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Fatores agravantes e atenuantes à percepção de morte em UTI: a visão dos pacientes

Aggravating and mitigating factors to death perception in the ICU: a vision of patients

Factores agravantes y atenuantes a la percepción de la muerte en la UCI: una visión de pacientes

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ABSTRACT

Objective: To identify the aggravating and mitigating factors to the perception of death of patients in the Intensive Care Unit. **Methods:** This is an exploratory and descriptive study with a qualitative approach, performed with 07 inpatients in the ICU, using the saturation criteria for delimitation of the sample. Data were collected through semi-structured scripted interviews with indirect approach to the subject, all patients signed the free and enlightened consent, and then the data was analyzed in light of the pertinent literature, after approval by the Research Ethics Committee University Hospital Alcides Carneiro HUAC under CAAE nº04818912.0.0000.5182. **Results:** Two thematic categories emerged, one showing the aggravating factors to the perception of death, and the other the mitigating factors to this perception. **Conclusion:** The existence of some factors may contribute to the worsening perception of death of patients, however, others mitigate this perception, often favoring for their recovery.

Descriptors: Intensive Care Unit; Patients; Perception; Death.

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RESUMO

Objetivo: Identificar os fatores agravantes e atenuantes à percepção de morte dos pacientes em Unidade de Terapia Intensiva. **Métodos:** Estudo exploratório e descritivo com abordagem qualitativa, realizado com 7 pacientes internos em UTI, utilizando-se o critério saturação para delimitação da amostra. Os dados foram coletados através de entrevistas com roteiro semi-estruturado, abordagem indireta ao sujeito, mediante assinatura de termos de consentimento livre e esclarecido, e procedendo-se à análise dos dados sob a luz da literatura pertinente, após aprovação do Comitê de Ética e Pesquisa do Hospital Universitário Alcides Carneiro HUAC, sob o CAAE nº 04818912.0.0000.5182. **Resultados:** Emergiram duas categorias temáticas. A primeira apresenta os fatores agravantes à percepção de morte, e a segunda traz os fatores atenuantes à essa percepção. **Conclusão:** A existência de alguns fatores pode contribuir com o agravamento da percepção de morte dos pacientes, entretanto, outros atenuam essa percepção, muitas vezes favorecendo a recuperação do paciente.

Descritores: Unidade de Terapia Intensiva; Pacientes; Percepção; Morte.

RESUMEN

Objetivo: Identificar los factores agravantes y atenuantes a la percepción de la muerte de los pacientes en la Unidad de Cuidados Intensivos. **Métodos:** Este estudio es exploratorio y descriptivo, con abordaje cualitativo, realizado con 07 pacientes ingresados en la UCI, utilizando el criterio de saturación para la delimitación de la muestra. Los datos fueron recolectados a través de entrevistas escrituradas de forma semi-estructuradas y enfoque indirecto con los sujetos, los pacientes firmaron el termo del consentimiento libre e informado, adiante se ha procedido a analizar los datos a la luz de la literatura pertinente, previa aprobación del Comité de Ética de la Investigación Hospital Universitario Alcides Carneiro HUAC bajo CAAE nº 04818912.0.0000.5182. **Resultados:** Dos categorías temáticas emergieron, uno que muestra los factores agravantes de la percepción de la muerte, y el segundo trae los factores atenuantes a esta percepción. **Conclusión:** Existencia de algunos factores que pueden contribuir a la percepción de empeoramiento de la muerte de los pacientes, sin embargo, otros mitigan esta percepción, a menudo favoreciendo para su recuperación.

Descriptores: Unidad de Cuidados Intensivos; Pacientes; Percepción; Muerte.

INTRODUCTION

The Intensive Care Unit (ICU) emerged after the Second World War, from the need to provide a specific environment to treat critically ill patients until the rebalancing of their health. In Brazil, this proposal was implemented in 1971 and the Syrian-Lebanese Hospital was pioneer with ten beds.[1] Thus making it possible to qualify the assistance and minimize the suffering, through individual visualization in all its dimensions, favoring its recovery.[2]

The ICU is characterized nowadays as a hospital area destined for the provision of expert assistance of a multidisciplinary team to care for potentially critically ill patients or patients with decompensation of one or more organ systems, requiring constant monitoring and complex care by means of advanced technological mechanisms and high precision.[3] Therefore, the ICU implies a high cost and the patient is subjected to intense monitoring until the stabilization of its health.[4]

This environment concentrates many severe and recoverable patients or people who underwent high-risk surgery, requiring of the working professionals continuous assistance and immediate decision making because hemodynamic instabilities occur rapidly, which favors a higher rate of deaths compared to the other sectors. Relevant study says that mortality in this hospital sector ranges from 40 to 50%, and its reduction is due to advances in the care and the ability to intervene accordingly.[5]

Therefore, the use of sophisticated technological resources becomes essential, in a way that the occurrence of noise generated by equipment is common, which is often linked to frequent therapeutic complications, the constant lighting and environmental conditions also difficult sleep. Intensive care units have been classified as a complex sector, stress generator and difficult to adapt both for patients and for family members and professionals.[5] In addition, there are still factors related to the patient, such as their physical condition, the assumption of the severity of the illness and the risk of death that also affects negatively the patient's stay in the ICU.[3]

Although it is considered a hospital unit designed to meet recoverable patients, it is notable that many of them are in a terminal stage in the ICU only to receive palliative care in an attempt to prolong and offer better living conditions. Thus, death happens constantly in this unit, even with all the professional team's effort to avoid it, using all their technical-scientific expertise aiming to achieve the maintenance of life.[6]

Death, despite being an inevitable process of human life, still is discussed in the everyday life with trepidation, and culturally rejection and fear prevail as taboos concerning this theme. This is due to the fact that the man is not prepared or simply can not spontaneously accept the end of life on the earth plane, which incidentally happens when one is affected by any disease or condition that puts his life at risc.[7]

The scientific study of death is called Thanatology. This science was developed through Hermann Feifel's research, who wrote the classic *The meaning of death*, after the world wars. This work signals the awareness movement about the importance of the discussion of the death theme, although there is still a prohibition mentality regarding this subject. The book includes texts on philosophy, religion and sociology.[8]

Talking about death goes beyond the focus on organic, it implies dealing with the feeling of sadness, with the finding of the human finitude and the fear of the unknown. It brings in its context, the whole feeling of weakness against the finitude, of non-conformity with the termination of the material being, with the interruption of longed-for future plans and the separation from loved ones.[8]

Thus, this feeling of death is quite common in ICU patients for the environment itself contributes to this keen perception, as it is the hospital sector that generates more stress, because of its own structure, techniques, procedures

performed and the clinical status of patients, among other factors that interfere with the ability to adapt to changes within the individual and within their families.[9]

Based on the above, this study aims to identify the aggravating and mitigating factors to the perception of death of the in-patient in the Intensive Care Unit. The achievement of these goals will form the basis for the multi-professional team, helping the staff, especially the intensive care nurse, to be capable of estimating the feelings of patients facing different situations experienced in the sector, being able to prevent them and offering greater comfort and, consequently, agility in the recovery of the patient.

METHODS

This study is of an exploratory and descriptive type, with qualitative approach.[10] The theoretical and methodological framework corresponds to the Content Analysis proposed by Bardin,[11:33] highlighted as "[...] a set of communication analysis techniques" that processes the information derived from the speeches of the subjects investigated on a particular subject, making the centralization of ideas and their categorization according to the theme possible.11 Therefore, the understanding of phenomena from the perspective of the participants is required of the researcher, who can not reduce it to the operationalization of variables.[11]

The survey was conducted in the adult ICU of the University Hospital Alcides Carneiro (HUAC), located in the city of Campina Grande, Paraíba. This choice was determined by the fact that the perception of death is more common in this sector, due to the constant complications associated with clinical diseases and consequently the high incidence of deaths.

The population was composed of seven ICU patients of HUAC, following the saturation criteria that appears in qualitative research, according to which the inclusion of new subjects is canceled at the moment the data collected begins to repeat itself. Thus, the addition of new subjects would add little to the material, because the data fails to be new, no longer significantly contributing to the research.[12]

All ethical principles established by Resolution No. 466/2012 of the National Health Council (CNS) were met, this resolution advocates in Chapter III that research involving human subjects must meet the fundamental scientific and ethical requirements, highlighting among its ethical principles the importance of the Free and Enlightened Consent Term, signed by the participants of the research.13 Accordingly, this study was submitted to the Research Ethics Committee of the HUAC, approved under the CAAE nº 04818912.0.0000.5182.

Data collection was conducted in January and February 2013, through interviews with an indirect approach to the subject, focusing on their perception of death. This approach choice is justified because it allows more freedom of expression in the respondents answers, as well as a decrease in the psychological repercussions.

The interview consists of nine essay questions, structured in two parts, the first corresponds to the characterization of the subject and this includes socioeconomic and educational issues, while the second includes specific questions, which correspond to the objectives of the study.

RESULTS AND DISCUSSION

Given the analysis of the interviews, it was possible to characterize the participants, according to sex, age, marital status, education, occupation and pathology through international diseases code CID 10.

These are relevant data for enabling the understanding of how the perception of death can be influenced by personal factors that are linked to the patient.

At first, the participants were classified according to sex, age and marital status (Table 1), the majority are female, corresponding to 57%; there is also a preponderance of older people, composed of 57% of seniors over 60 years. According to data found in the research, it becomes clear that old age is common among ICU patients, being one of the factors that brings greater chances for admissions in that sector, as shown in the literature.[14-5]

Regarding marital status, 71% are married and the others are widowers, which leads to the understanding that the majority of this population have family ties, which can influence the feelings concerning the hospitalization.

Table 1 – Absolute and percentage distribution of research participants, according to sex, age and marital status (N = 07)

	Indicator	N	%
Sex	Male	03	43%
	Female	04	57%
Age group	41-60 years	03	43%
	>60 years	04	57%
Marital status	Married	05	71%
	Widower	02	29%

Source: Research data, 2013.

Other variables were the level of education and profession, where it is perceived that 72% have not completed elementary school, 14% have completed secondary school, and equal percentage have completed higher education, featuring a population with low degree of education and knowledge, which possibly reflects in the reported professions: farmers 43%, teachers 29%, packagers 14% and domestics workers 14% (Table 2).

Table 2 – Absolute and percentage distribution of participants, according to education and occupation (N = 07)

	Indicator	N	%
Education	Elementary school Incomplete	05	72
	High School Incomplete	01	14
	College Complete	01	14
Occupation	Farmer	03	43
	Teacher	02	29
	Packager	01	14
	Domestic Worker	01	14

Source: Research data, 2013.

Finally, the participants were classified according to CID 10 of its pathology (Table 3), where it is perceived that the diagnoses were quite variable, no repetitions, given that the hospital under study is not specific to a group of diseases.

Table 3 – absolute and percentage distribution of research participants, according to disease CID 10 (N = 07)

INDICATOR		CID 10	N	%
Pathologies	DPOC	J44.1	01	14%
	Anemia	D64.9	01	14%
	Cholecystitis	K81	01	14%
	ICC	I50.0	01	14%
	EVA	I64	01	14%
	Heart Disease	I27.9	01	14%
	Chagas Disease	B57.3	01	14%

Source: Research data, 2013.

Among the pathologies presented by research subjects, Chronic Obstructive Pulmonary Disease (COPD) and cerebrovascular accident (CVA) appear, two diseases with significant frequency in ICUs. A recent study points COPD as corresponding to 12.3% of the causes of hospitalization in an ICU of a general hospital, and the AVE appears with 6.6% of all hospitalizations. This study also depicts hospitalization data from another ICU specialized in caring for trauma victims, where the stroke appears as the major cause of hospitalization, constituting 21.6% of the total.

Considering the analysis of the collected material in order to meet the objectives of the study two thematic categories emerged from the transcription and interpretation of the interviews, exposed below.

Category I

The power of negative thinking, the severity of other in-patients, frequent deaths, fear of death, intensive care offered, professional look: aggravating factors to the perception of death.

This category highlights the participant's speeches entered in the research that identifies the aggravating factors in the perception of death, according to statements set forth below.

"[...] I have the impression that we could die at any moment because of the care, I don't know, I think it's (...) The extra care that they provide, the look of the doctors, the worry, that worries us [...]." (ENT. 1)

"[...] Thinking of bad things, only brings bad things... Right?! [...]." (ENT. 2)

"[...] I try to focus, when I see that it was a natural thing, it's part (of life), that she hadn't been well, that it was going to happen at any moment, besides that, we fear that the doctors don't... they don't pass it on to us, that we are not okay, that they are ... Lying and any time it will happen to us, you understand? [...]." (ENT. 1)

"[...] There were sick people, they ran from one side to the other, that increased fear [...]." (ENT. 5)

"[...] I was afraid when I saw the patient dead right there, oh my God [...]." (ENT. 1)

"[...] Unless...we see, say, hum...a patient dying by our side then I think we get scared, yeah ... Then I think we get scared [...]." (ENT. 7)

Some factors that influence the awakening or exacerbation of the fear of death in ICU patients can be identified. Among these factors, some are noticeable, the intensive care services provided, referred to as "extra care" and the look offered by the professionals who care for the patients.

The aspects above are new data in relation to the existing literature, for they emphasize the relational situation with the team, its presence and the care provided play an important role in reducing stress and building a positive image of the ICU.[16] Therefore, a factor which is considered negative by some patients, is not always perceived in the same way by the other, which refers to certain specificity and human individuality.

The strength of negative thinking is worth noting for it may be present in patients under stressful conditions and it is a harmful factor that attracts negative results, constituting of an aggravating factor of fear and feelings of impending doom, since the patients tend to imagine that their condition will deteriorate gradually.

It is also found that death in the ICU is an aggravating factor to the perception of death to the patients, due to its frequency, which raises the fear that the same will happen to them. Still regarding the factors related to patients in neighboring beds, complications and aggravations of clinical

features were reported. Corroborating the literature, which states that the conditions surrounding the patients, including death, can disturb, stress and exacerbate the weakness and impotence of the patient that watches as that happens.[9]

Category I also confirms that in many clinical cases in which the diagnoses isn't final yet, uncertainty and doubt about the severity of the condition prevails, consequently incurring in ignorance and fear of what will happen in the coming hours or days, corroborating previous studies, which testifies that during the hospitalization period, the lack of information about the procedures performed, their health status, among others, are aspects that generate insecurity and fear in patients.[9]

Category II

The power of positive thinking, the presence of faith, intensive care provided by professionals, the humanization in care, agility and equipment: mitigating factors to the perception of death.

In this category, the factors that decrease the perception of death in ICU patients were presented, as shown in the transcribed speeches.

> *"[...] One has to be very strong, it just has to be, (it requires) a lot of positive thinking [...]." (ENT. 1)*

> *"[...] One has no need to fear, there needs to be faith in God and trust in the doctors [...]." (ENT. 5)*

> *"[...] They give us medicine, the girls are all good, the doctors are always here [...] (ENT. 3)*

> *"[...] The affection, the force that they provide us, they're always by our side... explaining… That's because they are good willed people. So we cheer up. [...] They were always close. Examined us, listened, conversed... Holly Mary, they seem like father and mother, made the fear disappear [...]." (ENT. 5)*

> *"[...] Well, there are more machines there, right?! Do you get it? Medication is on time. Everywhere is good, but there is always better [...]." (ENT. 4)*

> *"[...] All night long, doctor, nurse, care, is...very good. Yeh... it's very good assistance [...]." (ENT. 7)*

The second category includes excerpts extracted from the interviews that demonstrate the existence of factors that reduce the fear and feeling of impending death, leaving the subject more relaxed and confident in their recovery.

Among such factors, there is an emphasis in the presence of material resources, such as equipment and drugs, reported by the participants of the research as mitigating elements to their suffering facing death. Thus, these patients see the advanced technological resources as a source of hope for their recovery and their importance in this environment is unquestionable, as found in other studies.[17]

It is also noticed that the faith and the power of positive thinking constitute as fear of death mitigating factors, those are characteristics innate to the patient that help in the hospitalization process and in renewing hopes for one's recovery. This optimism, the will to live and faith in God are also reported in the literature for they mitigate suffering and help in obtaining a satisfactory response to treatment.[18]

The quality of the professionals, the care for the patients, the assistance and the attention were also mentioned by the patients as positive factors in the ICU, which helps with one's comfort and aids in recovery. Similar studies also show that the assistance provided by the team, its proximity to the patient, as well as provided dedication, are factors that contribute to a better understanding of the ICU patient, thus easing their discomfort and the feeling of imminent death.[9]

CONCLUSION

The intensive care unit is a hospital sector considered stressful and presents high mortality rates. This statement is justified by socially constructed concepts about it, besides the fact that it is a location which hosts the treatment of various diseases and puts the patient in serious condition, hemodynamic instability that sometimes culminates in death.

Thus, it is expected that a sector such as this contributes considerably to death accentuated perception of in-patients surveyed in this environment. Accordingly, this study brought reports of patients who elucidate the existence of factors that increase the perception of death, such as the look and intensive care dedicated by professionals, negative thinking, uncertainty about the diagnosis, frequent deaths, complications and worsening of medical conditions in the other patients in the ICU.

However, the survey could not fail to default to the existence of mitigating factors to this perception, often favoring for the recovery of patients. Among the mitigating factors are: technological resources, faith, power of positive thinking, quality of care and attention given by the professionals.

Given the whole context, the importance of this research becomes evident, both for patients and for the critical care professionals, who, equipped with this information, can detect the aggravating factors to the perception of death and come to fight them on one hand, and to value the mitigating factors on the other. Based on this knowledge and the applicability of the same, patients will benefit from better conditions in hospitalization and effective assistance, based in humanization and in the plenitude of knowing that death is not necessarily related to the hospitalization in the ICU and that it is one of the stages of life.

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