form of dealing with, and presenting, the statements that constitute the substratum of a given social representation. The CSD consists of assembling, into a single discourse-synthesis, the various individual discourses expressed as an answer to the same research question by subjects who are socially and institutionally equivalent or who take part in the same organizational culture or homogeneous social group, in so far as the individuals who are part of this group occupy the same or neighboring positions in a given social field. The CSD is thus a way to directly express the social representation of a given social subject.

*1st Phase*: Before starting data transcription, the tapes were listened to several times in order to get a panoramic idea and, consequently, a better comprehension of the texts. Next, the discourses were transcribed word for word using word processing software.

*2nd Phase*: An instrument for discourse analysis (IDA1) was used with a view to recovering the individual social representations, particularly for each one of the questions proposed in the interview script. This instrument describes the CI that the subjects presented in their discourses, as well as the KE for each answer to a given interview question.

*3rd Phase*: Next, all the CI and KE related to the same answers each subject had given to a certain interview question, were listed in a single instrument for discourse analysis (IDA2), paying special attention to totally retrieve the literalness of the subjects under study.

*4th Phase*: The next step, using the instrument for discourse analysis IDA3, was discourse-synthesis (i.e., the Collective Subject Discourse, CSD), which consisted of a transformation of and reduction in several CI and KE lists into just one discourse; as if there existed only a single individual speaking, a discourse-synthesis spokesman for all the individuals composing a given collective subject.

The instrument for discourse analysis (IDA) is nothing more than a resource to help organize and construct the final discourse according to the example below:

**Instrument for Discourse Analysis (IAD1)**

*Question 1*: Did you ever take any drug in a greater or lesser dose than the prescribed one?

Table 1

*Central Idea*

| |
|---|
| Patient 2 - I've always taken what he's prescribed. |
| Patient 6 - I take only one dose. |
| Patient 7 - No. |
| Patient 8 - Only the prescribed dose. |
| Patient 9 - Only the dose prescribed by the doctor. |
| Patient 11 - I always take the same dose. |
| Patient 14 – I always take the right dose. |
| Patient 16 - I always take it the way the doctor tells me. |
| Patient 17 - I always take the dose they tell me to take. |
| Patient 18 - Never. |
| Patient 19 - I take the dose that the doctor prescribes. |
| Patient 20 - I've never needed to. |
| Patient 21 - No. |
| Patient 23 - I don't increase or decrease it. |
| Patient 25 - No, I always take the correct amount. |
| Patient 26 - No. |
| Patient 29 - I've never needed to. |
| Patient 30 - Never. |

Table 2

*Key Expressions*

| |
|---|
| Patient 2 - I've always taken what he's prescribed... It has to be the right dose. |
| Patient 6 - Since I started dealing with the doctor... I take only one dose. |
| Patient 7 - No, no... |
| Patient 8 - No... only the prescribed dose. |
| Patient 9 - No, only the dose prescribed by the doctor |
| Patient 11 - No, I always take the same dose. If I need to, I'm not going to do it on my own, right? If there's a problem, I have to go to the doctor's. |
| Patient 14 – Oh, no. I always take the right dose; never more, never less than the |

| |
|---|
| prescribed amount.<br>Patient 16 - I always take it the way the doctor tells me. I don't do that.<br>Patient 17 - No, because I don't take medicine... only the dose they tell me to take, right?<br>Patient 18 - No, never, thank God.<br>Patient 19 - I never increase it... I don't decrease it either... I take the dose that the doctor prescribes.<br>Patient 20 - I've never needed to.<br>Patient 21 - No, I've never taken a dose different from what the doctor told me to take.<br>Patient 23 - No... I don't increase or decrease it...<br>Patient 25 - No, I always take the correct amount... the dose that the doctor tells me to take, right, pharmacist, everything. I'm very afraid.<br>Patient 26 - No. One day I had my pressure taken here at the health center... She said 'Your pressure is 80/60...' But it's not possible... My pressure is always above 140. I spoke with my husband; he takes me to the pharmacy. He took it again and it was 140/80... Then I said 'See! If I were to stop taking the medicine.'<br>Patient 29 - I've never needed to thank God. I'm afraid of kicking the bucket.<br>Patient 30 - Never, only what he tells me to do. I don't know how to read, but my daughter does. |

**Instrument for Discourse Analysis (IAD2)**

*Question 2:* Did you ever take any drug in a greater or lesser dose than the prescribed one?

Table 3

*Comparative Methodological Figures*

| **Central Idea** | **Key Expressions** |
|---|---|
| Patient 2 - I've always taken what he's prescribed. | Patient 2 - I've always taken what he's prescribed... It has to be the right dose. |
| Patient 6 - I take only one dose. | Patient 6 - Since I started dealing with the doctor... I take only one dose. |
| Patient 7 - No. | Patient 7 - No, no... |
| Patient 8 - Only the prescribed dose. | Patient 8 - No... only the prescribed dose. |
| Patient 9 - Only the dose prescribed by the doctor. | Patient 9 - No, only the dose prescribed by the doctor. |
| Patient 11 - I always take the same dose. | Patient 11 - No, I always take the same dose. If I need to, I'm not going to do it on my own, right? If there's a problem, I have to go to the doctor's. |
| Patient 14 – I always take the right dose. | Patient 14 – Oh, no. I always take the right dose; never more, never less than the prescribed amount. |
| Patient 16 - I always take it the way the doctor tells me. | Patient 16 - I always take it the way the |
| Patient 17 - I always take the dose they tell me to take. | |

| | |
|---|---|
| Patient 18 - Never.<br>Patient 19 - I take the dose that the doctor prescribes.<br>Patient 20 - I've never needed to.<br>Patient 21 - No.<br><br>Patient 23 - I don't increase or decrease it.<br>Patient 25 - No, I always take the correct amount.<br><br>Patient 26 - No.<br><br><br><br><br>Patient 29 - I've never needed to.<br><br>Patient 30 - Never. | doctor tells me. I don't do that.<br>Patient 17 - No, because I don't take medicine... only the dose they tell me to take, right?<br>Patient 18 - No, never, thank God.<br>Patient 19 - I never increase it... I don't decrease it either... I take the dose that the doctor prescribes.<br>Patient 20 - I've never needed to.<br>Patient 21 - No, I've never taken a dose different from what the doctor told me to take.<br>Patient 23 - No... I don't increase or decrease it...<br>Patient 25 - No, I always take the correct amount... the dose that the doctor tells me to take, right, pharmacist, everything. I'm very afraid.<br>Patient 26 – No. One day I had my pressure taken here at the health center... She said 'Your pressure is 80/60... But it's not possible... My pressure is always above 140…I spoke with my husband; he takes me to the pharmacy. He took it again and it was 140/80... Then I said 'See! If I were to stop taking the medicine.'<br>Patient 29 - I've never needed to thank God. I'm afraid of kicking the bucket.<br>Patient 30 - Never, only what he tells me to do. I don't know how to read, but my daughter does. |

**Instrument for Discourse Analysis (IAD3)**

*Question 2***:** Did you ever take any drug in a greater or lesser dose than the prescribed one?

Table 4

*Collective Subject Discourse*

| **Central Idea Synthesis** | **Collective Subject Discourse (CSD)** |
|---|---|
| Only the prescribed dose. | I've always taken the dose that the doctor has told me to take, right, pharmacist, everything. I never take more or less than the prescribed amount. I've never needed a different |

| | |
|---|---|
| | dose, thank God. If I need to, I'm not going to do it on my own, right? If there's a problem, I'm very afraid of kicking the bucket. I have to go to the doctor's. Since I started dealing with the doctor, this is my dose, it has to be the right dose. |
| **Individual Central Ideas** | **Individual Key Expressions** |
| E.2 I've always taken what he's prescribed. | I've always taken what he's prescribed... It has to be the right dose. |
| E.6 I take only one dose. | Since I started dealing with the doctor... I take only one dose. |
| E.7 No. | No, no... |
| E.8 Only the prescribed dose. | No... only the prescribed dose. |
| E.9 Only the dose prescribed by the doctor. | No, only the dose prescribed by the doctor. |
| E.11 I always take the same dose. | No, I always take the same dose. If I need to, I'm not going to do it on my own, right? If there's a problem, I have to go to the doctor's. |
| E.14 I always take the right dose. | Oh, no. I always take the right dose; never more, never less than the prescribed amount. |
| E.16 I always take it the way the doctor tells me. | I always take it the way the doctor tells me. I don't do that. |
| E.17 I always take the dose they tell me to take. | No, because I don't take medicine... only the dose they tell me to take, right? |
| E.18 Never. | No, never, thank God. |
| E.19 I take the dose that the doctor prescribes. | I never increase it... I don't decrease it either... I take the dose that the doctor prescribes. |
| E.20 I've never needed to. | No, I've never needed to. |
| E.21 No. | No, I've never taken a dose different from what the doctor told me to take. |
| E.23 I don't increase or decrease it. | No... I don't increase or decrease it... |
| E.25 No, I always take the correct amount. | No, I always take the correct amount... the dose that the doctor tells me to take, right, with the pharmacist, everything. I'm very afraid. |
| E.26 No. | No. One day I had my pressure taken here at the health center... She said 'Your pressure is 80/60...' But it's not possible... My pressure is always above 140... I spoke with my husband; he |

| | |
|---|---|
| | takes me to the pharmacy. He took it again and it was 140/80... Then I said 'See! If I were to stop taking the medicine'. |
| E.29 I've never needed to. | I've never needed to, thank God. I'm afraid of kicking the bucket. |
| E.30 Never. | Never, only what he tells me to do. I don't know how to read, but my daughter does. |

**Five Questions that Formed the Structure for the Interviews**

1. Do you take drugs prescribed by a physician? If there are no more symptoms of the disease, will you stop taking them?
2. Did you ever take any drug in a greater or lesser dose than the prescribed one?
3. With a drug prescription in hand, what do you think is important to know about it?
4. When going to a pharmacy or health center to have the prescription filled, do you usually ask whether there is a pharmacist or registered nurse in attendance?
5. How would you describe a good physician? How should he be?

## What Philosophical/Theoretical Framework Guided this Project?

### How the authors located the self of the researcher ontologically and epistemologically would interest the readers of this journal

Whenever trying to understand the beliefs, values and representations that underlie the behaviors (as regards health) of patients and professionals, our ontological and epistemological posture as researchers supporting qualitative methodology is characterized by the strict respect for the thoughts of each one of the interviewees. This respect manifests itself in the search for methodological forms of recovering, in the most spontaneous manner possible, the thoughts of these interviewees, and preserving to the utmost, on a collective scale, the spontaneity and naturalness of these thoughts, in their entirety and inherent discursiveness. Collective thinking should be constructed or re-constructed empirically using the aggregation, in discourses-synthesis, of parts of individual statements having similar meaning. As qualitative social researchers in the health field, we support an anthropological posture that always seeks the recovery and preservation of the intra and intercultural differences of the different social actors involved in the health "drama". We also try to make viable a broad dialog among these points of view, contributing to both the advancement of knowledge in the health field and to health itself.

## The Use of Collective Subject Discourses (CSDs) is the Real Contribution of the Paper

The use of CSD also raises a number of questions. For example, why is it important to present multiple individuals' voices as one "social representation of a given social subject"? Also, how does a researcher using CSD gain confidence that what has been collected in the interviews is representative? Lastly, when is it appropriate to use this approach as compared to other discourse analysis approaches? Please address these concerns.

> 1) According to the theoretical bases of the CSD methodology, collective thought should, like individual thought, be expressed using a discursive form. Therefore, it is necessary to aggregate "multiple individual's voices that have similar meaning" into a "single collective voice".
> 2) What was collected in the interviews is representative of individual thought if the questions allowed the individual to express himself in the freest manner possible and also if the questions did not produce induced or "politically correct" answers. On the other hand, the questions should also adequately reflect the objectives of the research. All this is incorporated into the CSD proposal.
> 3) We believe that it is always appropriate to use this methodology when dealing with qualitative social researches that function as empirical material based on relatively short statements of social actors on themes having collective or social representations.

## Validity/Rigor

The authors of the proposed instrumental model (Lefèvre & Lefèvre, 2000) emphasize that in methodological terms, the construction process of the CSD should be transparent, appearing whenever possible beside the individual subject discourses so that the necessary arbitrariness present in its construction may be evaluated and possibly refuted.

Another way to test the plausibility of the CSD consists in its presentation (re-presentation) in some instance that represents the collective of the individuals from whom it was extracted. By means of this instance, the collective may verbalize whether or not it feels that the discourse is representative and pertains to its universe.

In a review of the literature about the methodology of qualitative research, Murphy, Dingwall, Greatbatch, Parker, and Watson (1998) relate that:

> Most research is carried out within budget constraints and researchers are forced to make judgments about the priority to be given to one or another approach to enhance the validity and/or relevance of a study in the light of budget and practical constraints. These are decisions that are familiar to quantitative researchers and apply equally to quantitative research.

Rose and Webb (1998) comment that a similar type of understanding can occur in the process of data analysis. In interpreting an interview, the data stand in the same relation to the researcher as the poem does to the reader. Similarly, the informant stands in the place of the poet. Both are expressing their consciousness of their experiences through the medium of language and their words can be interpreted by the researcher and reader, respectively. In the case of the poem cited, the reader should understand that the poet is attempting to convey something more than that the poem is about old age. Similarly, the researcher should be able to make a more sensitive and sympathetic analysis of the interview data by employing a comparable intellectual technique. Asserting that a method of data analysis was helpful is not, however, sufficient to demonstrate that findings so generated are trustworthy. It is crucial to show that the method employed was rigorous.

## Results

### Socioeconomic and Demographic Characteristics

The average age of the interviewees was 67.6 years old, the majority of them (77%) being female. As to their school background, only 3% had completed eight years of study and the majority of the elderly (60%) were considered illiterate. The majority of them (64%) were married, and their income was 372.00 reais (around 198.50 dollars). Twenty-seven percent of the elderly were financially helped by relatives and friends who subsidized their medical expenses (mainly drugs) and basic activities of daily life. Findings pointed to 60% of the elderly living with their children and/or sons or daughters-in-law and/or grandchildren in second and third generation dwellings (Ramos, Rosa, Oliveira, Medina, & Santos, 1993). The number of medications taken by the elderly varied from 1 to 8, with an average of 3.6.

### Describing the Collective Subject Discourses (CSDs)

The 30 subjects selected for this research were asked five questions by means of a semi-structured interview. The answers were transcribed and analyzed, obtaining the central ideas and the collective subject discourses. Results of this analysis are presented in Charts I to V.

## Discussion

### Analyzing the Collective Subject Discourses (CSDs)

The present investigation intends to provide a contextual analysis of the central ideas and collective subject discourses based on an intentional sample with 30 aged patients.

Drug prescription implies a series of factors and concerns which, when not taken into account and not valued by the physician and other health professionals involved, as well as patients themselves, they might put the success of any drug therapy in jeopardy. The first central idea - *I don't stop* (Chart I) - focuses on the exemplary patient. What has been prescribed is automatically accepted with a firm purpose of fidelity. Here, the collective subject expresses himself by attributing value to the drug as an instrument for

restoring his health, not allowing its interruption. The meaning of the pharmacological treatment might be an extension of his or her own life and as such, undoubtedly, it is more important to follow the medical treatment than feed himself. Morris and Schulz (1993) report that the drug might be symbolic in the physician/patient relationship as long as the need for giving continuity to the relationship is genuine, while drug discontinuity might be seen as a prelude to the end of the relationship.

For the collective subject, the absence of one symptom does not mean that he is totally healed, since the disease might come back at any moment. The meaning is that as long as he continues taking the drug his health is assured and that if any problem in relation to the drug treatment occurs, it is crucial for him to resort to the physician. At the same time, other authors disclose that when patients are aware of the existence of a channel of direct communication with the professional, they are more inclined to do the right thing (in relation to the action and proposition) and comply with the prescribed therapeutic regimen (German, Klein, McPhee, & Smith, 1982). Britten (1994), in a qualitative study, singularizes a discourse on compliance with treatment: "If the doctor gives me 60 tablets I take 60 tablets...if you don't take those tablets you waste her time, the money, and you may not feel better at the end of it."

The second central idea - *It depends* (Chart I) - presents subject involvement in a form of a 'maybe' (of a 'need for evaluation'), since if he had money he would buy the drug; otherwise, he would not buy it. In Brazil, the Single Health System (SUS - Sistema Único de Saúde) provides fewer than one hundred free-of-charge drugs to the population. Currently in the US, drug prescription remains one of the most significant gaps in Medicare coverage for older Americans. These expenditures may be potentially catastrophic (Rogowski, Lillard, & Kington, 1997). Other researchers also emphasize the financial issue, saying that the high cost of drugs is one of the factors in the hospitalization of the elderly (Chubon, Schulz, Lingle, & Coster-Schulz, 1994). Here, it is clearly evident that, for the collective subject, the financial issue is a barrier to recovery.

Chart I

| Question 1: Do you take drugs prescribed by a physician? If there are no more symptoms of the disease, will you stop taking them? |
|---|
| *Central Idea* (1): *I don't stop.*<br><br>*Collective Subject's Discourse* (1): I've never stopped taking them, I've been taking them continuously; it never happened a day without my taking drugs, nor even half a day; for the time being, I did not stop taking them. I would rather go without food than stop taking the drugs. I need to follow the physician's prescription, even feeling nothing, until I take the last pill, because I'd not be cured yet, isn't? I don't stop taking them on my own; I complete the treatment. |
| *Central Idea* (2): It depends.<br><br>*Collective Subject's Discourse* (2): It depends. This has already happened and it did not happen to me. If one got enough money that afford him buying drugs, one continues taking them up to the end of the treatment; if one can't afford, |

| |
|---|
| what can one do? One has to face anything in order to get better. If one is already healed, one has to stop taking them, isn't? One could harm oneself if one takes too many. Once in a while, wen I feel I am taking too little, then I feel myself bad, and start taking the drugs again; I take a pill for one day or two; after that, I take no more. However, when I am in doubt, I make a new appointment with the physician in order to know whether I should increase or diminish the amount of pills; whether I should take another exam to see if I need to take more drugs or not, since the physician didn't tell me up to when I should take them, isn't? Then I go finding a pharmacist to get myself informed. |

The CSD also points out that if the CS (collective Subject) has already recovered, he has to stop the drug treatment, since he believes that taking too much is not a good thing to do. However, if he feels bad after having stopped the treatment, he should take a little bit more, since, for this subject, his organism acts like a "sensor", demanding more fuel. When the CS is not sure about how long he should continue taking the drug (whether he should diminish or increase the dose, or whether he should have a medical examination in order to identify the problem), he seeks medical advice from a physician or a pharmacist.

The reasons why the subjects of a study stopped taking medication include the annoyance in taking drugs and the difference between what the physician and the patient perceive as important. This shows how peculiar the behavior of the elderly is when faced with drug prescription (Walley & Scott, 1995). Other findings corroborate that the main reason a patient takes a "vacation" from a drug is that he thinks it is no longer necessary (Wallsten, Sullivan, Hanlon, Blazer, Tyrei, & Westlund, 1995). One in five patients takes a "vacation" of three or more days a month while under drug treatment (Benet, 1997).

In the first central idea – *only the prescribed dose* (Chart II) - the subject takes only the prescribed dose, validating what has been strictly recommended by the prescriber and not taking the dose in a way that would be more convenient, nor taking it based on his own knowledge. This collective subject does not take more or less than the prescribed dose. He believes that not following instructions might result in greater harm and might even lead to his own death.

Nevertheless, in the second central idea – *sometimes it happens* (Chart II) - the issue that the elderly might or might not take a greater or lesser dose than the recommended one is implicit, depending on the drug efficacy for the specific disease. A study points out the two most common reasons why the elderly alter their therapy: (1) The perception that the drug is ineffective and (2) The perception that the side effects have come to be a nuisance in their lives (Morris & Schulz, 1993). Another study discloses the real meaning some patients have developed concerning the dose of a given prescribed drug: "I took one pill and a half because they were not very strong and I've already increased it up to two" (Barter & Cormack, 1996).

Chart II

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| Question 2: Did you ever take any drug in a greater or lesser dose than the prescribed one? |

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| *Central Idea* (1): Only the prescribed dose.<br>*Collective Subject's Discourse* (1): I've always taken the dose the doctor prescribed, isn't, pharmacist, everything correctly. I never take more pills than what it is written in the prescription, nor less, either. Thank goodness, I've never needed a different dose. If I came to need it, I'm not going to take it on my own account, isn't? If something goes wrong, I'm very much afraid of "dropping dead" at any time. I get to go see the doctor, first. |
| *Central Idea* (2): Sometimes, it happens.<br>*Collective Subject's Discourse* (2): Sometimes, it happens, but it is very difficult to happen, then I tell the doctor. The doctor told me to take ¼ pill in a 5/5-hour schedule, I've no way to do it 'cause I'm in pain; is too long an interval to wait, it doesn't matter, I'm following a 3/3hour-schedule. The day I was in pain, he told me to take 30 drops of the medicine; I took 35 to stop the pain right a way. There was a time the doctor prescribed 2 pills in a 4/4hour-schedule; the woman in attendance got it all wrong and gave me 4 pills in a 2/2hour-schedule. Sometimes I take a little bit less, a very strong antibiotics, I diminish the dose the following way: if I feel I need it, I take it; if I feel nothing wrong, I don't take it that day. |

At another moment, the collective subject wants to know *what the drug is supposed to do.* The first central idea (Chart III) discloses the real meaning of the medical prescription. For the CS, it is not enough to have a prescription filled. It is not enough to have a diagnosis made and be immediately dismissed. The CS wants to know the pharmacological bases and all the implications. The friendly and safe words of the physician will give the patient the assurance and comfort so needed for the success of a therapy, with less risk of disruption. According to the collective discourse, the physician should put himself in the place of the patient and be as unsophisticated as possible, using language that is both approachable and easy to understand. In two focus groups researched on drug use, the persons interviewed asked for more information on the drug (Astier Peña, Pueyo Usón, Pascual-Salcedo, & Vicente Barra, 1995). Patients wish and are entitled to know all about their diagnosis and treatment. If they do not get any encouragement in their right to know all that has to be known about their illness and therapy, the treatment will be incomplete (Radhamanohar, Than, & Rizvi, 1993).

The second central idea – *whether the drug is going to make me feel bad* (Chart III) is implicit in the search for a therapeutic agent that does not cause harm. The issues underlying this CSD are concerned with confidence in the prescriber and getting information on whether the prescribed drug will solve the problem and whether it will cause side effects, consequently, aggravate the condition. It is essential that the physician inform the patient of all possible complications in the prescribed treatment and the correct way to comply with it. For the collective subject, there exists a kind of fear of the physician and from the amount of drug therapy. In some circumstances, only the fear of so many reactions and warnings related to the drug is sufficient to trigger a second grievance in the condition.

Chart III

| Question 3: With a drug prescription in hand, what do you think is important to know about it? |
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| Central Idea (1): What is the drug supposed to do.<br><br>*Collective Subject's Discourse*: All the things the drug is to accomplish, what is the purpose of it, whether that drug will be good to me, that I can take it, that there is no danger in my taking it, that I'll get better from the pain I've been feeling, then it seems that the faith one holds increases even more, it increases still more the chances of one's healing, isn't? What kind of illness it is indicated for, I feel it's important to get to know everything, exactly. I want to know the drug's composition, to see if there is any condition in which it would be dangerous to oneself to take it, the side effects, post-reactions, allergies, the correct way to take it, whether I should take it with milk, water, or with full/empty stomach, the right schedule, all the guidance, isn't? I think it is most important to know, from the doctor, everything that is to be known, because it is not only to go see the doctor and you get there and he chats with you a little bit and you go away, isn't? |
| Central Idea (2): Whether the drug is going to make me feel bad.<br><br>*Collective Subject's Discourse*: I'd want to know whether the drug is really good, if it would not make me feel bad, if it will no put your health in danger, whether it will or will not solve the problem you have; and if it will make me feel better. If the drug is enough, I take it, isn't that so? Whether the drug is new in the market, whether it has side-effects, whether the pill is "strong", what I can, what kind of stuff I can eat, what I can, what kind of drinking stuff I'm not allowed, isn't that so? Whether I should take it with water, or milk, or with an empty or full stomach, and the right dose, as well. Then, I keep waiting. The important thing is to get to know the right schedules, mainly the pills. There are times that you know nothing, but even so, you take them just the same. I'm even afraid of going to a physician, such is the quantity of drugs. D'you see, man? I'm not the one who likes taking drugs, the motive is that some times they make you feel bad, isn't that so? |

Within the context of the collective discourse, both the pharmacist and the nurse are much valued in the pharmacy and in the health center, respectively. The first central idea - *I don't ask, but I think it is important* (Chart IV) calls attention to the search for a therapeutic instrument that would be able to restore the health of the patient. Provided the existence of a good pharmaco-therapeutic follow-up, both the health professional and the patient will benefit from the therapy. Another aspect worth analyzing is related to the difference, in terms of responsibility and knowledge, between a health professional and a pharmacy clerk regarding dispensing medication, providing information, and marketing interests. The advice provided to patients by physicians, pharmacists, and nurses after

hospital discharge is a factor that contributes to the improvement of their understanding of and compliance with treatment (O'Connell & Johnson, 1992).

The second central idea – *I already know that there is one* (Chart IV) presents a CSD with a certain degree of conviction as to the importance of the presence of these professionals in the pharmacy or health center. The patient remarks that he does not actually ask for him, but he knows the pharmacist in charge is present. He places importance on always buying the drugs in the same pharmacy, on the assumption that by doing so it is advantageous in terms of establishing a close association with the professional. This kind of behavior means greater interaction between patient and pharmacist, which, in the long run, benefits treatment. In this sense, pharmacists should reinforce the physicians' instructions through direct advice, since about 85% of patients are unwilling to ask for any type of explanation (Kessler, 1991).

Chart IV

| Question 4: When going to a pharmacy or health center to have the prescription filled, do you usually ask whether there is a pharmacist or registered nurse in attendance? |
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| *Central Idea (1)*: I don't ask, but I think it is important.<br><br>*Collective Subject's Discourse* : I don't ask for. I don't remember whether I've asked for it or not, but I think it is important to have a professional in charge, he can help us and at a great extent, and also a nurse, isn't? I've always have my prescriptions filled in with well-known pharmacies, he helps us, this is good, isn't? I've great confidence in a good pharmacist, isn't? One that gives orientation, that is graduate, one that would not be a nobody, isn't? He can't be a charlatan. The law says that all pharmacies should have a graduated pharmacist, isn't? If I could, every time I'd have a prescription filled in, I'd do it with the pharmacist in charge, it should always be somebody there with a doctor's degree, shouldn't it? In a pharmacy, the pharmacist is the one who knows better, one who has more knowledge about a prescription, one who provides more information to us, he knows further more than the people there, the clerks, who are there only to sell, isn't? Sometimes it can happen that the drug prescribed is not a hundred per cent correct and, if there is a pharmacist who knows about, then he can give orientation to us, isn't? A person who doesn't understand, sometimes he can even give another drug instead of the right one, a wrong drug, he is there only to sell, and one has to know what kind of drug he is "pushing" one to buy, isn't? Because he has an interest in doing this, isn't? I always try to strike up a conversation with the pharmacist, isn't? Because the doctor leads already a hurried life, isn't? He already leaves things to be done by his assistants. When one is being attended to within a health center, one doesn't ask for a nurse, because one knows that there will always be one there. When we get there, the person in a nursing uniform, who is graduated, should have more knowledge, isn't, than the ones who are just working |

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| there, isn't? I think it is important that there is a graduated professional in the health center, he is committed to us. |
| *Central Idea (2)*: I already know that there is one.<br>*Collective Subject's Discourse:* I've never asked for, since most of the times it is the very pharmacist that is in charge. I always buy in the same pharmacy, I got used to, I already know that there is one [pharmacist] , I ask where is the pharmacist, I'm wanting to talk with the pharmacist. You are the person that is responsible, your emploees are not, some times he is even more ignorant than yourself and doesn't say a word..., a mistaken drug, and it kills the person. I don't like being served by a child, the handwriting confuses one, the name [of the drug] confuses one. I think, in my opinion, that all of them should be graduated. Me, if I could, all the times I'd had to buy a drug I'd do this with the fellow in charge. Isn't there always a doctor? I thought all of them were graduated. In the health center, I don't go, I don't ask for, no wonder!, all the times there are no drugs, isn't that so? I think it is important in the health center, isn't, a nurse. I think it is important to have these professionals there, isn't that so? Because they must understand, isn't that so? They already know all that the person needs, isn't that so? |

The collective subject presents himself as being a really exacting individual in relation to the way he thinks he should be served, giving preference to the person who has studied and accumulated a great deal of knowledge about drugs in general. He questions pharmacies without professionals with a university degree or health centers without registered nurses in charge. For him, these professionals are the ones who have technical, scientific knowledge and will be able to help and solve a problem, in a quicker way, in the absence of a physician.

As to what it means to be a good physician, various facets are expressed in the CSD. In the first central idea - *one who cares, who pays attention, who is humane* (Chart V) the collective subject wants to recover dignity (an extremely legitimate value for a human being) and searches for comfort from one who has the gift and professional background for preventing illness and preserving life (indifferent to how rich or poor his patient is). The subject searches for amiable treatment by a physician who considers him a person who has been walking the roads of life for a long time. He feels that he cannot be treated by someone who does not love his profession. Thus, he searches for a professional. The physician should explore the social and emotional contexts of the patient in order to understand the meaning of his illness (Skorpen & Malterud, 1997). It is worth emphasizing that the sick person does not want special treatment, but hopes to be treated with the respect and consideration his morbid status entitles him. He wants the prescriber to succeed in finding the cause of his illness, taking into account that he is an individual who wants to give voice to his body, who wants to take part in the discovery of the problem and its solution. The collective subject believes that without his help it would be difficult for a physician to provide an accurate diagnosis. When empathy is absent from the life of the professional, his therapeutic behavior has very likely been damaged. Inappropriate drug prescriptions for elderly patients are common (Straand & Rokstad, 1999).

The collective subject is in search of a lot of information about the treatment instituted. He wants to be acquainted with all the details of a good drug therapy in order to know how to deal with the problem when an emergency situation occurs, mainly concerning side effects or adverse reactions. Improving patients' decision-making competencies may require more discussion of benefits and risks, as well as discussion of the patients' opinion about the prescribed medications and their ability to follow through with treatment (Makoul, Arntson, & Schofield, 1995).

On the other hand, still concerning what it means to be a good physician, there is the discourse of the doubt present in the second central idea – *I don't know!* (Chart V). In reality, this subject is not sure about what constitutes a good physician, but comments that he must prescribe the right drug therapy. His life experience of seeking medical attention has taught him that some physicians do not have their heart in what they are doing. Finally, the central idea – *one who prescribes the right drug* (Chart V) emphasizes the assurance of one attaining an objective. For the subject described here, the essential point is that the physician prescribes the correct medical treatment; that he explains very carefully the details of the therapy and its possible complications. This subject wants to be informed about his condition in simple language, as well as be treated with affection, wisdom and courtesy. In an evaluation study on the quality of primary health care, the authors reported that from the patients' point of view, satisfaction with the health service rendered was associated with the solution of the problem that had motivated his coming for a medical consultation (Halal et al., 1994).

Chart V

| Question 5: How would you describe a good physician? How should he be? |
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| *Central Idea(1)*: One who cares, who pays attention, who is humane. |
| *Collective Subject's Discourse*: One who provides a good care, who is humane, who really dedicates himself to the work he is doing, who is really concerned with the patient, who doesn't treat you just to treat, he treats to see the patient getting better, isn't? One who attends you with care, with love. You are already in anguish and you go there and find a doctor who is not willing to see you, nervous, it is the patient who is ill, isn't? compromising here, there, with tenderness, then it seems that all will be fine. One who is honest, full of zealous with the cause he has embraced, with his fellowman's health, above all one who feels the patient's pain, the other's pain as if it were his own, or as if he were attending one of his kin. One who is really patient of the other patient's complains, very attentive with you, this is rather important. Attention is an ideal word, and a doctor's little chat with a patient will do wonders, much more than the drugs. It is important that a doctor lets his patient talk, don't you think so? Because if you don't speak, how would he to know? There are doctors who speak with you just like this, a little bit, and then he is gone, it is all over, you can go away ... he is like a humming-bird, he doesn't read your blood pressure, doesn't look at you, you seat there, no more than a minute, and it is all over ... he is already standing up, he is already shaking your hand, already giving little slaps on your back and seeing you off ... he is a humming-bird that comes there |

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| and then vruum, there he goes. There was a day I said good afternoon to a doctor, he didn't even look at me, didn't offer his hand, didn't even greet me nor looked at my face. Not even when I was already going away, did greet me, either. There is another doctor who is totally different ... he gives you full attention. He sees that you understand all that is to be understood, the way he treats you, he spends a lot of time chatting with you, he gives his best to attend you, to save you, he does all he can to see you going away better. |
| *Central Idea(2)*: I don't know.<br><br>*Collective Subject's Discourse*: Who cares? I don't know. I've already seen so many doctors. [One who] hits upon the right drug, isn't? There are some doctors that you feel they do things in a rush, isn't that so? He has to be more attentive, isn't that so? [He] Should inspire confidence. |
| *Central Idea (3)*: One who prescribes the right drug.<br><br>*Collective Subject's Discourse:* [He] Should give the right drug to you, be always aware of how you feel, instruct you about the things, in detail, treat you decently, be attentive, attend you well, ask you to enter the consultation room , to take a seat, prescribe the drugs and you get better. D'you know something? There is a day you have to see a doctor, because if the doctor doesn't understand your illness, then, I'm afraid he will give me a wrong drug, isn't that so? He has to hold enough science to understand his profession, in order to understand everything, isn't that so? But, first comes God, afterwards, he. |

## Recommendations and Implications for Clinical Practice

The authors believe that despite all the medical advances (diagnostic and therapeutic), many sectors still need to be optimized by health professionals. We list some steps below that should help improve the health professional-patient relationship and the benefit of the therapeutics.

- Listen to the patient attentively and respectfully.
- Show affection
- Before prescription, evaluate the real need for the medicine.
- Check dosage schemes periodically.
- Investigate the presence of a polypharmacy in the residence of the elderly patient.
- Observe individual factors to guarantee adhesion.
- Evaluate significant drug interactions carefully.
- Be sure that the patient has understood when and how to take all of his medicines.
- Develop pharmacotherapeutic accompaniment practices to evaluate responses to therapy and possible undesired effects.
- Supervision of the pharmacotherapy by a person in charge, neighbor, relative, friend, pharmacist or a nurse is sometimes necessary.

- Choose an adequate pharmaceutical form: liquid, pill, pastille, suppository or injection.
- Supply sufficient information about the prescribed medicine.
- Read the prescription to the patient, giving clear explications.
- Choose medicines with a short half-life.
- In general, use doses smaller than those of younger adults.
- The medicines should be clearly labeled using large letters.
- The medicines should be placed in easy-to-open containers.
- Limit the number of prescribed medicines (place the treatment in a hierarchy).
- Do not forget other medicines prescribed by other specialists and the patient himself.

**Surprises Found in the Data Analysis**

What most called the attention of the researchers was the value the elderly collective subject gives to information and knowledge about the prescribed therapy. The elderly patient, due to his long familiarity with therapeutic practices and a multiprofressional health team, is able to evaluate, in his way, the quality of the service and prescription. This population contingent feels more secure and confident during treatment when it receives a minimum of information resulting from a respectful, affectionate, and pleasant physician-patient relationship. This relationship becomes even more positive when complemented by other professionals like the pharmacist and nurse. Thus, the optimum benefit of the prescribed therapeutic can, for the most part, be attained by the elderly patient, but not alone.

**Limitations of the Study**

Due to being a qualitative research of an exploratory and descriptive nature, the data and its evaluation cannot be generalized. The findings cannot be applied to all elderly patients and health professionals. Although the respondents do not represent every social stratum, ethnic, and cultural group, and co-morbidity, they offer various perspectives for a better relationship when faced with medicinal prescription. The study offers only the meaning of the point of view of the patient. The credibility of the findings of the study may be equally influenced by the fact that the investigators only conducted one interview with each participant. Despite the small sample of elderly patients interviewed, its exploratory and descriptive nature may provide interesting bases that may produce future research and guidance hypotheses for the development of intervention mechanisms. The evolution of the studies referring to this methodology leads to the belief that possible problems have been reduced.

**Future Research Projects in this Area**

Around one hundred projects and works have already been developed in this area, citing only some recent themes as an example:

1. Sale of over-the-counter medications. Collective Subject Discourse involving the hypertensive elderly (2003).
2. Drug prescription from the perspective of elderly patients (2001).
3. The meaning of medical intervention and religious faith for the elderly patient with cancer and the perception of health professionals (2003).
4**.** Book one. *Collective Subject Discourse - A new methodological approach in qualitative research.*
Book two. A new book about the Collective Subject Discourse will be released soon. It is going to be called *Collective Subject Discourse - A new approach in qualitative research* (spin-offs).
5. Health marketing project for the government of Argentina involving research using the CSD and a population of consumers and physicians from Buenos Aires and transformation of the results into advertising campaigns to promote good health.
6. Evaluation research of the Nutrition Department of the Public Health College of Universidade de São Paulo (USP).

Some projects that are already in progress that will have the CSD methodology applied:

1. Phase two of the health marketing research in Argentina involving five other regions besides Buenos Aires.
2. Evaluation research of the satisfaction of the users of the Center for Specialized Attention for the Elderly (São Paulo State government).
3. Evaluation research of the income generation projects of the Labor Department of the city of São Paulo.

**Reflections on the Method Employed**

Through this discursive way it is possible to better visualize the social representation in so far as it appears in the form (more lively and direct) of a discourse, which is the way in which real, concrete individuals think.

However, the fact that the social representations are only recoverable by means of necessarily reconstructed social discourse (which also happened here, since the possibility of a community directly expressing an opinion does not exist) implies, naturally, a certain dose of artificiality in the preparation of these reconstructed discourses. Still, such artificiality is much less if compared to that present in the "mathematized" communities, characteristic of the quantitative researches carried out using closed questionnaires. The reason is that in qualitative research that uses discursive instruments to tabulate data (like the present work), the eminently discursive nature of the thoughts of the individuals is respected both on an individual plane, where each individual gives discursive answers to open questions and on a collective plain, where these individual discourses are synthesized under forms equally discursive, like those of the collective subject discourse (Simioni, Lefèvre, & Pereira, 1997).

The CSD constitutes a qualitative sum. It is qualitative and not quantitative in so far as the aggregation of the elements that compose it (given the special nature of these elements, which are significant fragments of discursive responses of similar content) do

not result in a determined quantity of discourses that form a given collection of equals (e.g., a bag with 100 potatoes), but a quality of discourse that is quality because the above aggregation allows the individualization of a determined meaning, different from another meaning (i.e., from another collection of discursive response fragments with similar content that forms another quality).

The Collective Subject Discourse (CSD) is a methodological procedure, characteristic of empirical social researches of a qualitative cut, that consists of a non-mathematical way to represent (and produce) the thinking of a collection, which is aggregated in only one discourse-synthesis. Different people express discursive content of a similar meaning in responses to a questionnaire.

## Next Steps in the Development of the Collective Subject Discourse (CSD) Method

We are testing (final phase) CSD software that is going to be called QualiSoft. The program is going to help a lot in CSD researches, allowing qualitative investigations with relatively large samples and control of variables.

The software is revealing itself to be a very powerful and useful instrument in the carrying out of characteristically qualitative work and its quantitative (spin-offs), representing a new and promising phase of CSD development.

## Final Considerations

Taking into account the various Collective Subject Discourses (CSDs), two modalities of thinking can be considered. In the first, there is the figure of the faithful CSD who does not stop taking the prescribed drug. He takes only the recommended dose and wants to know what the drug is suppose to do be sure about what he will ingest. When going to the pharmacy or health center to respectively buy or pick up drugs, he already knows that the facilities have a pharmacist or registered nurse to better advise him. This attitude suggests that a better patient-health professional interaction should exist and, with it, better benefits from the pharmacotherapy. In this CSD, the good physician is presented as a strong figure. Drug prescription is not enough; it is of the utmost importance that the physician who is in charge of the caring be attentive, humane, and really concerned about the patient. Here, the aged patient-health professional relationship is presented in a positive form.

In the second modality of discourse, worries and doubts can be observed. For example, when symptoms are no longer present, the subject believes he should stop taking the drug and evaluate the situation thoroughly. Since he depends on the availability of financial resources to continue treatment, the dosage might be greater or lesser than the one prescribed, depending, naturally, on the efficacy of the drug he takes for his illness. In this CSD, there is a search for a safe drug, with no side effects. At the pharmacy or health center, he does not ask, respectively, for the pharmacist or registered nurse because he knows how to differentiate these professionals (in terms of responsibility and knowledge) from the clerk or attendant with no professional qualification. Regarding the prescriber, this CSD is in doubt. He is not able to formulate his own opinion as to what constitutes a good physician, but states that he should prescribe the right treatment.

In this second instance, the aged patient-health professional relationship is worrisome, since the benefits expected from the therapy depend on both the efficiency and sensitivity of the health professionals involved in this process. If there is a problem in either of these two areas, the patient is likely to continue using the drug according to his own convenience. This situation puts the rationality of the therapy in jeopardy, with serious losses to the patient, health team and public health agencies. In this sense, the physician, pharmacist and registered nurse should make every effort to attenuate the inherent risks of drug use by stressing the value of the humanistic character in the patient-health professional relationship. Finally, further investigations of a qualitative cut should be developed with a view to attaining better comprehension of this problematic health matter.

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The authors would like to express their thanks to the Foundation for Research Support in the State of São Paulo (FAPESP), Brazil, for all the support and incentive provided for this research, according to processes nos. 97/08836-6 and 98/01020-3; to Dr. Lygia Iversson Buch, for her precious suggestions and revision.



## Author's Citation

Lefèvre, F., Teixeira, J.J.V., Lefèvre, A.M.C., Castro, L.L.C., Spínola, A.W.P. (2004). The relationship between health professionals and the elderly patient facing drug prescription: A qualitative approach. *The Qualitative Report, 9*(4), 706-731. Retrieved [Insert date], from http://www.nova.edu/ssss/QR/QR9-4/lefevre.pdf