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Original Article

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ADVOCACY IN INTENSIVE CARE AND HOSPITALIZATION BY COURT ORDER: WHAT ARE THE PERSPECTIVES OF NURSES?

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ABSTRACT

Objective: to analyze how intensive care nurses practice patient advocacy in view of the need for hospitalization by court order to an intensive care due to bed unviability.
Method: analytical exploratory qualitative research. Data were obtained through interviews with 42 nurses, selected via snowball sampling, between January and December 2016. The interviews were analyzed using elements of the Discursive Textual Analysis.
Results: two categories emerged: 1) Between obedience to the law and the ethical-moral duty of the intensive care nurse; 2) The position of nurses in the practice of patient advocacy for patients requiring intensive care beds.
Conclusions: intensive care nurses exercise sensitivity and moral duty of the care process when defending their patients by informing them of their rights, guiding, acting and talking to and on behalf of patients and their families, valuing care free of judgment and harm to the patient hospitalized by court order.

DESCRIPTORS: Advocacy in health. Nurse-patient relations. Critical care nursing. Judicialization of health. Intensive care units.

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ADVOCACIA NA TERAPIA INTENSIVA DIANTE DA INTERNAÇÃO POR ORDEM JUDICIAL: QUAL A PERSPECTIVA DOS ENFERMEIROS?

RESUMO

Objetivo: analisar como enfermeiros intensivistas têm exercido a advocacia do paciente diante da necessidade de internação em unidade de terapia intensiva por ordem judicial, perante in/viabilidade de leito.
Método: pesquisa qualitativa exploratória, analítica. Os dados foram obtidos através da realização de entrevistas com 42 enfermeiros, selecionados mediante amostragem por bola de neve, entre janeiro e dezembro de 2016. As entrevistas foram analisadas mediante elementos da Análise Textual Discursiva.
Resultados: emergiram duas categorias: 1) Entre a obediência à lei e o dever ético-moral do enfermeiro intensivista e; 2) A posição dos enfermeiros no exercício da advocacia do paciente que necessita de leito na terapia intensiva.
Conclusões: enfermeiros intensivistas exercem a sensibilidade e dever moral do processo de cuidar quando defendem seus pacientes informando-os sobre seus direitos, orientando, agindo e falando sobre e em nome dos pacientes e seus familiares, prezando por um cuidado livre de julgamentos e prejuízos ao paciente que interna através da ordem judicial.

DESCRITORES: Advocacia em saúde. Relações enfermeiro-paciente. Enfermagem de cuidados críticos. Judicialização da saúde. Unidades de terapia intensiva.

ABOGACIA EN ATENCIÓN INTENSIVA Y HOSPITALIZACIÓN POR ORDEN JUDICIAL: ¿CUÁLES SON LAS PERSPECTIVAS DE LOS ENFERMEROS?

RESUMEN

Objetivo: analizar cómo los enfermeros de cuidados intensivos practican la defensa del paciente en vista de la necesidad de hospitalización por orden judicial a cuidados intensivos debido a la inviabilidad de la cama.
Método: investigación exploratoria, analítica cualitativa. Los datos se obtuvieron a través de entrevistas con 42 enfermeros, seleccionados mediante muestreo de bola de nieve, entre enero y diciembre de 2016. Las entrevistas se analizaron utilizando elementos del Análisis textual discursivo.
Resultados: surgieron dos categorías: 1) Entre la obediencia a la ley y el deber ético-moral del enfermero de cuidados intensivos; 2) La posición de los enfermeros en la práctica de la defensa del paciente para pacientes que requieren camas de cuidados intensivos.
Conclusiones: los enfermeros de cuidados intensivos ejercen la sensibilidad y el deber moral del proceso de atención cuando defienden a sus pacientes informándoles sobre sus derechos, guiándoles, actuando y hablando con y en nombre de los pacientes y sus familias, valorando la atención libre de juicio y daños al paciente hospitalizado por orden judicial.

DESCRIPTORES: Defensa de la salud. Relaciones enfermero-paciente. Enfermería de cuidados críticos. Judicialización de la salud. Unidades de cuidados intensivos.

INTRODUCTION

In the Intensive Care Unit (ICU), technology impacts patient survival in ways that no one could have predicted in the early days of intensive care medicine.[1] From this perspective, ICU bed admission is determined by the degree of risk that a specific disease brings to the person's life.[2] The indication of ICU admission is technical and respects protocols in order to be safe and effective for the health system user.[3]

However, the availability of complex technology that prevents and cures diseases is not necessarily viable for the majority of the population, precisely because of high costs.[3–4] Which means, while some patients can afford to have access to treatments needed to recover from life-threatening disease, most rely on the protection and access to which they are entitled to, but which are limited due to the scarce resources and limitations of the health system.[3,5]

The Brazilian Ministry of Health established the need for 4 to 10% of ICU beds of the total hospital beds (corresponding to 1-3 ICU beds per 10,000 inhabitants). However, people covered only by the public health system have access to 0.9 ICU beds per 10,000 inhabitants; while private health sector beneficiaries have access to 4.14 beds per 10,000 inhabitants. The disparity of access is increasing outside of large cities and in the poorest states of Brazil. In addition, where 44% of ICU establishments are private institutions, 26% are philanthropic (which also offer ICU beds for private hospitalization), and 28% are public ICU establishments.[6–7] This is a paradox, as in Brazil health is classified an inalienable public good, according to Brazilian Unified Health System (SUS), and defined as a right of every citizen, Brazilian or not, throughout national territory. This right was made effective in the Federal Constitution of 1988 which, in article 196, states that health is a right of all and a duty of the state.[8]

Faced with the negation of constitutionally guaranteed rights, health system users seek alternatives to guarantee their right to health, one of them being the judicialization of health.[9] Thus, judicialization represents a contemporary sentence in the Brazilian health care setting, materialized essentially by court orders to perform diagnostic and therapeutic procedures, consultations, hospitalizations and dispensing of medical-surgical supplies.[10] In the ICU context, judicialization occurs in the form of hospitalization by court order. Hospitalizations due to court orders occur when the municipality or the state does not have the conditions or means to ensure adequate care for critically ill patients, in urgent / emergency situations that pose a risk to this individual's life. In this circumstance, aware of the severity of their family member and the need for a bed in another center, the family or their lawyer, appeals to the prosecutor to bring an action for the request for supervisory guardianship.[11]

By 2011, more than 240,000 lawsuits for health benefits were estimated in Brazil. The most requested procedure was hospitalization, including ICU admission, representing individual and collective health needs. Although the reasons that lead individuals to request access to health care through the courts were not mentioned, diagnosis time and lack of places may indicate the difficult access.[12]

It is argued here that the process of judicialization in the ICU directly impacts the demand for the practice of patient advocacy by intensive care nurses. In practice, these health professionals witness extreme vulnerabilities and social inequalities, the aggravation of people who do not have access to certain therapeutic resources necessary for their recovery, the obligation to immediately execute a court warrant, which is not always technically indicated and often results in the early discharge of another patient in order to release the ICU bed.

In this perspective, the constant presence of nurses in health services, their good relationship with patients and family and the extensive knowledge about the functioning of health systems is justifiable and, perhaps even unlikely, that nurses do not act as patient advocates.[13–14] The idea of patient advocacy in nursing practice is inserted in the philosophical traditions of nursing and reinforced in nurse

education. In health care, however, advocacy has a range of definitions, which are contextually based: on acting on behalf of or defending the patient's best interest; in protecting their rights by ensuring clarification regarding their health decisions and decision making and in the quality of nursing care.[15] Advocacy can be viewed as proactive and reactive. It is proactive when motivated by the patient's right to information, i.e. actions designed to help the patient clarify health issues and support them in decision-making about their care; It is reactive when it comes from the patient's right to personal safety and is necessary in situations where the patient's rights are in danger; and a competence as a philosophical principle of nursing.[16]

Finally, we consider the social, political and ethical-moral relevance of the link between the concept of patient advocacy by the intensive care nurse with the emerging discussion of the judicialization of health. The assumption is that nurses have a moral identity situated in a particular historical and sociopolitical context, which reflects responsibilities, relationships and values.[17] Therefore, the objective is to analyze how intensive care nurses practice patient advocacy in view of the need for hospitalization by court order to an intensive care due to bed unviability.

METHOD

An analytical exploratory qualitative research conducted with 42 intensive care nurses from the South and Southeast of Brazil, selected through snowball sampling. The initial participants were selected in each of the capitals of the seven states selected for the study (three states in the South region and four states in the Southeast region). At the end of their interviews, they were asked to nominate other participants with the characteristics necessary for the research and so on. The selection criteria for participants were limited to being a nurse, performing care activities in adult intensive care, not being on vacation, or any type of leave, having one year or more of experience in intensive care and who had experienced hospitalizations by court order. Contact with the first participant of each capital was made by the author of the study, due to her contact with many colleagues in this area of research and the next participant succeeded by the indication of the first and so on.

The data collection period took place between January and December 2016, through interviews conducted by macroproject researchers in different locations and times, indicated according to the participants' preference and with an average duration of 45 minutes. In addition, the script of the questions was made available online to facilitate data collection.

The recommendations of Resolution 466/12 of the National Health Council were followed and the participants were informed about the methods and objectives of the study and were given an informed consent form to sign. To ensure anonymity, the study participants are named using letters that identify their status, followed by a cardinal number in the order in which the interviews took place at each location, age; length of professional experience and length of work experience in the ICU.

The analysis took place through elements of Textual Discourse Analysis (TDA). The process began with the data unitization by dividing interviews into units of meaning, which made it possible to generate other sets of units, derived from the empirical and theoretical interlocutions, in addition to the interpretations performed. During this process, voices were attributed to the data in order to understand the text better. After data unitization, the articulation of meanings between their similarities began, in a process called categorization. During this stage, the units of meaning by similarity and approximation were gathered into intermediate categories, creating the categories of analysis.[18]

RESULTS

Forty-two intensive care nurses (nine from Rio Grande do Sul; seven from São Paulo; 6=sex from Minas Gerais and five from Espírito Santo, Paraná, Rio de Janeiro and Santa Catarina, respectively) participated in the research. 86% are specialized in Intensive Care Nursing, 38% have between 6 and 10 years of professional experience and 26% have between 11 and 15 years' experience working in intensive care.

Two categories of analysis emerged from the interviews: 1) Between obedience to the law and the ethical-moral duty of the intensive care nurse; 2) The position of nurses in the practice of patient advocacy and the need for intensive care beds.

The category "Between obedience to the law and the ethical-moral duty of the intensive care nurse" reveals the barriers to practicing advocacy on behalf of patients hospitalized by court order. In relation to this, the participants used expressions such as. *I have no idea how to intervene* (RS3, 35 years old, 10 years' professional experience, 10 years in ICU)*; I don't see the importance of the nurse's role at the door* (SC1, 38 years old, 13 years' professional experience, 1 year in ICU); *all situations that were experienced denote the fulfillment of an order from superiors, not allowing us to express opinions* (SP1, 34 years, 12 years' professional experience, 11 years in the ICU).

The statements also express that the role of advocating or not advocating for the patient depends even on external facts, which are sometimes unquestionable.

A situation which stood out was when a judge ordered a patient from the emergency room to be admitted, using the criteria that the patient had been waiting in the waiting room for a long time. Conclusion: We received a stable patient using oxygen via nasal cannulation, while there were critical patients in the emergency room on mechanical ventilation waiting for a bed (RS4, 38 years old, 17 years' professional experience, 16 years in the ICU).

I find this issue of the court order difficult because at the same time I don't know if the patient really needs intensive care. The judge analyzed it, but does he have enough knowledge to say that he really needs it? Most of the time it is accepted when you have a bed because nobody wants problems, but if it were evaluated, I don't know if the patient would need it (RS6, 29 years old, 5 years' professional experience, 1 year in the ICU).

Some participants expressed that it is the doctor who decides, which makes it impossible to share responsibilities.

In this ICU, and I believe that in the others too, the doctor always manages the beds. I have no direct interference with this management, so I do not advocate for any patient in this regard because I do not have the autonomy to decide who comes to the ICU or not. There was a patient who was hospitalized by court order, who was not as unstable as others there, but the doctor who manages the beds chose to hospitalize this patient (RJ5, 39 years old, 4 years' professional experience, 1 year in ICU).

Here we have shift workers who don't even want us to say they have beds. And the same thing probably happens in other places too. There was a time when the nurses gave the beds. Now, we and our management don´t have any authority regarding beds. And surely if the family member says that it was the doctor who directed him to seek his rights, there is no problem; but if he says it was the nurse, surely that goes back against the nurse, an accusation; You have to be careful about these issues (RS5, 42 years old, 14 years' professional experience old, 14 years in ICU).

Still, the demand from society and health professionals for more ICU beds in health facilities is not a recent fact and the mechanisms used to treat these critically ill patients become a life-saving operation.

*Hospitalization by court order is still an emerging idea which is not widely known (or widespread in larger ICUs). Therefore, distortions and misinterpretations arise, as well as incoherent attitudes. It is important to promote this "new" way of caring through discussion and training via theoretical deepening with deontological and ethical foundation and incorporation. (even in specific courses on the subject) (*SP7, 39 years old, 15 years' professional experience, 10 years in ICU).

10 years ago, we put extra beds in the ICU, we had 12 beds and increased to 24 beds with an extra oxygen outlet so that it served 2 patients. [...] Then there was the creation of observational beds in the emergency department and the emergence of the risk classification [But] *I have always defended the patient in the sense that I knew the whole hospital and the emergency demand, I always thought the patient was better cared for in an extra ICU bed than filling the emergency room with patients waiting for the bed. The medical and nursing emergency teams do not have the same expertise as the ICU team, the emergency team has a more immediate view, to save lives and to push ahead! So, the critical patient who is in the emergency room has to go to the ICU* (RS2, 57 years old, 33 years' professional experience, 33 years in the ICU).

In particular, nurses and doctors in the ICU work together, and their skills complement each other. However, decision-making, in relation to hospitalization by court order is a complex process, which interacts with stress, the experience and the external environment.

The nurse, together with the ICU doctor and the clinical director, must provide the requested bed safely and consistently (SC4, 33 years old, 10 years' professional experience, 10 years in the ICU).

It is the nurse who is at the front line, who manages the team to receive this patient (MG1, 34 years old, 10 years' professional experience, 7 years in ICU).

The statements related to hospitalization by court order, also convey sensitivity and moral duty in relation to the care process, as shown below.

I remember one situation: someone came in and said that there was a court ordered hospitalization at the door! And the patient comes in and you have to put him to bed. For us, from there what happened no longer matters. And, we think, if it was my family, the person is bad in an ICU or an emergency department in a small town that has no resources. Whoever is with the family member barely does that, appeals! It's what the people have! At that time there was no bed management center (RS5, 42 years old, 14 years' professional experience, 14 years in the ICU).

The practice of advocacy is also related to that patient who is already occupying a bed and is unable to leave, and also those who need a bed and cannot get one.

*This patient advocacy role depends on where I am; I will defend the patient if I am in a hospital with no resources and then I want the judge to give a warrant to the patient to go to a larger hospital. And when I'm here, I don't want to hurt those who are with me. So, I think that in order for professionals to not go through these ethical situations, the bed center was started to regulate these beds, but you have to see how ethical the professionals are who are behind it. Because the regulatory doctor calls you, "How many ICU beds do you have?" And I've said many times, "I can't give the available bed because our emergency room door is open and I won´t have another bed until tomorrow morning... so, if I give you this bed now, in half an hour you will have to look for a place for a patient of mine who arrived in the emergency room" (*RS2, 57 years old, 33 years' professional experience, 33 years in ICU).

The category called "The position of nurses in the practice patient advocacy and the need for intensive care beds" highlights the actions of nurses through guidance directed at information about the patient's rights, reception and clarification regarding the conditions of treatment conditions and the assessment of the severity of the patient.

T*he patient needed qualified treatment for his unknown cause of septic shock (progressed severely within 24 hours of onset of fever and malaise in his home). I worked in an ICU with emergency characteristics and this patient needed an urgent transfer. The family was instructed [by the team] to*

provide a bed by court order in order to speed up the process, as we were unable to get a bed over the phone (RJ1, 44 years old, 16 years' professional experience, 12 years in ICU).

The patient needed an ICU bed for continuous hemodialysis and specialist care. We received the patient and the relatives told us that they were guided by doctors and nurses who were in another institution with a smaller structure of equipment and specialty (ES3, 34 years old, 9 years' professional experience, 8 years ago in the ICU).

The patient needed treatment which the service did not provide. I directed the family to look for a public health prosecutor (SC5, 31 years old, 8 years' professional experience, 8 years in ICU).

If the nurse sees the need for an ICU bed for the patient, he needs to orientate the family to go after their rights. We must always orient both those who really need the bed and those who don't (ES1, 37 years old, 16 years' professional experience, 14 years in ICU).

Judicial judgments become an expression of the voice and decision-making power of the citizen regarding their health when their rights are denied.

I can't pretend I don't see it, so of course I recognize the advocacy role to get ICU vacancies. I can tell the family about the good ICUs I know of, the treatment that is offered, how to get it, inform them of their rights. I did nursing and I need to be a good nurse and work together with people and help them to achieve better health conditions (ES4, 29 years old, 6 years' professional experience, 4 years in ICU).

The nurse plays an important role in advocacy, as the majority of the population do not understand the severity of the disease or thinks the transfer delay is normal (MG5, 34 years, 1-year professional experience, 1 year in ICU).

I think that, as a patient advocate and somebody who the family trusts, nurses can and should provide clear guidance to family members, including a recommendation for ICU admission and exposure to the risks of such hospitalization, including: being away from family members, sleep disorders , presence of multiresistant bacteria, cold environment, with excessive noise. Once the real need for ICU admission is defined, the nurse seeks the position as recommended by the institution, with the aim of providing the best care, at the levels of complexity that the patient needs (SP6, 33 years, 8 years' professional experience, 7 years in the ICU).

The ICU environment is suitable for the formation of interpersonal relationships, which are guided by strategies based on the collective, the diversity of perspectives and actions. This statement can be applied to both the nurse / team relationship and the nurse / patient relationship:

The nurse is an essential professional during patient triage and in the sensitization of the multidisciplinary team (PR3, 39 years old, 15 years' professional experience, 15 years in the ICU).

Nurses defend their patients when they pay attention to what is happening to that person. Being the best and offering everything we can offer (ES4, 29 years, 6 years' professional experience, 4 years in ICU).

The respondents perform patient advocacy by protecting the patient and their families from team decisions that may compromise care.

When hospitalization by court order occurs, staff view the patient differently, so treatment and care may be less qualified and less safe. The nurse should remind the team that we should treat the patient with quality and respect, regardless of the way they were hospitalized and the real need for hospitalization (SP3, 34 years old, 13 years' professional experience, 13 years in ICU).

We must try to remove the prejudice that is present among the team PR4, 34 years of age, 12 years' professional experience, 12 years in the ICU).

DISCUSSION

Studies show that older nurses with more experience and expertise in the area of intensive care or those you who have more than one specialization tend to advocate more for the patient.[19–20] Thus, a higher level of education is associated with greater perceived autonomy, and a greater likelihood for patient advocacy, seeking to reduce errors in practice and provide quality standards for patient care.[21]

In this study, the barriers to practicing patient advocacy in situations of hospitalization by court order manifest themselves in three ways. The first is the understanding that doctors make the decision, because they are responsible for the management of the ICU bed; the second by acknowledging the authority and compliance with the court order and the third is the nurses' concern with possible exposure and punishment. However, in this case, it is understood that these three aspects are manifested together, precisely due to the issue of hospitalization by court order. In other words, although other studies[20,22–24] indicate that speaking and acting on behalf of patients and their families is a responsibility commonly adopted by nurses in the ICU setting, as the patient's vulnerability to acute illness and dependence on complex technology is extreme, a change seems to appear in this situation of hospitalization by court order.

Thus, it is understood that the statement that the decision-making power is the doctor's, also, refers to the added threat of criminalization of his professional performance; The double compliance – to the doctor´s decision and to the judge's decision - appears to be the only option, which causes the practice of these nurses to become bureaucratic and stressful permeated by a "culture of fear". Requests directed to the judiciary are distinguished by speed and the decision by the magistrate occurs without the opportunity to oppose the medical arguments of the plaintiff with those of another medical professional.[9]

Also, it is argued that in other daily situations in the ICU, disharmony may occur in situations between patients and health professionals. In turn, in situations of hospitalization by court order, there is an explicit power imbalance between health professional and those from the legal profession. Thus, these same professionals, upon receiving a court order for ICU admission, are obliged to comply with what was determined by the judge, regardless of the approval of the sentence. Failure to comply with the order can be characterized as a civil disobedience under the Penal Code, resulting in a detention sentence of 15 days to 6 months plus a fine.[25]

Nurses working in public or private institutions report that the patient hospitalized in the ICU by court order is the one whose family is aware of their rights as citizens and those who use the public service and do not always know the existence or purpose of the prosecution and the prosecutor. However, patient advocacy is present in the latter, when nurses recognize situations in which it is urgent to refer patients with acute severity to a specialized ICU, advise the family on what they consider to be suitable care for the patient. In this sense, nurses working in emergency departments experience the same difficulty: patient admission into the ICU; the emergency diagnosis; and, due to the unavailability of ICU beds, the patient is put in the Bed Management System and, one of the determining reasons for the court order is the delay in the release of this bed, causing discomfort for the health team due to limitations in offering effective care, in addition to stress for the patient's family.[11]

It is also possible to analyze aspects related to the problem that the judge is not solely responsible for determining hospitalization by court order, because this decision is based on a medical opinion, which is not necessarily always a professional with intensive care expertise or knowledge that the best place for the critically ill patient is the ICU and not, for example, in the emergency department waiting for an intensive care bed.

In Brazil, public health system users and the state are confronted, and to ensure that there is no dissociation between the constitutional text and the reality of citizens, judges issue orders that preserve the right to health, generally supported by a legal framework. Judges' knowledge of the technical sphere of health, along with the executive health committees, which support judges and other legal professionals to ensure greater efficiency in resolving health care claims can facilitate a thorough analysis of the legal dispute. However, the lack of such technical support may be related to automatic and standardized responses from both the judiciary, with the granting of most requests, and from the executive branch, with the execution of the warrant. This leads to an unsatisfactory outcome regarding the management of public health services and may increase social injustices.[9]

It is important to point out that, although the judge is an extremely qualified professional, he judges based on a medical report, i.e., he does not decide on the clinical need, he decides on the evidence of clinical need and enforces the law, allowing the care of this patient via a court order. In this case, if an unjustified demand for ICU beds is identified, what is the competence and interest of the professional who issued the clinical report? Should the court examine all reports before the warrant is issued? Is there time for this?

A study composed of judges, lawyers, and public health officials indicates a different perspective on litigation process, it gave the perspective of the judiciary as another entrance to the health system. In this scenario, many judges recognize that they are fulfilling their constitutional duty and are responding to the State's inability to offer the fundamental right to health.[26] In other words, the sick citizen needs treatment that they cannot afford and whose deprivation can lead to death. Thus, the performance of the Judiciary is highlighted because it represents the only feasible way to avoid this deprivation, an argument that is supported by a research performed with professional hospital bed managers in a Brazilian city. Two aspects are presented among the results: the lack of vacancies, revealed as a barrier to access, and the lack of resources of more complex specialties, which represents an overvaluation of high complexity. They highlight that the greatest demand is for ICU beds. Faced with the shortcomings of the system, users rely on the court order to "jump the queue".[8,27–28]

Another study which analyzed lawsuits found that until 2007, the demand for ICUs accounted for 32%, which increased in the following year to 71% of the total demands. From this perspective, 95% of the arguments based on the case were based on the right to health and 50% on the right to life, both difficult to challenge from a legal point of view, as there is a request for ICU vacancies due to diagnosis of acute diseases, representing 78% of cases.[29]

Finally, this category contextualizes the issue of attitudes and decisions that are ethically and morally correct for nurses in view of the situation that, to meet the demand of obtaining a bed by court order, the care and protection of one person's life can mean risking another person´s life and for this reason advocacy is needed in this context. The responsibility for upholding and defending physical integrity, treatment, care and well-being, as provided for in the Code of Ethics of Nursing Professionals in its core principles,[11,30] and considered by the American Nurses Association.[31] Therefore, as a member of a multidisciplinary ICU team, a nurse works with the patient to stabilize the acute situation, while preventing and managing potential complications that may arise during hospitalization, treating pre-existing comorbidities, and providing care to families as a extension of the patient, and collaborating with other health professionals involved in the care of these patients.[13,23]

Understanding how staff are valued and how this is related to the care provided to critically ill patients remains a central element, although the concept of staff seems to have intuitive value, individual contributions within the team are more supported. Having an intensivist involved in ICU patient care is undoubtedly the most effective intervention for improving the survival of critically ill patients.[13]

In the second category, it is possible to analyze how the ICU nurse defends the patient and how it manifests in the orientation of patients and family members. One study indicates that professionals admit that they have already urged family members to seek legal aid in cases in which they realized that the difficulties faced by the system could impair the patient's treatment. They also recognize the harm that can result from judicialization, as it exercises citizenship that overlaps the individual right to the collective and compromises the effectiveness of health policies, this behavior demonstrates a social and ethical commitment of health professionals to the right to health of people.[3]

The nurse acts as a link between physicians and other health team members, strengthening interaction and communication between different health team professionals. Communication that requires mutual respect, collaboration, joint deliberation and not just the convergence of knowledge. It is known that the act of informing the patient about his diagnosis and treatment is a legal duty of the doctor. Even so, it is up to the nurse to give advice about the available nursing care and its relationship with diagnosis and treatment, this their educational role is essential.[32]

We highlight the insertion and appreciation of nurses in the interdisciplinary team, as, when inserted in this complex system, they assume an articulating and relevant role in the change processes, ensuring quality care, which is offered in conjunction with many other disciplines and that reinforce the relationships of the nurse / human being / health team triad. In this perspective, an integrative literature review contextualizes interdisciplinarity as important for the exchange of experiences, knowledge and actions, in addition to overcoming the fragmented view of reality.[33]

Health teams must be composed of professionals from different areas of education who are willing to clarify the possibilities that are available to patients and their families in this difficult moment, alleviating the suffering of everyone, including the team itself. In fact, the characteristics of care relationships are re-signified, emphasizing ethical values such as trust and autonomy.[34]

These conversations require a dialogue that addresses such questions as: What is your understanding of the situation?; what counts as a good result?; what is at stake for you?; how do you see your responsibilities in the situation?; what's more important to you?, what is your opinion of yourself or others if option A is chosen or option B?. This dialogue is an understanding of moral discourse that enables the critical reflection of moral agents and their moral practices, and this critical reflection justifies our actions. Moral spaces are necessary for an institution to understand the needs of all its members, including patients, because every single person needs care.[17] And through these spaces, another aspect is considered: being able to share with the family the real expectation of saving the patient's life.

A study in the United States expresses what can happen when moral spaces are not socialized. It showed that the professional should prioritize the hospitalization of a single available bed in one of two situations: 1) a particular cancer patient, critically ill with little chance of survival (5%) and would gain an extra year of life, or 2) a brain-dead patient, a potential organ donor, for whom ICU admission would benefit some people awaiting transplantation, the organs would provide a total of 5 extra years of life for these patients. From the total number of professionals who chose to give the bed to the cancer patient, 65% of doctors and 75% of nurses argued about the obligations between the good of a single known patient among multiple anonymous organ recipients. This study suggests that many ICU physicians feel compelled to provide critical lifesaving care for patients with severe prognoses that meet traditional patient prioritization standards but contrast with recent concepts about the responsibility of healthcare professionals.[35]

It is noticed that there are barriers to intensive nursing advocacy regarding the patient who needs an ICU bed, and resorts to the court order. This situation is demonstrated from two different perspectives: the defense occurs in favor of the patient who is hospitalized but is not able to be discharged, but is likely to be discharged in order to give the bed to the one who is in need and who has resorted to litigation, and the nurse advocates for this patient under her care, who needs to be admitted to intensive care.

However, professional nursing practice should be based on ethical care, which requires the nurse to exercise individualized safe care and to aim to protect the patient from harm and possible risks, whether they be physical, mental, deliberate, inadvertent, inadequate treatment or incorrect treatment.[20,24] In addition, nurses should protect the patient and family members from judgments coming from the team regarding hospitalization by court order, which could compromise care.

Justifying this importance, family-centered care was instituted in 2005 by the Ministry of Health through the National Critical Patient Policy, with the aim of improving the care of family members and ICU patients, and valuing humanized care for patients and their family members.[36]

One study revealed that the ICU is still a dreaded place for many family members, where 80% of the respondents related it to death and the other 20% related it to a place of care that offers greater safety for the recovery of health. And the family, in this context, is not understood as part of the treatment process, but it should also receive the attention and support of health professionals, as they become motivators and participants in the patient's entire evolution, when well oriented. In addition, the family sets their expectations of these professionals and expects help in understanding the difficult times they are going through. Thus, each professional should perceive care in an ICU as a balance between technical and human care.[37]

It should be noted that due to its complexity and depth, this theme is not restricted to one single space. However, as there is little scientific production on both patient advocacy and hospitalization by court order, the limitations of this study may be related to the discussion of the results with the literature, considering that the perceptions and specificities of the nursing professional organization and the structure of health systems in the countries of origin of the respective studies also influence the discussion of the data. It is understood that the issues related to practice in the intensive care setting are reproduced in different ways depending on the countries; What is divergent is precisely the question of hospitalization by court order.

CONCLUSION

The concept of patient advocacy is important to nursing and is constantly being resignified. Within intensive care, there is the direct benefit to health care and improved outcomes in this type of complex environment that is required by court ordered. As one of the largest health professional workforces, Nursing has a key role in supporting patients, is on the front lines and understands the obstacles that patients face to get the care they need, and can share information and promote high quality health while preserving the interests and rights of patients.

This article highlights the gap between ideal patient advocacy and the reality of daily nursing practice, given the difficulties in recognizing the patient advocate role influenced by the prerogative of the warrant, with compliance as the only option, generating discomfort for the sovereignty of the decision and the apprehension of punishment. Another triggering factor related to the non-recognition is how the doctor decides on discharge, whether early or not, as well as the patient's admission to the ICU, disregarding a central element in the care provided to critically ill patients that understanding the value of the team and processes that can facilitate or restrict work in the ICU. Nurses should also be advocates when patients experience threats to their safety. If this does not happen, a number of

events can cause catastrophic damage, considering that in order to meet a court-ordered bed demand, care and protection of one's life may cause abandonment and possible death to another individual.

This study reveals that critical care nurses exercise sensitivity and moral duty of the care process when defending their patients by informing them of their rights, demonstrating concern for defenseless individuals or those unaware of their rights and who need help regarding this subject. In addition, they act and talk on behalf of patients and their families, advising about the treatment conditions and the severity of the case and ensuring care that is free of judgments and harm to the patient who is hospitalized by court order.

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NOTES

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CONFLICT OF INTEREST

There is no conflict of interest.

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