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RESEARCH

BELIEFS, VALUES AND ATTITUDES OF COHABITING RELATIVES OF CORONARY ARTERY DISEASE PATIENTS

CRENÇAS, VALORES E ATITUDES DOS FAMILIARES CONVIVENTES COM PACIENTES CORONARIOPATAS

CREENCIAS, VALORES Y ACTITUDES DE FAMILIARES DE PACIENTES CON CORONARIOPATÍA

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ABSTRACT

The high incidence and prevalence of coronary heart disease is evident in Brazil and worldwide. The concept that individuals have on health and illness influences their attitudes and behaviors before the health-disease process and affects the performance and development of the family nucleus. The objective was to analyze beliefs, values and attitudes of family members that live with patients with acute coronary syndrome of coronary heart disease. This is a cross-sectional study with qualitative approach conducted at a university hospital. The sample consisted of nine relatives of patient. Semi-structured interviews were applied. Data were collected through instruments with questions prepared upon the assumptions of the theoretical framework. Data were evaluated according to the Health Belief Model. Family members were aged between 26 and 66 years. The categories susceptibility, severity, benefits and perceived barriers derived from Health Belief Model, as well as the categories awareness and change, showed that family members have knowledge about the prevention and control aspects of the consequences of coronary heart disease. However, the beliefs and values acquired throughout their lives, influenced by cultural, social, economic, emotional and especially family context, hinder behaviors with preventive and health promoter character. Despite the knowledge that family member of coronary patients have about the disease, nurses need to tailor the educational process aiming to minimize conflicts arising from beliefs, values and family environment context, as well as facilitate and promote the incorporation of new habits.

Keywords: Social Values; Health Knowledge, Attitudes, Practice; Caregivers; Coronary Disease.

RESUMO

A alta incidência e prevalência da doença coronariana é evidente no Brasil e no mundo. A concepção de saúde e enfermidade influencia nas atitudes e condutas dos indivíduos diante do processo saúde-doença e afeta o desempenho e o desenvolvimento do núcleo familiar. O objetivo foi analisar crenças, valores e atitudes dos familiares conviventes com pacientes com síndrome coronariana aguda sobre a doença coronariana. Trata-se de estudo transversal com abordagem qualitativa realizado em um Hospital Universitário. A amostra foi composta de nove familiares, mediante uma entrevista semiestruturada. Os dados foram coletados por meio de instrumentos com questões elaboradas tendo como base as premissas do referencial teórico e avaliados segundo o Modelo de Crença em Saúde. Os familiares tinham entre 26 e 66 anos. As categorias suscetibilidade, severidade, benefícios e barreiras percebidas derivadas do Modelo de Crença em Saúde, assim como a categoria conscientização e mudança, mostraram que os familiares possuem conhecimento sobre os aspectos preventivos e de controle das consequências da doença coronariana, porém as crenças e valores adquiridos ao longo de suas vidas, influenciados pelo contexto cultural, social, econômico, emocional e principalmente familiar, interferem nos comportamentos preventivos da doença e promotores de saúde. A despeito do conhecimento que os familiares conviventes possuem sobre a doença, o enfermeiro precisa adequar o processo educacional para minimizar os conflitos decorrentes de crenças, valores e contexto do ambiente familiar, facilitar e promover a incorporação de novos hábitos.

Palavras-chave: *Valores Sociais; Conhecimentos, Atitudes e Prática em Saúde; Cuidadores; Doença das Coronárias.*

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RESUMEN

La elevada incidencia y prevalencia de la enfermedad coronaria en Brasil y en el mundo es evidente. El concepto de salud y enfermedad influye en las actitudes y comportamientos de los individuos en el proceso de salud-enfermedad y afecta el rendimiento y desarrollo del núcleo familiar. El objetivo del presente estudio fue analizar las creencias, valores y actitudes de familiares que conviven con pacientes con síndrome coronario agudo de la enfermedad arterial coronaria. Se trata de un estudio cualitativo transversal realizado en un hospital universitario. La muestra estaba compuesta por nueve familiares. Los datos fueron recogidos en entrevistas semiestructuradas a través de instrumentos con preguntas preparadas en base a los supuestos del marco teórico según el Modelo de Creencias en Salud. Los familiares tenían entre 26 y 66 años. Las categorías "susceptibilidad", "gravedad", "beneficios" y "barreras" percibidas derivadas del modelo Creencias en Salud, así como la categoría "concienciación y cambio", mostraron que los familiares tienen conocimiento sobre los aspectos de prevención y control de las consecuencias de la enfermedad cardíaca coronaria. Sin embargo, las creencias y valores adquiridos durante toda la vida, influenciados por el contexto cultural, social, económico y emocional de la familia interfieren con los comportamientos preventivos de la enfermedad y promotores de la salud. A pesar del conocimiento que los familiares tienen sobre la enfermedad, los enfermeros precisan adecuar el proceso educativo para minimizar los conflictos resultantes de las creencias, valores y contexto familiar para facilitar y promover la incorporación de nuevos hábitos.

***Palabras clave**: Valores Sociales; Conocimientos, Actitudes y Práctica en Salud; Cuidadores; Enfermedad Coronaria.*

INTRODUCTION

Cardiovascular diseases (CVD) have been responsible for 17 million deaths in recent decades and this number may increase to 150 million patients in 2020.[1]Among CVD, coronary artery disease (CAD) is the leading cause of death among adults in developed countries[1] and a major cause of morbidity and mortality worldwide. [1]In Brazil, CAD accounted for 8.8% of deaths in 2010.[2,3] Thus, these data become a challenge to the health care system, because CVD is preventable.[4] Such diseases can result in major socio-economic impacts[1]. Thus, results can be favorable when there is the control of risk factors such as systemic arterial hypertension (SAH), diabetes *mellitus* (DM), dyslipidemia (DLP), obesity, physical inactivity, excessive alcohol consumption, smoking and psycho-emotional stress.[5] Cardiovascular risk factors often combine with genetic predisposition. Environmental factors contribute to this combination in families that have unhealthy lifestyles.[6] Therefore, in order to reduce the development of risk factors for cardiovascular disease and prevent coronary artery disease, it is necessary to propose educational and preventive measures to promote health.

CAD often affects aspects of livelihood of the family group and tends to interfere in the family structure regarding the maintenance of socioeconomic *status* [7] and the psychological and emotional balance of cohabiting individuals. When the disease affects individuals in the household, this affects the performance and biopsychosocial development not only of the affected individual but of the entire family,[8]since the health-disease process involves, besides biological issues, also the political, social and cultural context.[9]

Study showed that at least one family member has a comorbidity to the development of CVD[10] due to exposure to risk factors, behavioral pattern associated with lifestyle habits, the offer of the political system and the social and cultural context.[5]

Cohabiting family members (CFMs) of coronary artery disease patients are individuals who participate in nursing consultations and also receive information about CAD and its consequences, prevention and the need to adhere to treatment.[10,11]

Health professionals are responsible for health education. Integrating the patient and family in the recognition of accurate information, beliefs and attitudes about the disease is part of this process because the patient/family and the health/disease process are interconnected.[12]

Beliefs, ideas, values, emotional aspects and behaviors related to subjectivity and life experience of each individual/family are reflected in the conception of health and illness[13]and influence the attitudes and behaviors before falling ill.

Beliefs are ideas and meanings that individuals have about the world. They are filters through which individuals interpret a stimulus and, based on that interpretation, direct or prioritize their actions. Therefore, it is a concept associated with what the individual thinks to be the truth, while values reflect what the individual considers to be object of appreciation.[14] Values are assumed positions or statements from words or actions that translate what the person thinks to be important and for what it is worth suffering, dying or continuing to live. [14] As for attitudes, these represent the way of thinking and feeling of the individual, which in combination with the real context, predispose him to certain ways of acting or behaving in the face of phenomena. They are influenced by cognitive or evaluative, affective or emotional, and also behavioral elements. They represent ways to minimize or resolve the troublesome situation. Decisions, therefore, take place under the influence of the inherited view of the world, which explains behavioral differences in a group.[14]

Adherence to CVD preventive and control behaviors has been a concern of researchers and health professionals, because the high morbidity and mortality of this disease.[15] However, prevention only happens when individuals relate to and understand the significance of the disease in their lives and when they realize that their needs are met and valued by health professionals.[16]

Thus, the rationale of the study is to propose a holistic view of the studied population in order to disseminate knowl-

edge on CAD and adapt the educational actions favorable to the development of the individual before the health-disease process. This way, understanding, accommodation of beliefs and values and quality of life will be adequate and effective, contributing to disease prevention and health promotion.

This study had the purpose to analyze the beliefs, values and attitudes towards coronary artery disease of family members living with acute coronary syndrome (ACS) patients. The aim was to know the families' reality and lifestyle, considering their peculiarities, limitations, possibilities, individuality and integrity, in order to prevent the development of cardiovascular disease.

The theoretical framework used was the Health Belief Model (HBM), a theory that seeks to identify variables that contribute to understand the behavior in health. For the area of Nursing, "the main model to explain and predict the acceptance of recommendations on health care" or "the most influential and the most widely researched model" has been considered.[17] This model has contributed to tailor educational interventions to both, patients and individuals who live with them, improving cardiovascular health indices of the population.[15] The model is based on four assumptions: perceived susceptibility, i.e., the belief that the individual is susceptible to a disease; perceived severity, i.e., the fact that this disease will bring consequences to any area of the patient's life; perceived benefits, with respect to the benefit that the individual believes to receive when adopting a particular action, whether sick or not, as he believes that these actions will reduce the effects and severity; and perceived barriers, which relate to the difficulties of implementing the actions, as the individual takes into account the costs and benefits of such action.

METHODS

This is an exploratory and cross-sectional study with a qualitative approach conducted at the Cardiology Unit of a large university hospital in São Paulo. The research project was approved under process n° 1247/11 by the Ethics Committee of the Federal University of São Paulo and data were collected between December, 2011, and February, 2012, after completion of all ethical precepts specified by Resolution 196/96 on research involving human beings and after the family member express willingness to take part in the study and sign the Informed Consent form.

The sample consisted of nine family members who met the following inclusion criteria: age above 18 years, cohabitants of acute coronary syndrome patients, have visited the hospitalized family member and have signed the Informed Consent form. Family members were approached by the first author/researcher, student of 3rd year of Nursing, undergraduate participant of the program of scientfic initiation after receiving training to perform data collection.

Semi-structured interviews were carried out with aid of an instrument built by the researchers and based on the literature containing two parts: the first with questions for socio-economic and cultural characterization of the family, and the second with questions drawn up based on the four premises of the HBM:[17,18] Perceived susceptibility, perceived severity, perceived benefits and perceived barriers. The questions were: what do you understand from coronary artery disease? What are the risks that coronary artery disease bring to you? What are the benefits of controlling the risk factors for coronary artery disease? What difficulties (whether personal, family, professional) you face to control the risk of developing coronary artery disease? Have you taken a decision (adopted strategies or made plans) about this?

Data were recorded, transcribed and analyzed according to content analysis described by Bardin[19] as the categories' model, under the thematic modality, i.e., identifying the units of meaning or thematic units that made up the speeches of the deponents, analyzing them. This process was conducted by the first author/investigator after receiving training to perform the analysis, but the other authors were able to analyze the data as they reconstructed and named categories together, when they considered appropriate. After pre-analysis, data were coded by identifying the most significant lines of each category and aggregated into predetermined categories according to the assumptions of the HBM: perceived susceptibility, perceived severity, perceived benefits and perceived barriers. There was the need to build a fifth category to group data which, according to their meanings, was entitled "awareness and change."

RESULTS AND DISCUSSION

Interviewees were aged between 26 and 66 years. As for sex, seven were females (wife, daughter and companion of the patient) and two males (husband and son of the patient). Six CFMs, when asked about religion, said to be Catholic, two were evangelical and one was spiritistic. Regarding education, three females reported having incomplete primary education; one had completed primary school; two had completed high school; and finally, three stated to have completed higher education.

Family income was classified according to the minimum wage (MW) of period of data collection (R$ 545.00) and classified as a national minimum wage according to the IBGE Census - Brazilian Institute of Geography and Statistics.[20] Family income ranged from more than three to five MW in the case of six respondents, whose average individuals residing in the same household is three; two reported an income amounting to more than five to seven MW and have four and five residents in the household; and one individual had income exceeding nine MW, with four individuals living in the household.

The sample profile allows us to infer that the family group is formed by a significant number of cohabitants who contribute to the financial budget necessary for the family income; women's values have more influence on the family unit; the Catholic religion enables the development of beliefs and principles within the family context; and the level of education contributes to the adoption of actions and attitudes toward family performance.

Perceived susceptibility includes the following thematic units: belonging to the risk group; the disease is a fatality; prevention does not guarantee the absence of the disease; being insusceptible to the disease; and previous knowledge and contact with the disease. Regarding the perception of the danger of developing CAD and knowledge that CFMs have on this disease, most of them were encouraged to talk about their own susceptibility. Otherwise, they tended to comment on the susceptibility of the family members. Question (CFM6): Do you think you may have coronary artery disease? *Look, I have not made examinations yet, do you understand?.... But, my brother died suddenly, she had a fulminating heart attack...* And do you think that for this reason you may develop the disease? *Yeah, after him [hospitalized husband] I was worried about me, now I got very worried... because he is skinny... and I have this problem of obesity, you know, because of my age and my height... I think I can develop the disease...* (CFM6). Question (CFM10) Do you think you can develop coronary artery disease? *Look, my mother died of heart attack... my father died of cancer, I do not have any symptoms, I am not going to doctors frequently either ... I do not know anything about myself... but I'm fine, so I'm fine, I do not know if I have it, I may have it or not. I do not have any symptoms. Nothing. For now, right?* (CFM10)

The thematic unit "being at risk" indicates that cohabitant family members recognize themselves, or their relative who is hospitalized, as someone who has one of the risk factors for the development of CAD and, therefore, they are prone to disease. Except for one cohabitant family member (CFM), all the others reported having at least two risk factors for developing CAD. Stress either related to the hectic lifestyle, or sometimes to family problems, smoking and having a family history of the disease were the most frequent factors. Sedentary lifestyle and eating habits were less frequently mentioned. *I think, yes, because my mother had, then now he has [father], my grandfather had too. I can also develop the disease too, right?* (CFM4).

The following three units show the tendency to minimize the predisposition to CAD and the propensity to speak of the hospitalized family member rather than about themselves. Thus, the testimony of CFMs indicate that they believe that "the disease may be inevitable", they can eventually develop it, that is, it is a human contingency, simply because they are "alive" and exposed to natural transformation.

In turn, the belief that "prevention does not guarantee the absence of the disease" explains the possible acquisition of CAD regardless the adoption of preventive behaviors. Believing to be "insusceptible" is present in the speeches of CFMs who claim having healthy lifestyle habits and/or be considering themselves quiet and without animosities towards other individuals. *My husband has changed the eating habits, but I think that was not of much help because he suddenly fell ill* (CFM6). *I think I have not developed the disease yet because of that, I've always been a sport person...* (CFM8). *I can develop this disease, but I have no specific reasons; the body is subjected to developing the disease at any time* (CFM7).

Also related to susceptibilities, the speeches that focused both on the knowledge acquired about CAD and on risk factors were added to the unit "understanding of the disease". This understanding is due to coexistence with relatives who have heart disease or previous guidance from multidisciplinary teams in health services. *CAD includes all clogged coronary arteries, this is what I understand* (CFM10).

Thematic units in the category perceived severity indicate the conflict that CFMs feel when reflecting on how their habits can cause harmful effects to their own lives or to the relative affected by CAD.

The "regret for not preventing the disease" was one of the emotional reactions that indicate the remorse they feel for having caused damaged to their lives, the greatest gift, because the habits and lifestyle of the hospitalized relative and their own led to the development of CAD. This is so, that they express feelings of fear, sadness, anxiety and regret before the admission of the patient for CAD, an illness that could have been avoided. *If I knew and I could go back, when I was 30, I would get rid of salt and sugar* (CFM2). *I get tense, sad, desperate, anxious and afraid because I do not want to lose* (CFM5).

The development of the disease can strongly affect the personal and professional productivity. Thus, the possibility of "becoming disabled" is a significant parameter when assessing the severity of the disease and the conflict that this can generate. Furthermore, still regarding the two thematic categories described above, the "perception of the consequences of CAD" evidenced by the new diseases that affected the family member admitted intensifies their distress. *High blood pressure is the worst thing you may have in the world, I do not want to have that! He cannot even drive the car, where I used to work, he said he had high blood pressure, they took the car and his license away, to control the pressure* (CFM2). *I think that this disease affects circulation in general and the respiratory aspect, I think that connects lungs, heart* (CFM8).

The perceived benefits category contains one thematic unit. This represents a value and was entitled "live longer and better". Thus, CFMs recognize that the adoption of preventive

measures to avoid CAD can prolong life expectancy and provide quality of life. *I think you get to eighty, ninety years with health, lucid and you can take care of yourself, do not depending on anyone, this is a great... I think that's quality of life...* (CFM8).

The perceived barriers category provides information related to the difficulties of coinhabitant family members to initiate and/or maintain control measures, thus preventing the risk factors of CAD.

Among the difficulties mentioned is the recognition that, for a long time they have acted based on "outdated beliefs" as, for example, encouraging grandchildren to overeat because the CFM himself was raised believing that being chubby was a sign of health. Times ago, *they would give us food for us to eat, even by force... but fat is not healthy, being a fat person does not mean you have health... fat is not a sign of health as it used to be thought* (CFM2).

Another barrier refers to the battle that one constantly loses because of impulses or desires, eventually "give in to temptation". Thus, also in this category, the conflict between what one likes to do (habits) and what is beneficial for health is evident. *I want to quit smoking, I tried several times but to no avail, I tried several times to stop, but it's hard, it's very difficult* (CFM9).

However, to mitigate this conflicting situation, the person verbalizes resentment for "not having an accomplice and/or support", the thematic unit that shows the attempt to change lifestyle habits and adopt control measures of risk factors... *I started to be vegetarian, thinking of having good health... I am vegetarian, but that caused me much trouble because the family was not... then at one point, I started gradually changing... to the red meat again... but because of my mother I did came back being a vegetarian...* (CFM8).

Another way to explain the poor habits and lessen their sense of guilt is the observation that they make about "the absence of structure to prevent CAD". This barrier relates to more generic and external situations to themselves or to their family, that is, they are considered influential factors of non-personal nature. This is the opposite to the thematic units "giving in to temptation" and "having no accomplice and/or support"... *If I have to feed here [hospital], I would have to eat ... things that are not very recommended for people who have some health problem... it's difficult for us to find a snack bar which things like fruits, fresh things... so, sometimes you do not want to eat, but that is the option you have, it is difficult* (CFM3).

Financial aspects are the biggest problem, because for you to buy organic or low sugar things you spend a fortune, then you cannot, you have to do as you can... it's hard, I do not buy these things... besides being little [amount], *it is expensive* (CFM5).

After all, they recognize the need for personal effort to carry out preventive measures, but their energies are limited when they go through such distressing situations and, therefore, they put their needs in second place. For this reason, the thematic unit "feelings come first to the need for change" was established. [...] *I had a period that I was unemployed... the distress is too much, so you do not care about the food...*(CFM8). *Look, I want to take care of him [husband] now... I can not even worry about myself right now... I'm not the least bit worried about my health... I am worried about him...* (CFM10).

Although establishing changes in lifestyle is difficult, family members recognize the need to adapt their actions, and some have already introduced preventive measures in their daily routine. Thus, the awareness and change category refers to the perceived need to change the lifestyle by incorporating actions to prevent disease risk factors... *What I always do to try to change our habits is to walk... get out a bit, travel... For my husband I almost do not use salt, oil, I spend more than a month with one glass of oil, meat I almost do not prepare meet, I prepare fish, chicken... mostly vegetables, rice, beans, vegetables...* (CFM5).

The study showed that individuals and their families have unique features incorporated throughout their life stories.

In this sense, the beliefs have an important role in predicting actions towards health and in the difficulties to make a decision, which are described in the perceived barriers category. These difficulties are the products of articulation, knowledge and considerations that individuals have on the beliefs, values and customs, including those of their families and of the society they live in. The appreciation of freedom and daily autonomy reflects the need to adapt the way of living, to avoid become ill and depending on others. The authors of a study[15] that analyzed the beliefs of cardiovascular health behaviors indicate that the benefits perceived by individuals about the importance of making changes in lifestyle contribute to adapt and promote the population's lifestyles. Likewise, the lack of knowledge and support for intervention contributes for the lack of changes in behavior and negatively affects the development of human beings to prevent CAD.[21]

Most behavioral changes are actually established after the initial diagnosis of CVD.[21] The decision to act depends on the combination of perceived susceptibility and severity seen in the disease, while the action itself is effective from the perception of the benefits of adopting preventive measures.[15]

Studies[9,13] showed that "knowing and expanding positive and pleasant experiences arising from contact with the disease represents a possibility of care". Therefore, the perception of the benefits and the recognition of the quality of life through the prevention of CAD contribute to the introduction of changes. According to the beliefs, values and social context, the individual will reflect on the advantages and disadvantages of acquiring new behaviors and different degrees of adhesion.

The adequacy of lifestyle often provides intense emotional stress related to change of behavior associated with the de-

velopment of the feeling of fear and rejection [22]and, in some situations, even social isolation. Thus, there are few individuals who actually use prevention strategies only when informed and urged about the severity of CAD, as evidenced also by the results of this study. It is the acquisition of disease/illness that leads CFMs to realize their own susceptibility, i.e., the fact that they belong to the risk group for CAD. In this situation, CFMs make decisions about changing the lifestyle more easily, to avoid falling ill. This is how the results of this study reflect the need to overcome the difficulties and make decisions with a view to benefit from prevention and lifestyle change. Study[8] proves that the primary caregivers of a chronic patient are family members, and this motivates individuals to adhere to treatment and health promotion.

Thus, when support and encouragement are not present within the family group, the changes are compromised. This is seen in the thematic units found in this research: having no accomplice, no structure to prevent CAD and feelings come first to the need of change. However, nurses' guidance identifying and taking into account the beliefs and values are more likely to promote lifestyle change and assisting and motivating the changing attitudes of the cohabiting family members and other relatives.

Thus, in order to adopt new preventive methods, the individuals need monitoring and support not only from professionals, but also from individuals who live with them, either in the family or professional environment, so that they may feel stimulated and able to take decisions. Therefore, a chronic disease does not affect exclusively the patient, but also their family and social network,[9] because they are all protagonists of the change process.

On the other hand, the thematic unity outdated beliefs gives evidence of "assumptions about the reality before the information that the individual has related to a given goal and that interferes with the behavior", [23] showing that beliefs are acquired and passed from generation to generation, as they are linked to traditions, and social and cultural customs.

Thus, beliefs demonstrate the ideas, concepts, and possible attitudes related to health and/or disease and the way they can influence the lifestyle and health of individuals.[24]

CONCLUSIONS

From this research, it was possible to see that, although CFMs understand CAD and recognize their susceptibility, the difficulties, the seriousness and the benefits of prevention, the majority of individuals still has several beliefs related to health, values and attitudes regarding the cultural process, making it difficult to change behaviors related towards the health-disease process. It is not only the perception that establishes preventive measures, but the set of premises associated with emotional, social and cultural issues, physical and psychological conditions and life experience. In other words, individuals recognize the susceptibility and barriers they have to face, but they do not establish preventive measures because they experience different stories related to different beliefs and values that justify the actions taken.

The prevention of CAD by CFMs becomes important only after living with the disease and its consequences in the family environment, but with treatment and control of comorbidity, the demand for care and decision-making are left aside. Plans are left only as imaginary attitudes and/or to be adopted on the distant future, far from other needs and priorities existing on the day to day life. Thus they need guidance, structure, initiative and support to be completed.

Health professionals, means of communication and government institutions provide information and recommendations to imporve lifestyles and prevent diseases, but the possibilities for the population to achieve their goals are few because of the disparity between social classes and the lack of access to opportunities and products that the market and the globalized world offer.

Therefore, the steps to control the life habits are still beyond the reach of patients and families, because of their beliefs, acquired values and attitudes accumulated over their lives associated with risk factors for the development of CAD and cultural, social, economic, emotional and especially family aspects. However, health education is part of this recognition process and is one of the ways to encourage adherence to treatment and preventive measures. Even though challenging for nursing professionals, it is something that should be prioritized in order to inform, guide and educate the population, as individuals are influenced by the environment, the society and the "system" in which they live.

The results obtained in this study show that it is important to stress the need for changes in the forms of guiding coronary artery disease patients and their cohabiting family members, with the purpose of promoting the educational process in this population. Therefore, nursing must plan, organize and promote educational activities soon after meeting individuals and their family group with respect to their beliefs, values and customs, self-efficacy, family structure, socioeconomic factors and the biopsychosocial relationships. This way, effective measures against risk factors for developing the disease can be employed. It is essential that adequate communication takes place between professionals, patients and families, recognizing the health-disease process, establish appropriate methods to stimulate good practices to prevent and inform the possibility of having quality of life in the aging process and regardless of age. Finally, it is important to educate them with care and attention by adapting lifestyle with positive and lasting results, providing

quality of care and monitoring for people so that healthy habits do not be abandoned, but adopted and improved throughout their life experience. Finally, CFMs should always be involved to make the process to be enhanced and effective, so that everyone may enjoy a better quality of life.

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