

An audit evaluating quality and completeness of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form documentation at Bradford Royal Infirmary

Hammaad Khalid,¹ Abbey Boyle,¹ Marina Yiasemidou²

¹Department of General Surgery, Bradford Teaching Hospitals, Bradford; ²Department of Colorectal Surgery, The Royal London Hospital, Barts Health NHS Trust, London, United Kingdom

Abstract

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form was created and implemented to encourage discussion and standardize documentation of advance

Correspondence: Hammaad Khalid, Department of General Surgery, Bradford Teaching Hospitals, Bradford, United Kingdom.
E-mail: hammaadkhalid@doctors.org.uk

Key words: ReSPECT, advance care planning, elderly, geriatrics, end of life.

Contributions: HK, AB, data synthesis, writing; MY, supervision.

Conflict of interest: the authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Funding: none.

Ethics approval: the audit received institutional approval from the Audit and Clinical Effectiveness Department at Bradford Hospital.

Informed consent: for this audit, although the general principles of the Declaration of Helsinki were followed, the declaration itself is not applicable since this is an audit/quality improvement project rather than a research project.

Patient consent for publication: for the same reason as above, individual patient consent was not sought. However, data was anonymised and used in accordance with the UK Data Protection Act 2018.

Acknowledgements: the authors express appreciation to all the ward teams to allow use of their facilities when collecting the data.

Received: 15 March 2024.

Accepted: 19 July 2024.

Publisher's note: all claims expressed in this article are solely those of the authors and do not necessarily represent those of their affiliated organizations, or those of the publisher, the editors and the reviewers. Any product that may be evaluated in this article or claim that may be made by its manufacturer is not guaranteed or endorsed by the publisher.

©Copyright: the Author(s), 2024

Licencee PAGEPress, Italy

Surgery in Geriatrics and Frailty 2024; 1:12

doi: 10.4081/sigaf.2024.12

This article is distributed under the terms of the Creative Commons Attribution-NonCommercial International License (CC BY-NC 4.0) which permits any noncommercial use, distribution, and reproduction in any medium, provided the original author(s) and source are credited.

care decisions for emergency management. To assess the completion of the ReSPECT form documentation at Bradford Royal Infirmary. Section 4 received special attention: "The quality of the clinical recommendations". In December 2022, data were collected retrospectively from patients' notes. To make comparisons easier, the data was converted to percentages. This was followed by an intervention that included education sessions, posters, and the implementation of required changes. Following that, a second audit cycle was conducted in February 2023 to evaluate the intervention's effectiveness. All audited forms were found in the appropriate patient files. Section 4, "The clinical recommendations for emergency care and treatment," revealed that all forms contained a signed "Do Not Attempt CPR" box and that this information was correctly transferred to the Electronic Patient Record (EPR). However, only 20% of the forms had the free text box filled out with information about the patient's needs and wants, and only 50% of the audited forms had completed subsection 1 in Section 4. The information requested on the ReSPECT form could be extremely useful if provided in greater detail. However, the forms suffer from a significant lack of data, which limits their intended utility. Furthermore, each transcription of the form lowers the quality of the data provided.

Introduction

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form has been instrumental in guiding provision of emergency care and treatment in line with patient wishes where they are unable to convey their preference or decision.¹ This process was introduced in 2016 to address potential inconsistencies in documentation of advanced care and do not attempt cardiopulmonary resuscitation (DNACPR) decisions.² This form is now widely used in the UK and is an integral part of an advanced decision-making process that considers the patient's wants and needs, with active involvement from their families where desired.³ However, there have been numerous instances where these forms have not been completed correctly by medical personnel, resulting in adverse outcomes for patients.⁴

The ReSPECT form⁵ is structured to facilitate a systematic and detailed discussion between clinicians and patients and allow clear documentation of decisions relating to cardiopulmonary resuscitation with an expansion on which interventions may or may not be appropriate or desired within this scenario. Moreover, it serves as a platform for discussing and documenting patient preferences with regards to specific emergency interventions. This encourages advanced decision planning and may guide treatment in line with patient wishes where the individual loses capacity or is otherwise

unable to communicate their preferences. At time of completion, if a patient is deemed to lack capacity, there is a dedicated section of the form encouraging documentation of discussion with patient relatives or advocates.⁶ Collectively, information gathered within the ReSPECT form can be utilised to guide clinical treatment in line with patient wishes and avoid interventions that may be undesirable to or feared by the individual.

In October 2020, the Bradford Royal Infirmary (BRI) adopted the ReSPECT form as part of their healthcare protocols. The primary objective of this study was to evaluate the adequacy of ReSPECT form completion and documentations within a hospital setting, with a specific emphasis on Section 4, which pertains to the quality of clinical recommendations. The increased awareness through interventions such as posters, meetings and education sessions were then evaluated to see the impact on the second round of data collection. Second, the study aimed to compare the resuscitation status of the patients in the Electronic Patient Record (EPR) with the decision recorded on the ReSPECT form.

Materials and Methods

Data was collected from paper ReSPECT forms and EPR over a two-week period in December 2022. Forms were collected randomly and reviewed from a variety of elderly (over 77 or 65 years if from a care home) adult inpatient medical and surgical wards. After the initial audit cycle, results were shared with staff via electronic message and within ward meetings. Teams were encouraged to identify patients during board rounds and Multidisciplinary Team (MDT) meetings who require a ReSPECT form and ensure that EPR and ReSPECT documentation matched. In addition, posters were used to raise awareness and guide ReSPECT documentation in EPR.⁷ These were displayed within handover spaces and doctor offices on the wards. A second cycle was done with new data collection in February 2023. The aim of the audit was to evaluate the efficacy of the interventions in promoting awareness and see the impact in the re-audit using the mentioned means.

All the data on the ReSPECT form was collected and transferred across to the proforma in section order (section 1 to 9). Going through the form the first section encompassed demographic information, encompassing details such as the patient's age, gender, the presence of the ReSPECT form in the file, the completion date, and the Electronic Patient Record (EPR) ReSPECT status.

The subsequent section focused on each completable part of the ReSPECT form, spanning from Section 1 through Section 9. Each section of the form was analysed for completion.

The collected data is systematically represented, with a dual focus on demographic information and completion of ReSPECT form sections. Demographic variables, such as patient age, gender, and the presence of the ReSPECT form in the file, are treated as categorical data. Counts and proportions are employed to depict the distribution and prevalence of these variables within the dataset. Completion of each of the ReSPECT form sections (section 1 through 9) is represented as counts and proportions.

The ReSPECT form sections, each completable section (Section 1 through Section 9) was expressed as counts, reflecting the number of instances where the section was completed, and proportions, providing a percentage-based understanding. As part of the analysis, statistical methods such as descriptive statistics were employed to derive meaningful insights from the dataset.

Ethical approval was not required for this project.

Results

Round 1 (December 2022)

A total of 10 ReSPECT forms were randomly selected for review in December 2022. All of 10 ReSPECT forms were of elderly patients.

In Section 4, the clinical recommendations for emergency care and treatment, 100% (n=10) of forms had a signature in the DNACPR box and the DNACPR decision was correctly transferred across to the EPR (electronic patient record). However, 50% (n=5) of the forms did not contain and completed "clinical recommendations" section. Although this section provides three options, 50% (n=5) of the forms lacked a response. The free text box for expressing more details regarding the patient's wants and needs was completed in only 20% (n=2) of the forms.

Results for completion of the remaining sections are described below.

Section 1, "This plan belongs to": all forms 100% (n=10) were of elderly patients (67 years and over in age) with the correct patient identifiable information on the form. 60% (n=6) of the forms that had a "completion date" recorded on the form. All 100% (n=10) of the patients were elderly and thus was admitted on respective elderly wards so specific "age" was not reviewed in this audit.

Section 2, "Shared understanding of my health and current condition": showed that 100% of patients had a summary of the relevant information section completed, ensuring that crucial medical information was available. Conversely, 0% (n=0) of the forms had other advance care planning guidance documented on the form, which implies a lack of comprehensive planning beyond the basic patient information. Additionally, 90% (n=9) of the forms had "nil documented" for the legal proxy section, indicating a need for improvement in designating legal proxies.

Section 3, "What matters to me in decisions about my treatment and care in an emergency": highlighted that only one form (10%) (n=1) had documented patient priorities, indicating a significant lack of patient input and preferences in emergency care decisions.

Section 4, "Clinical recommendations for emergency care and treatment": revealed that 100% (n=10) of the forms had a signature in the DNACPR box of the section, ensuring the Do Not Attempt Cardiopulmonary Resuscitation status was properly addressed. However, clinical recommendations varied: 40% (n=4) had a signature for "Balance extending life with comfort & valued outcomes", 10% (n=1) had a signature on the "prioritise comfort" section and 50% (n=5) did not have any box ticked, indicating a need for more consistency in clinical decision-making. Moreover, 80% (n=8) of the forms were empty for "clinical recommendations" and only 20% (n=2) had clinical recommendations completed with a focus on remaining comfortable and non-invasive procedures while 30% (n=3) had documentation on the EPR regarding clinical recommendations, showing variation in the level of detail and clarity in clinical guidance.

Section 5, "Capacity for involvement in making this plan": demonstrated that 60% (n=6) of the forms had been completed to assess patient capacity while 40% (n=4) did not have an option documented/ticked, indicating a lack of clarity regarding patient capacity. In 10% of the forms, a tick next to "no capacity" matched EPR, although no other information was documented on the form itself. Furthermore, 90% (n=9) of the forms had family discussions noted on the EPR, but without specific single documents for clinical recommendations, and 10% (n=1) of the forms had no discussion but documented that a discussion would take place on a certain date.

Section 6, "Involvement in making this plan": indicated that 60% (n=6) of the forms had option "A" ticked, while 40% (n=4) did not have an option ticked, suggesting inconsistency in specifying patient involvement. Option A is where the patient has capacity to make the decision and has been involved in the process.

Section 7, "Clinicians' signatures": revealed that 80% (n=8) of the forms had been signed by a clinician and their respective roles had been written. In cases where the form was signed by a junior doctor, it was counter-signed by a senior doctor, ensuring proper authorisation. However, 20% (n=2) had not yet been signed.

Section 8, "Emergency contacts and those involved in discussing this plan": showed that 20% (n=2) of the forms provided a name and contact number for emergency contacts, 20% (n=2) had a name but no contact number and 60% (n=6) left this section blank, indicating significant variation in information documented and available for emergency contacts and next of kin.

Section 9, "Form reviewed": no form had been reviewed following initial completion, highlighting the need for a review process to ensure accuracy and completeness of documentation.

Round 2 (February 2023)

In February 2023, a further 10 ReSPECT forms were selected randomly for review following the interventions to promote awareness. Notably, all ReSPECT (n=10) forms that were audited were of the elderly demographic and they were all found in the patients' mini files on the ward, demonstrating the accessibility and organisation of these crucial documents (Table 1).

In Section 1, "This plan belongs to", it was observed that 90% (n=9) of the forms had recorded a "completion date" on the form, indicating that a significant majority of the forms were updated with this crucial information. This is an improvement from the first cycle of 60% (n=6).

In Section 2, "Shared understanding of my health & current condition", it was noted that 100% (n=10) of the forms had the "summary of the relevant information" section completed. Additionally, 100% (n=10) of forms had "nil documented" within the legal proxy section, This is a slight improvement from 90% (n=9) in the first cycle.

Section 3, "What matters to me in decisions about my treatment and care in an emergency" demonstrated that 20% (n=2) of the forms had documented patient priorities and these forms had

all patient priorities subsections completed. This represents an improvement compared to the first cycle which had a 10% (n=1) completion rate.

Section 4, "Clinical recommendations for emergency care and treatment" revealed that 100% (n=10) of the forms had a signature in the DNACPR box, ensuring that the Do Not Attempt Cardiopulmonary Resuscitation status was clearly indicated. Furthermore, all decisions on the forms were correctly reflected on EPR. While 50% (n=5) of the forms had detailed clinical recommendations with an additional, 30% (n=3) of the forms had documentation on the EPR regarding clinical recommendations. These results remained fairly similar to the first round where 50% (n=5) of the forms had a signature for the clinical recommendations but only 20% (n=2) had further information about it completed.

Section 5, "Capacity for involvement in making this plan" indicated that 60% (n=6) of the forms were marked as the patient having capacity, suggesting that patients had an active role in decision-making. This is an improvement when compared to the first cycle where 40% (n=4) of the forms had nothing ticked.

Section 6, "Involvement in making this plan" demonstrated a completion of 90% (n=9). Which is an overall improvement from the first round. This broken down into 40% (n=4) of the forms had "option A" ticked which indicated the patient had capacity. Moreover, 30% (n=3) of the forms had "option B" ticked which was patient lacked capacity and 20% (n=2) had "option D" ticked for other reasons.

Section 7, "Clinicians' signatures" showed that all 100% (n=10) being signed appropriately an improvement on 80% (n=8) of the forms being signed in cycle 1.

Section 8, "Emergency contacts & those involved in discussing this plan" revealed that 70% (n=7) of the forms included a name and contact number, This is an improvement compared to the first cycle where only 20% (n=2) had some information completed.

In Section 9, "Form reviewed", it was noted that 0% (n=0) of the forms had been reviewed, this is the same as the first cycle 0% (n=0).

Table 1. Proportion of sections completed on ReSPECT forms pre- and post-intervention.

	December 2022 (%)	February 2023 (%)
Number of forms reviewed	10	10
Forms in mini files	100	100
Adult forms	100	100
Section 1 completion	60	100
Section 2 completion	100	100
Section 3 completion	10	20
Section 4 completion	50	40
Section 5 completion	60	60
Section 6 completion	60	90
Section 7 completion	80	100
Section 8 completion	40	90
Section 9 completion	10	0

Discussion

The audit collected data on all aspects of the ReSPECT form; however, the primary focus was Section 4, which indicates the patient's decision regarding DNACPR or CPR. It seems that many people regard this like the "old DNACPR form" and, therefore, only complete this section.⁸ The "old DNACPR" form was a single sheet with a box to indicate whether the patient was for escalation or not, without any space for additional information. In contrast, the newer ReSPECT forms include areas for more detailed information. This could be a possible reason why all the forms had the signature in the DNACPR box even in the initial audit cycle.

The results of the repeated audit showed a slight improvement overall but similar results for this specific section when compared to the first audit. There was still 100% (n=10) completion of the DNACPR box as well as the EPR status. There were no forms for patients that indicated CPR would be appropriate; hence, some additional education promotion may be needed for that aspect to encourage ReSPECT form completion even where a DNACPR decision is not indicated. However, this is beyond the remit of this audit.

All decisions on the ReSPECT forms were correctly copied to the EPR. This is an important aspect as having two different sources of information for the same decisions can make things complicated and impact patient interventions (9). Having updated and correct information on the system is essential to allow all parties involved in

the care of the patient to see when it was updated, by whom and what the latest decision is.

For the part of Section 4 where further clinical recommendations could be documented alongside a CPR decision by selecting one of three pre-defined options on the form—prioritise life, balance or prioritise comfort—50% (n=5) of the forms had been ticked following discussion with the patient. However, this number is significantly lower than is advised and should be aspired to achieve with all patients being involved in decision making where practicable. Standard guidance by the Resus Council advises that this section should be completed on 100% of the forms.¹⁰ This section alone gives only limited information as it must be supplemented with information in the following section. This additional section was not completed in 80% (n=8) of the forms audited.

Following interventions there was some improvement to this section from 20% (n=2) to 50% (n=5) in the clinical recommendations area of Section 4. 50% (n=5) of the forms had clinical recommendations completed with phrases such as “remaining comfortable”, “non-invasive procedures and tests”, “ward-level care” and “discussion following MDT”. 30% (n=3) of the forms had documentation on EPR regarding clinical recommendations (for example, if the patient was not for blood or antibiotics etc.). Although insignificant, this result showed some improvement but still falls short of the Resus Council’s recommendations.¹ The information written in this area still was very generic and would benefit from more specific information to be written that is tailored to the patient.¹¹

This highlights a need for further education of the healthcare teams as this is an important part of the ReSPECT form along with involving the patient in decisions about their care. This may place extra burden on community teams if they are unsure of the clinical recommendations decided within a hospital admission or clinic. For example, if the patient would wish for readmission and their preferred place of death.

For the part of Section 4 where a tick could be placed on three different options—prioritise life, balance or prioritise comfort—40% (n=4) were ticked in the middle box, 10% (n=1) had a signature in the prioritise comfort section and 50% had nothing ticked. This is a good starting point that 50% (n=5) of the forms had been ticked depending on what was discussed with the patient. However, this number is still low as it’s important to document what the patient wants. Moreover, this section alone does not provide much information as it needs to be supplemented with the box underneath.¹¹ The box underneath was empty on 80% (n=8) of the forms audited. 20% (n=2) of the forms had clinical recommendations documented and information on what the patient can have and what the team must avoid in this patient’s care. This needs more education and teaching as this is an important part of the ReSPECT form along with involving the patient in deciding what they want out of their care. The clinical guidance analysis is not part of this audit, but we should consider having some guidelines for minimum information required for the form to be completed for it to be effective. Such as if they wanted to be admitted to hospital, place of death and what kind of interventions they want or not etc.

ReSPECT documentation is not always clear on the EPR as there is currently no standardised way in which to document this. It may often be included within a clinical note addendum or in a documentation with another name (e.g. family discussion). This makes it hard for other members of the team to clearly identify where ReSPECT discussions have taken place and what decisions or recommendations have been made following discussion with the patient and family where indicated. As there is no standardised format to summarise and document these vital discussions, it is very time-consuming to find such documentation within the EPR and can

lead to a high risk of such conversations and their documentation being missed.

The ReSPECT flag on the EPR had been documented correctly for 100% (n=10) of the patients. This may be because the consultant would complete the form and then the relevant EPR documentations. It is important for other staff to know how to do this and also to pick up if any have been missed. All team members need to know how to see if the correct flag is applied. Information for this is already summarised in a poster that could be distributed to the ward staff.

Most ReSPECT forms did not document family information 80% (n=8). This aspect requires enhancement as the identification of the individual with whom the discussions were conducted with holds significant importance. In specific scenarios, the ability to contact them may be necessary and having this information readily accessible proves invaluable. Should any clarifications become necessary, the correct person can be promptly contacted. Given that the next-of-kin’s information is not consistently available in the system—and even when it is, they may not be the party involved in the discussion—improving this aspect can greatly facilitate better communication and rapport between clinicians and families, ultimately leading to more streamlined discussions.

Finally, reviewing forms when patients move wards, departments or medical settings is important. This helps updated information to be circulated among all members involved in the patient’s care. As all ReSPECT forms did not have a completed review section (section 9), it was difficult to ascertain whether it was an original form or had been completed on a previous admission. It is important that essential forms and documentation, such as the ReSPECT form, are reviewed and dated according to guidelines.

Interventions that took place were all done locally. Posters were made and printed and placed throughout the wards and doctors’ offices.¹² Electronic posters were distributed via doctors’ WhatsApp groups. Board round and ward meeting education and advocacy were also done. Using education and advocacy via posters has been shown to have a significant impact.¹³ Notably, overall these results represent a slight improvement in ReSPECT documentation and the planning process following our interventions to promote awareness however, lots of work still needs to be done.

It is noted that many forms are lost in transfer within the hospital or between the community and hospital. This issue is particularly prevalent among elderly patients, who often rely on carers and family members to manage their documents, potentially leading to information loss. Consequently, these forms must be completed again, resulting in a reduction in their quality and detail. They then must be completed again, which causes a reduction in quality and detail.

Overall, the DNACPR status for patients appears to be correctly recorded, but section 4 only showed a slight improvement rising from 20% (n=2) to 50% (n=5), following interventions implemented after the first audit cycle. However, substantial educational efforts and a push for better completion standards are necessary to raise the overall quality of ReSPECT forms.

Recommendations

Ward Multidisciplinary Team (MDT) meetings provide an excellent platform to discuss findings and promote areas of improvement. The presence of all team members ensures that the message is effectively communicated throughout the team. Here are some strategies to enhance the ReSPECT form completion process. These strategies could serve as a foundation for further audits and research, though they would need independent evaluation to determine their own effectiveness. The recommendations are based on actions taken during the audit and proven successes at the local level.

Utilise MDT meetings for discussion

Ward MDT meetings should be leveraged as a vital forum for discussing ReSPECT findings and identifying areas for improvement. These meetings provide an excellent opportunity to nurture collaboration and ensure that everyone is aligned in their understanding and goals.

Display information posters

Placing information posters in all clinical areas, including handover rooms and doctors' rooms, can effectively disseminate instructions on how to update the ReSPECT flag in the EPR. This increases awareness and ensures staff have easy access to relevant guidance.

Alignment of EPR and ReSPECT documents

The MDT meetings can also be used to ensure that the EPR and the ReSPECT documents match. During these meetings, as each patient's daily plan is noted on the board, discussions should include verifying and updating the resus status for each patient before moving on.

Proactive identification of ReSPECT requirements

Encourage the identification of patients requiring a ReSPECT form during daily MDT meetings or rounds. This proactive approach ensures that ReSPECT documentation is initiated promptly when needed.

Review when patients move

It is crucial to review ReSPECT forms when patients move between wards, departments, or medical settings. This practice ensures that up-to-date information is shared with all team members involved in the patient's care, maintaining consistency in the provision of treatment.

Consider electronic forms

Exploring the use of electronic forms within the EPR is a promising step. Electronic forms can incorporate mandatory fields, which must be completed, ensuring that all essential information is captured. This approach not only enhances documentation but also centralises patient information for easier access and reference.

By implementing these strategies and utilising MDT meetings effectively, healthcare facilities can enhance the ReSPECT form completion process, improve the quality of patient care, and ensure that essential information is readily available to the entire care team.

Conclusions

It is evident that the ReSPECT forms have not yet reached their full potential due to various challenges. The completion of these forms needs to be significantly improved to make them more effective

and useful. One recurring issue is the loss of forms, resulting in diminished information quality with each new completion. While the DNACPR status for patients appears to be correctly recorded, the other sections would still need further work. Overall, the quality of form completion did slightly improve but would need substantial work to reach the full benefit of these forms.

Looking ahead, it might be beneficial to consider the implementation of an electronic form with mandatory fields. Such a system could not only enhance completion standards but also facilitate the transferability of these crucial documents across the healthcare system, ultimately improving the quality of care provided to patients during emergencies.

References

1. Resuscitation Council UK. ReSPECT [Internet]. Resus.org.uk. Resuscitation Council UK; 2015. Available from: <https://www.resus.org.uk/respect>
2. Eli K, Hawkes CA, Fritz Z, et al. Assessing the quality of ReSPECT documentation using an accountability for reasonableness framework. *Resuscitation Plus* 2021;7:100145.
3. Fritz Z, Slowther AM, Perkins GD. Resuscitation policy should focus on the patient, not the decision. *BMJ* 2017;356:813
4. Fritz Z, Fuld J, Haydock S, Palmer C. Interpretation and intent: A study of the (mis)understanding of DNAR orders in a teaching hospital. *Resuscitation* 2010;81:1138–41.
5. Harris D, Davies R. An audit of “do not attempt resuscitation” decisions in two district general hospitals: do current guidelines need changing? *Postgraduate Med J* 2007;83:137–40.
6. Fritz Z, Cork N, Dodd A, Malyon A. DNACPR decisions: challenging and changing practice in the wake of the Tracey judgment. *Clinical Medicine* 2014;14:571–6.
7. Mockford C, Fritz Z, George R, et al. Do not attempt cardiopulmonary resuscitation (DNACPR) orders: a systematic review of the barriers and facilitators of decision-making and implementation. *Resuscitation* 2015;88:99–113.
8. Eli K, Hawkes CA, Fritz Z, et al. Assessing the quality of ReSPECT documentation using an accountability for reasonableness framework. *Resuscitation Plus* 2021;7:100145.
9. Wu CHK, Luk SMH, Holder RL, et al. How do paper and electronic records compare for completeness? A three centre study. *Eye* 2018;32:1232–6.
10. Wu CHK, Luk SMH, Holder RL, et al. How do paper and electronic records compare for completeness? A three centre study. *Eye* 2018;32:1232–6.
11. Council R. Criteria for auditing and evaluating the ReSPECT process and suggested measures for service evaluation in Secondary/Tertiary care. online: Resus Council; 2022 Nov p. 4.
12. Rowe N, Ilic D. What impact do posters have on academic knowledge transfer? A pilot survey on author attitudes and experiences. *BMC Medical Education* 2009;9:71.
13. Hasanica N, Catak A, Mujezinovic A, et al. The Effectiveness of Leaflets and Posters as a Health Education Method. *Materia Socio Medica* 2020;32:135.