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Comfort for a good death: perspective nursing staff's of intensive care

Conforto para uma boa morte: perspectiva de uma equipe de enfermagem intensivista

Comodidad para una buena muerte: la perspectiva de un equipo de enfermería intensivista

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Abstract

Objective: It is a qualitative research aimed to know the meaning of nursing care for a good death from the perspective of a team of intensive care nursing. **Methods:** Symbolic Interactionism was adopted as a theoretical framework and content analysis of Bardin as the methodological framework for analysis. Ten nurses were interviewed, who experienced the care of the terminally ill person, in the ICU of a hospital specializing in oncology. **Results:** It showed that the meaning of caring for a good death focuses on the promotion of comfort as the central category and three subcategories: Relief of physical discomforts, social and emotional support and maintenance of the health and body positioning. **Conclusion:** To care for a good death means to promote comfort as a results of therapeutic interventions that combine rationality and sensitivity in interactions of health professionals with patients and their families, ensuring their dignity.

Keywords: Death; Palliative Care; Nursing Care; Intensive Care Units.

Resumo

Objetivo: Trata-se de uma pesquisa qualitativa que objetivou conhecer o significado do cuidar em enfermagem para uma boa morte na perspectiva de uma equipe de enfermagem intensivista. **Métodos:** Adotou-se o Interacionismo Simbólico como referencial teórico e a Análise de Conteúdo de Bardin como referencial metodológico para análise. Foram entrevistados 10 profissionais de enfermagem, que vivenciavam o cuidado à pessoa em processo de terminalidade, numa UTI de um hospital especializado em oncologia. **Resultados:** O significado do cuidar para uma boa morte centra-se na promoção do conforto como categoria central e três subcategorias: Alívio de desconfortos físicos, Suporte social e emocional e Manutenção da integridade e do posicionamento corporal. **Conclusão:** Cuidar para uma boa morte significa promover conforto como um resultado de intervenções terapêuticas que conciliem racionalidade e sensibilidade nas interações dos profissionais de saúde com o paciente e sua família assegurando a sua dignidade.

Palavras-chave: Morte; Cuidados Paliativos; Cuidados de Enfermagem; Unidades de Terapia Intensiva.

Resumen

Objetivo: Conocer el significado del cuidado de enfermería para una buena muerte en la perspectiva de un equipo de enfermería de cuidados intensivos. **Métodos:** El Interaccionismo Simbólico fue adoptado como un análisis teórico y el análisis del contenido de Bardin como marco metodológico. Fueron entrevistados 10 enfermeros especializados en el cuidado de persona con enfermedad terminal en la UCI de un hospital de oncología. **Resultados:** El significado del cuidar para una buena muerte se centra en la promoción de la comodidad como categoría central y tres subcategorías: alivio de las molestias físicas; apoyo social y emocional; mantenimiento de la integridad y de la posición del cuerpo. **Conclusión:** El cuidar para buena muerte significa promover confort como resultado de intervenciones terapéuticas que combinan la racionalidad y la sensibilidad en la interacción de profesionales de salud con los pacientes y sus familias, garantizando su dignidad.

Palabras-clave: Muerte; Cuidados Paliativos; Atención de Enfermería; Unidades de Cuidados Intensivos.

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INTRODUCTION

In recent decades, death has motivated students and researchers to address its various facets, so that studies are contributing to reflexively knowledge development in the field of Thanatology in Brazil. However, the topic is still regarded as a taboo, even causing surprise and awkwardness when someone proposes investigations about the point of generating a stigma for those who seek to search about this topic[1]. It is necessary to win this stigma, and look at the death with a quiet at least relative, since it is part of human existence and needs to be understood as part of the cycle of life.

It is known that the process of death and dying has suffered variations as the historical moment and the sociocultural context in which the man is inserted, being a process built by social interaction between societies and cultures, as well as other dimensions of the universe. Therefore, the human being in the process of social interaction might build different symbolism about death.

In the field of social sciences, studies about death gained larger dimension from 1960, when researchers began to notice changes in the practices and representations related to death and dying[1]. With that, the symbolism of death suffered historical, social and cultural variations.

Based on the historical moment and the sociocultural context in which man is, it can be realized that the idea of a good death has changed with the passing of time. In Western culture, over a period before the emergence of modern science and medicine, the symbolism attributed to a good death maintaining a relationship with elements linked to religion, considering that dying well means dying in peace with God, at home, in the presence of their family and the people of everyday living. In this perspective, the medical expenses were regarded as secondary, taking into account that tolerating the physical pain was an acceptable sacrifice for salvation[2].

With the strengthening of medical sciences, in the second half of the 18th century, it was observed a transformation about the symbolism attributed to a good death. Many causes of death started to be seen as preventable and therefore death became something to be prevented and their occurrence would be considered a failure of medical science. Death is no longer conceived as a natural event. Therefore, the ideal of a good death for modernity men, was designed in the unimaginable death; the death that was not happening and gradually was removed from the family and the community domain, to a hospital and the death that happened unexpectedly, in the garden or after a meal or silently during sleep[2].

It is noticed, therefore, that the exclusion of death and the one who is dying are fundamental characteristics of modernity. In this sense, to talk spontaneously about death with the dying person, an urgent need, is becoming increasingly difficult. Death shall be addressed as a human and social problem, encouraging the feeling that death is contagious and menacing, a excuse that the living are away involuntarily, of those who are dying, causing what is characterize as a social death[3].

Certainly, the symbolism of modernity is still present in contemporary times, even because it is difficult to understand, at the beginning of the 21st century, that something has been changed radically. However, on the dynamism and evolution of human behavior, the symbolism of the good death comes in post-modernity with a new meaning: the enhancement of the control of death by the person in the terminally process. It is expected that in this condition the person has an active participation in decision making about his death, which in modernity was exclusively assigned to the doctor. This fact is due to the influence of palliative care in the field of health sciences. On post-modernity death is imagined and becomes a subject that can be openly discussed and treated in films and novels. However, modernity cannot be ignored, only transcended[2].

The philosophy of palliative care is an approach that seeks to improve the quality of life of ill people and their families, facing the disease that is threatening the continuity of life through the prevention and relief of suffering. It demands early identification, assessment and treatment of pain and other physical, psychosocial and spiritual problems[4].

Palliative care was born primarily to assist cancer patients in advanced stage of the disease, however, today it is extended to all those who have some kind of disease that causes severe pain, physical, emotional and/or spiritual symptoms, making life extremely intolerable. Targeted care to the person considered by the medical science without possibility of healing, but that can be taken care of to ensure comfort and dignity in the process of dying and death[5].

Thus, the care for a good death should be based on principles of truth, respect and solidarity, and ensure the will and autonomy of individuals in the process of treatment and consider the cost/benefit of therapeutic measure in the prevention of potential problems and non-abandonment[5]. Care practices need to be guided to the relief of suffering, focusing on the person and not on his illness, valuing intersubjective exchanges and the authentic meeting between who cares and is cared.

Health care is central to the process of nursing work[5,6]. The nursing team professionals are in hospitals twenty-four hours a day next to inpatients and they are those who most often perform care practices having, therefore, the opportunity to meet the existential sense of illness, the demands and desires for practices of promotion, protection and recovery of health, the needs facing the process of dying and death.

In this privileged position, they can certainly establish a closer relationship and help, what justifies study the significance of the person cared in complete process from the perspective of a team of intensive care nursing. It is noticed that, although the hospitalization in intensive care unit (ICU) is usually recommended for people in critical health condition and recoverable, it is possible to find people with advanced disease, incurable and in terminally process in this environment because the palliative care do not exclude the possibility of care and intensive treatment since it allows the relief of suffering.

Although the literature establishes the different conceptions of a good death throughout the history of humanity, there are few studies[7] about what for nursing professionals the care for a good death means. To meet this question, it will allow identifying their conceptions about the topic and elicit reflection in nursing care to the person in the process of dying and death and the importance of sensitive and humanistic care, based on respect and autonomy of the person and supporting his family in the grieving process.

Based on the above, it was determined as the objective of this study: to know the meaning of caring in nursing for a good death from the perspective of a team of intensive care nursing.

METHOD

This study with a qualitative approach which adopted as theoretical framework the interactionism symbolic[8] that values, above all, the meaning that individuals attach their experiences and having its foundations in three assumptions: the human being who acts in relation to things, based on senses that they have for him; the sense of things is derived, or originates from the social interaction that the individual establishes with others. These directions are manipulated and modified through an interpretive process, used by the person when dealing with things and situations that he meets. Thus, the care of the nursing staff for a good death is the senses that the team assigns to objects with which it interacts in the process of care.

The study was carried out in the ICU of a teaching hospital specializing in Oncology, located in the city of Salvador-BA, with ten nursing professionals with more than one year of experience in ICU, which were interviewed using a semi-structured interview, between April and July 2010. The nursing staff consisted of 13 nurses and 15 nursing technicians and after addressing it there was acquiescence of four nurses and six nursing technicians[7].

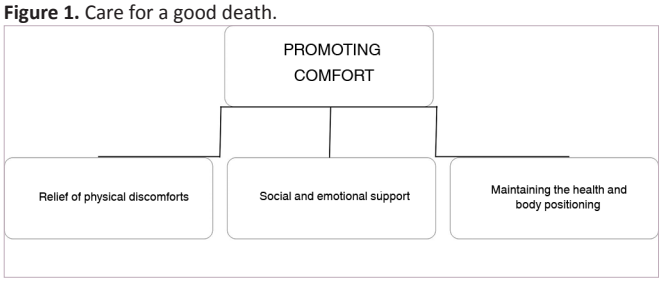
The data collection instrument was composed of two parts. The first containing closed questions on demographic characterization data and professional training of the participants of the study, and the second was composed by guiding questions such as: tell me about your experience of caring for a patient who is dying. What does it mean for you to promote a good death?[7]

The project was approved by the Research Ethics Committee of the hospital field of the study, getting the opinion number 264/2010, in 3/29/2010. The ethical principles have attended to Resolution number 466/12 of the National Health Council. The participants agreed on the term of free and informed consent presented and signed before conducting the interviews. They were recorded and subsequently transcribed in full, and the participants identified by the number of interview (I1, I2, I3, etc.).

The characterization data of the participants in the study were analyzed descriptively. For the data analysis of the guiding questions, content analysis proposed by Bardin[9] was adopted, consisting of a set of analytical techniques, communications by a sequence of procedures for sorting and organizing data, from the replies of respondents. A systematic and practical method was developed in three stages: the pre-analysis, exploration of the material and the processing of results from inferences and interpretations.

The pre-analysis consisted initially of a brief reading of the interviews allowing the researcher to invade on impressions of the material collected. Later, they were read thoroughly, aiming at the deepen understanding of the material. In the exploration phase of the material the core of meaning was identified (units of meanings) that were grouped systematically, considering their similarities and differences. These groupings were analyzed and reorganized according to the meaning attributed to them, giving rise to categories, as shown in Figure 1.

Figure 1. Care for a good death.



RESULTS

Characterization of nursing professionals participants on the research

Of the 10 participants in the study, seven were women and three men, between 25 and 39 years old. Seven declared to be Catholics, five practitioners and two non-practitioners, one was a spiritualist practitioner and two said just to believe in God.

All the nurses had *latu sensu* specialization, two were intensive care specialists; one was Oncology specialist and one was nursing work specialist. The nursing technicians, two were middle-level specialization in intensive care. The training time ranged between three and ten years and the time of operation in intensive care were between two and seven years.

Meaning of care for a good death from the perspective of a nursing team of intensive care

From the data analysis emerged the central category entitled "Promotion of comfort" which expressed the meaning of care for a good death from the perspective of a nursing team of intensive care. Three subcategories called Relief from physical discomforts, Social and emotional Support and Maintenance of health and body positioning symbolized the promotion of comfort (Figure 1).

Promoting comfort

This category was created on the symbol, but also a purpose of the nursing care for a good death identified in the speeches of the members of the nursing team of intensive care. The promotion of comfort meant to relief physical discomfort like pain and respiratory distress; social and emotional support to the person in the terminally process and his family, allowing the presence

of his loved one at the time of death as requested from who is dying, and ensuring the maintenance of the integrity and the body positioning with hygiene measures and prevention of skin lesions, avoiding the discomfort of the odors and the emergence of wounds that stigmatizes and cause suffering.

That category showed that the caring in nursing demand technical and scientific competence, ethics and humanities and needs to be based on practices of care directed to the person and his family in his particularity and completeness.

The centrality of the promotion of comfort for a good death can be illustrated by the following testimony:

> *A good death is to provide comfort to the patient does not feel pain, has a good passing, and that is just done by nursing, which is who is next to the patient, knows its uniqueness. [...] It must be very emphatic to the team provide comfort, don't allowing to suffering. Nursing can provide, and it is who provides a good death in ICU, the nursing team (I1).*
>
> *For a good patient care, it is [needed] to give every comfort, affection, attention until the end of the time of death. Doing our part and give that patient care that is going to death, giving all comfort (I4).*
>
> *I think the priority care to terminally ill patient is exactly the job of nursing, in relation to the comfort. I consider that the nursing care should be taken, as well as possible, so that the patient die in comfort (I10).*

The category promotion of comfort for a good death was expressed by three subcategories, namely:

Relief of physical discomforts: meant to develop practices to take care to minimize pain and relieve respiratory distress through analgesics, sedatives and the technological tools available that can provide a process of dying and death with greater tranquility and dignity. It meant also avoid pain from invasive procedures in the face of terminally condition, as illustrating the testimonials.

> *Minimizing the pain of the patient, making it easy for him to have a dignified death [...] trying to minimize, as much as possible so that it [the death] come to a least painful way as possible (I2).*
>
> *Care with the adequate sedation. Keeping him always quiet, apparently without respiratory distress, seeking to do in that moment to the patient does not suffer, suffering as little as possible (I3).*
>
> *I think every hospital has to have ICU so I can give a good death to patient needs. In the case of a disease such as cancer, the patient has to have an ICU so I can give increased assistance. Because it is so hard you see a patient going to death without having the appropriate equipment to give him that comfort to death (I4).*
>
> *A good peaceful death is to prevent the patient to stay there suffering pain, agonizing, there are patients we see agonizing, with shortness of breath, [it must be] provided oxygen for him, offer a medication that can alleviate some of his pain. Don't let feeling pain without necessity or lack of oxygen, since when we can offer an improvement for him... (I9).*

Social and emotional support: it meant support for the person in terminally process and his family through demonstrations of affection, attention, words of courage and strength at all times and the use of relaxation and leisure strategies by the health professionals. It meant yet, to encourage the constant presence of the family beside that he is dying, even if it means in loosening standards and hospital routines and keep the family informed of the condition of the family member.

> *To provide all support. I think the family facilitates us in this process. The human resources that is all the team. There are a lot of human beings in the area of health. I sat [in a particular situation] I talked to the doctor on duty: what's up? (he asked to the doctor on duty) She said: no, we release [the family]. We mobilize, in a way to come [the family], to be released. So, the person you're following there, all providing the family this time, providing the comfort (I1).*
>
> *To reassure the patient whenever possible, providing support, encouragement to this patient, even knowing that there's no way. Playing, trying to unwind this patient, in several ways: playing, using television, trying to do as much for him to overcome this situation. The family, the family all the time next to the patient (I2).*
>
> *To give all comfort, affection, attention to death. A good death is to give that patient care that is going to death, giving all comfort... (I4).*
>
> *Dignified death I think it is the moment we have no more conditions. It is to keep the patient with his loved one on the side. This is important! The priority is exactly the job of nursing in relation to comfort (I10).*

This subcategory includes also to offer support to the families by helping them understand the inevitability of loss and the health situation of its member. The team recognized that the care and attention given to the dying person meant comfort, which should also be extended to the family as illustrating the testimonials:

> *It is to the family be at that moment, make them to understand that sometimes the loss is inevitable. Every afternoon, at 4 p.m., there is the medical report, the doctor always clarifies that, we don't have nothing to hide right? (I1).*

The perspective that we have in mind is an integral care, covering also the family because the family has to have a larger attention at this moment. In addition to technical care, we have to have a very big attention, as the family of the patient (I6).

Helping the family too, that sometimes comes to visit the patient and is so shaken (...) to support the family. It is what we can do at the moment (I10).

Maintaining the health and body positioning: It meant to ensure the right to physical integrity, respect the body against anything that might hurt him, preserving the good body image and the absence of odors. This integrity can be ensured by maintaining good hygiene care, including the moment after death, and injury prevention as pressure ulcers. Ensuring that integrity is a way to avoid the physical, emotional and social discomfort that is dying and the family's emotional discomfort to see his family member with the deformed body and exuding foul smell. This subcategory meant also to keep the person warm and feeling in a comfortable position.

I, as a nurse look for providing a bath, heating, because we think like this: with that scab, this is all very bad for the family. It's good to the family see the patient well cared. I think nursing has a unique role with regard to the care of the body, hygiene, a care with a comfortable position. Sometimes, only what the patient needs at that moment is a pillow (I1).

To avoid the stench, taking the secretions from various places of the patient's body (I2).

Take a good care, keep him clean, healthy (I7).

To die clean, to die and have the body clean after death. Keeping the body clean after death. Don't let the patient die with bedsores, full of injury, change the patient always of position (I8).

DISCUSSION

The nursing team was characterized predominantly by women, young adults, adherents of the Catholic religion. There was a profile of professionals seeking to update, since all the nurses had *lato sensu* graduate course and two of the six nursing technicians had specialization course of medium level. None of the professionals had specialization in Nursing in Palliative Care and perhaps that is due to lack of offering this course in the State of Bahia. In relation to the training time and the average time of work in the ICU, between two and seven years, indicates that the team has professional experience in palliative actions.

The central meaning of caring in nursing for a good death from the perspective of a nursing team of intensive care was associated with the promotion of comfort. This phenomenon has been considered since the beginnings of the profession as a goal of nursing care, as well as in hospital practice is observed which is something expected by the individual in the process of treatment.

The comfort is a positive, subjective and multidimensional experience in interaction of individuals with themselves, with the practices of health and rationality that underlie and with institutional objects[10]. Therefore, these social objects can be sources of comfort or discomfort, and this discomfort could be minimized when people in the terminally process and family become subjects of health care that combines technical and scientific, ethics and humanistic competence[11].

The interaction between individuals and health practices, it is expected to result a state, even temporary, of well-being, which can occur during any stage of the health-illness continuum. In the face of imminent death, it is hoped that the promotion of comfort is the primary objective of health care. On the impossibility of the experience of comfort as a last stage of peace and serenity, it is expected the relief, even if temporary, of most of have discomforts[12].

From the central category that gives the promotion of comfort as being the central meaning of caring in nursing for a good death, it is shown that it is possible the nursing staff to plan therapeutic interventions to the person in terminally process having goals contributing to avoid potential discomforts, mitigate the current discomfort and promote comfort. Practice of nursing focusing on the relief of physical discomforts like pain, offering social and emotional support and ensuring the body integrity can minimize changes, disturbances and difficulties in physical, mental and social nature experienced by the person in the terminally process and his family, and thus promoting comfort[13,14].

The category and subcategories that expressed the meaning of comfort for a good death from the perspective of a nursing team demonstrated that this working group reiterates the comfort as a multidimensional phenomenon. This multidimensionality is expressed also in the definition of comfort of Katherine Kolcaba as "the satisfaction of basic human needs of relief, tranquility and transcendence in physical, psycho-spiritual, socio-cultural and environmental contexts"[13:433].

The subcategory "Relief of physical discomforts" highlighted the concern of nursing staff to avoid or minimize any physical discomforts, considering a good death, as that one in which the person is free of pain. A study[14] found that pain control, while a physical discomfort of the person dying was a concern of most nurses in the care process.

Other authors[14,15] corroborate with those results by saying that one of the essential elements for a "good death" is the absence of pain, enabling the person to be physically and mentally able to reach any goal he wants to achieve before death. Therefore, the comfort comes from confidence in the technical quality of care that provides assurance that the process of dying and death may be operated with less suffering[10].

To relief or reverse the physical discomforts, improving the state of comfort, will promote a dying with dignity. As regards the control of pain, although in the lines of the interviewed measures of level have not been explicated, it is known that being a subjective symptom, it is necessary to its assessment, whenever possible, with the use of visual ranges, a practice regarded as a starting point for the control of symptoms[15].

If on one hand the care for a good death was associated with the promotion of physical comfort through the use of hard technologies, especially for relief of pain and respiratory discomfort, it is also true that the participants understood that the service provided must not require the use of invasive procedures unable to offer any real alternative to reverse the situation of the terminally ill. That is which prolong the life and do not result in cure, only the extension of the suffering of the person in the process of dying and their families.

The subcategory Maintenance of the health and body positioning revealed that care for a good death meant also, to undertake care practices to meet the standards of hygiene and preserving the body injuries. The word hygiene originates from the Greek "hugieinós" and means dispensing help to maintain health, so, it is worth trying that this help must meet the set of socio-cultural values of the person, so that he can achieve the desired comfort level[16].

When it comes to palliative care, the tonic related to healthcare hygiene is one dimension increasing as result of the loss of autonomy of the patient[16], what justifies this concern of the team. Respect the body while preserving its image, the absence of odors, the emergence of injuries is a way to take care of pain and suffering and thus to promote comfort, which is fundamental to the rescue of the dignity of the human being in this critical context to terminally process.

The social and emotional support subcategory highlighted a concern of the team to promote comfort through demonstrations of support, attention and affection to the patient and his family, as well as for promoting the interaction between the person in the terminally process and his family, enabling intersubjective exchanges in recent times. Such attitudes of the group studied show that comfort is associated with a sympathetic and sensitive approach towards them.

Studies[11] show that comfort can be promoted by family interactions with professionals not only technical and scientifically, but also, with the humanity of the health team. Be accepted and valued by professionals, be heard and understood, notice concern about the suffering of the family and with the possibilities to minimize it, be treated with tranquility, greeted with a smile or approached with a conversation, receive information gently and understandable and realize good will and sincerity in the professionals was also comfort to families with a family member in the ICU.

In this way, it becomes important to enhance the reception of a person, in the process of dying and in the face of death and his families adopting an effective system of communication by detailed and whenever desired information, a relaxation of standards and hospital visits related routines, allowing greater interaction between the family and its member hospitalized and respect for affective ties, as well as, becoming necessary emotional empowerment of the multidisciplinary team to deal with the suffering of both, thus promoting the comfort.

The emotional and social support was also evident in the speeches of the participants of the study when related to the importance of playful on the dying person, promoting comfort. In this perspective, literature about the recreational activities in the hospital environment points out that the activities that provide pleasure, consist of a positive strategy to minimize the negative effects of hospitalization, occupying the idle time and stimulating the interrelationship with their peers and professionals in the health team, among other benefits[17].

Social and emotional support as meaning of care for a good death to the person in the terminally process and his family is in line with the definition of palliative care from the World Health Organization[4] in an approach that seeks to improve the quality of life of ill people and their families and decrease the stress experienced at this time of distress and anxiety.

The meaning of care for a good death lies in providing the experience of comfort in interaction with health care practices that promote safety and host[11], tranquility, relief and transcendence[13], guaranteeing the preservation of human dignity. Intersubjective interactions between the person in the dying process and health professionals can redeem the human in front of the mechanized world of the hospital, mobilizing forces in that which is fragile in the face of relentless confrontation of death.

It is valid to highlight also that comfort the other brings comfort to those who care. The nursing professional who possesses knowledge, skill and willingness to provide welfare to the person who they care, has a chance to contribute to the achievement of a high level of comfort, feeling at once comforted and held[18].

In order to promote the comfort to a person in the terminally process, the professional should not have as parameter what he wishes for him, but respecting what a person needs and wants, what he thinks is best for him, listening to including the family when it is unable to express. It must be remembered that a person is never equal to another, even though the manifestation of the disease can be. To understand the uniqueness of each one is what drives to promote the comfort of someone who cares. It cannot be forgotten that care practices should be developed in order to ensure the completeness of the person, while respecting his autonomy and individuality.

Taking care for a good death meant to the group studied to promote comfort as result of therapeutic interventions that combine rationality and feeling in interactions of health professionals with the patient and his family to ensure their dignity.

Another perspective of study that deserves investigation and study is to know the meaning of a good death in the eyes of the people who experience the terminally process. Such investigations may help professionals identifying the situations that promote comfort and/or discomfort to these subjects, provoking reflections and guiding practice for qualification of the process of care.

FINAL CONSIDERATIONS

The meaning of nursing care for a good death expressed the central category entitled Promoting comfort and its subcategories: Relief of physical discomforts, Social and emotional support and Maintenance of health and body positioning. It was concluded that care for a good death means above all to promote comfort that can be resulting from health and care practices in nursing that reconcile rationality and sensibility ensuring the dignity of the patient and his family.

The field of analysis based on the care for a good death is still incipient and deepening in new research can expand the horizons of palliative care enabling health professionals and nursing an integral and interdisciplinary care to ensure a dignified death.

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