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ACTIONS AND BARRIERS TO THE DEFENSE OF THE PATIENT BY NURSES IN THE INTENSIVE CARE UNIT

AÇÕES E BARREIRAS PARA A DEFESA DO PACIENTE POR ENFERMEIROS NA UNIDADE DE TERAPIA INTENSIVA

ACCIONES Y BARRERAS A LA DEFENSA DEL PACIENTE POR PARTE DE LAS ENFERMERAS DE LA UNIDAD DE CUIDADOS INTENSIVOS

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Objective: to analyze actions and barriers of intensive care nurses to practice the patient's advocacy. Method: exploratory and descriptive study of qualitative nature. Data were collected between August 2018 and February 2019, with 75 Brazilian intensive care nurses. Participants were asked to list three situations experienced in need of defense of the patient whose result was positive for the nurse and three situations of need for defense of the patient whose result was negative for the nurse. The data were organized according to thematic content analysis. Results: 3 categories and 10 subcategories related to the actions of nurses emerged, in addition to 4 categories and 13 subcategories related to the barriers found. Final Considerations: the study demonstrated the actions that visualized the autonomous performance of intensive care nurses in the practice of the patient's advocacy and that the practice of advocating should seek to overcome the imposition of daily barriers found, capable of impacting on the quality of care.

Descriptors: Patient Advocacy. Ethics. Intensive Care Units. Nursing. Decision Making.

Objetivo: analisar ações e barreiras dos enfermeiros intensivistas para o exercício da advocacia do paciente. Método: estudo exploratório e descritivo de natureza qualitativa. Os dados foram coletados entre agosto 2018 e fevereiro de 2019, com 75 enfermeiros intensivistas brasileiros. Solicitou-se aos participantes que listassem três situações vivenciadas

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de necessidade de defesa do paciente cujo resultado foi positivo para o enfermeiro e três situações de necessidade de defesa do paciente cujo resultado foi negativo para o enfermeiro. Os dados foram organizados consoante a Análise de Conteúdo Temática. Resultados: emergiram 3 categorias e 10 subcategorias relacionadas às ações dos enfermeiros, além de 4 categorias e 13 subcategorias relacionadas às barreiras encontradas. Considerações Finais: o estudo demonstrou as ações que visibilizaram a atuação autônoma dos enfermeiros intensivistas no exercício da advocacia do paciente e que o exercício de advogar deve buscar superar a imposição de barreiras diariamente encontradas, capazes de impactar na qualidade da assistência.

Descritores: Defesa do Paciente. Ética. Unidades de Cuidados Intensivos. Enfermagem. Tomada de Decisões.

Objetivo: analizar las acciones y barreras de las enfermeras de cuidados intensivos para practicar la defensa del paciente. Método: estudio exploratorio y descriptivo de carácter cualitativo. Los datos fueron recolectados entre agosto de 2018 y febrero de 2019, con 75 enfermeras brasileñas de cuidados intensivos. Se pidió a los participantes que enumeraran tres situaciones experimentadas en necesidad de defensa del paciente cuyo resultado fue positivo para la enfermera y tres situaciones de necesidad de defensa del paciente cuyo resultado fue negativo para la enfermera. Los datos se organizaron de acuerdo con el análisis de contenido temático. Resultados: surgieron 3 categorías y 10 subcategorías relacionadas con las acciones de las enfermeras, además de 4 categorías y 13 subcategorías relacionadas con las barreras encontradas. Consideraciones finales: el estudio demostró las acciones que visualizaron el desempeño autónomo de las enfermeras de cuidados intensivos en la práctica de la abogacía del paciente y que la práctica de abogar debe buscar superar la imposición de barreras diarias encontradas, capaces de impactar en la calidad de la atención.

Descriptores: Defensa del Paciente. Ética. Unidades de Terapia Intensiva. Enfermería. Toma de Decisiones.

Introduction

Intensive Care Units (ICU), environments that provide high complexity care during patient hospitalization uninterruptedly, often require quick and accurate decision-making[1]. This is mainly due to the epidemiological profile of the patients admitted to them[2]. In Brazil, the increase in the severity and mortality of demonstrated patients requires a widely qualified multidisciplinary team, in addition to a physical structure with various technologies and resources, which together provide the necessary high complexity care[2]. Moreover, the knowledge of the epidemiological profile of patients who are in the ICU helps in decision-making and qualifies care[3], as well as directs the knowledge to be obtained by the health team, so that it practices the patient's advocacy.

The term advocacy associated with the defense of patients by nurses was recognized at the international level only in the 1970s, by the Code of Ethics of the nursing profession approved by the International Council of Nurses[4]. In Brazil, advocacy by nurses is recognized as an ethical and moral duty that is difficult to materialize in nursing daily life[4].

Advocating, coming from the Latin term *advocatus*, means providing evidence. In the case of nursing, this evidence is used to promote the defense of the patient. Thus, the patient's advocacy can be considered a member of nursing care, which has as its epistemological object care. However, to exercise this care, it is essential that the health team, the patient and family members are empowered with evidence capable of promoting the best health recovery process, tied to the patient's objectives[4-5].

It is noteworthy that the act of advocating for the patient is closely linked to human rights and the right to health. The idea of defending the patient, as well as of every citizen, originated with the elaboration, by the United Nations (UN), of the Universal Declaration of Human Rights in 1948. In Brazil, the right to health and, consequently, the rights of the patient only became objects of law with the Federal Constitution of 1988 and the regulation of the Unified Health System (SUS), through organic law N 8,080 of 1990[6].

Over the years, the theme of patient advocacy began to be introduced in the discussion of

the national literature associated with nursing. In Brazil, a major advance in this discussion was the cross-cultural validation of the patient advocacy scale for nurses, the Protective Nursing Advocacy Scale (PNAS), carried out in 2015 by Tomaschewski-Barlem. This instrument provides for the quantitative measurement of the beliefs and actions of nurses who protect patients by exercising the patient's advocacy in the hospital context[4]. However, although the scale proved to be efficient in the generalist nurse population, its repercussion among intensive care nurses is not known, due to the scarcity of research[7].

Studies of patient advocacy by intensive care nurses are recent. An article of integrative literature review, covering the period between 2010 and 2020, found that, among the restricted 18 scientific articles that addressed the issue of patient advocacy in intensive care[8], 14 were published after 2015. This demonstrates the actuality and relevance of the subject, justifying the realization of the current research, so that knowledge about this theme can be deepened.

Although the patient's advocacy should be exercised in all areas of nursing competence, the complex intensive care environment and the vulnerability of patients provide a propitious atmosphere, so that nurses are the patient's voice or establish a link between the patient and the health environment[7].

However, although it is clear that defending the patient is essential, this does not make this task easy to perform, since nurses must overcome obstacles, especially those related to the institution and/or hierarchical relationships of power, which justifies the need to expand knowledge about the advocacy framework to enhance the development of patient defense strategies. Thus, the aim of this article is to analyze actions and barriers of intensive care nurses to practice the patient's advocacy.

Method

This is an exploratory and descriptive research of a qualitative nature. To obtain data, the Survey technique was used, which consists of a questionnaire used by means of a questionnaire applicable to a random sample, in order to demonstrate the representativeness of a population[9]. The research adopted the consolidated criteria for reporting qualitative research (COREQ).

The study participants were intensive care nurses from all over the Brazilian territory, selected by a non-probabilistic sample for convenience, in which the researcher judges the selected individuals accessible and collaborative with the research. The inclusion criteria consisted of working as an intensive care nurse for at least one year and being available and interested in answering the instrument. Intensive care nurses who did not respond to the full data collection instrument were excluded.

The Survey was conducted through the online form application (Google docs) between August 2018 and February 2019. When accessing the entry link to the form, a homepage was available, with the presentation of the survey objective, the invitation to participate in the study, as well as the Free and Informed Consent Form (TCLE), which was duly signed by all participants. Then, fields were made available to fill in data about sociodemographic information and, finally, the following questions were presented: Describe three situations of need for patient defense experienced by you or that you have witnessed, the result of which was positive for the nurse; Describe three situations of need for patient defense experienced by you or that you have witnessed, the result of which was negative for the nurse.

The research participants were identified with the number sequence from 1 to 75. The collected data were submitted to content analysis supported by Bardin[10]. Following the assumptions of content analysis, the study was organized into three phases: pre-analysis - phase of organization of the material through reading, period in which the systematization of the initial ideas of the interviews takes place; exploitation of the material – analytical description phase, in which the definition of categories and subcategories takes place, which correspond to

the interpretations of meaning emerging from the data; treatment of the results, inference and interpretation – final stage, which corresponds to the moment of critical and reflexive analysis of the results found, confronting them with the objectives outlined at the beginning of the research and with the existing literature on the theme[10].

The Research Project was approved by the Research Ethics Committee of the *Universidade Federal de Santa Catarina* under CAAE N 84197418.8.0000.0121 and Opinion N 2,620,178.

Results

The characterization of the participants is presented in Table 1.

Table 1 – Characterization of study participants. Brazil – 2018-2019. N=75 (continued)

Variables	n	%
Categorization of respondents		
Number of respondents	75	
Average age	37	
Average years of experience in intensive care	10	
Average years of work in the main employment relationship	8	
Average working hours in the main employment relationship	38	
Average number of beds in the main employment relationship	18	
Brazilian regions		
South		40
Southeast		32
North		23
Northeast		3
Midwest		3
Gender		
Women		79
Men		21
Training carried out after graduation		
Specialization in Intensive Care		75
Training		31
Master's degree		27
Doctorate degree		13
Employment relationships		
Just an employment relationship		73
Two employment relationships		24
Nature of the main employment relationship		
Public		65
Private		25
Both		9
Effectiveness of the main employment relationship		
Effective		84
Temporary		16
Complexity of the main employment relationship		
High complexity		81
Medium complexity		16
Low complexity		3
Existence of an ethics committee in the institution of the main employment relationship		
Yes		75
No		16
I don't know		9

Table 1 – Characterization of study participants. Brazil – 2018-2019. N=75 (conclusion)

Variables	n	%
Occurrence of meetings in the work unit of the main employment relationship		
Yes		79
No		21

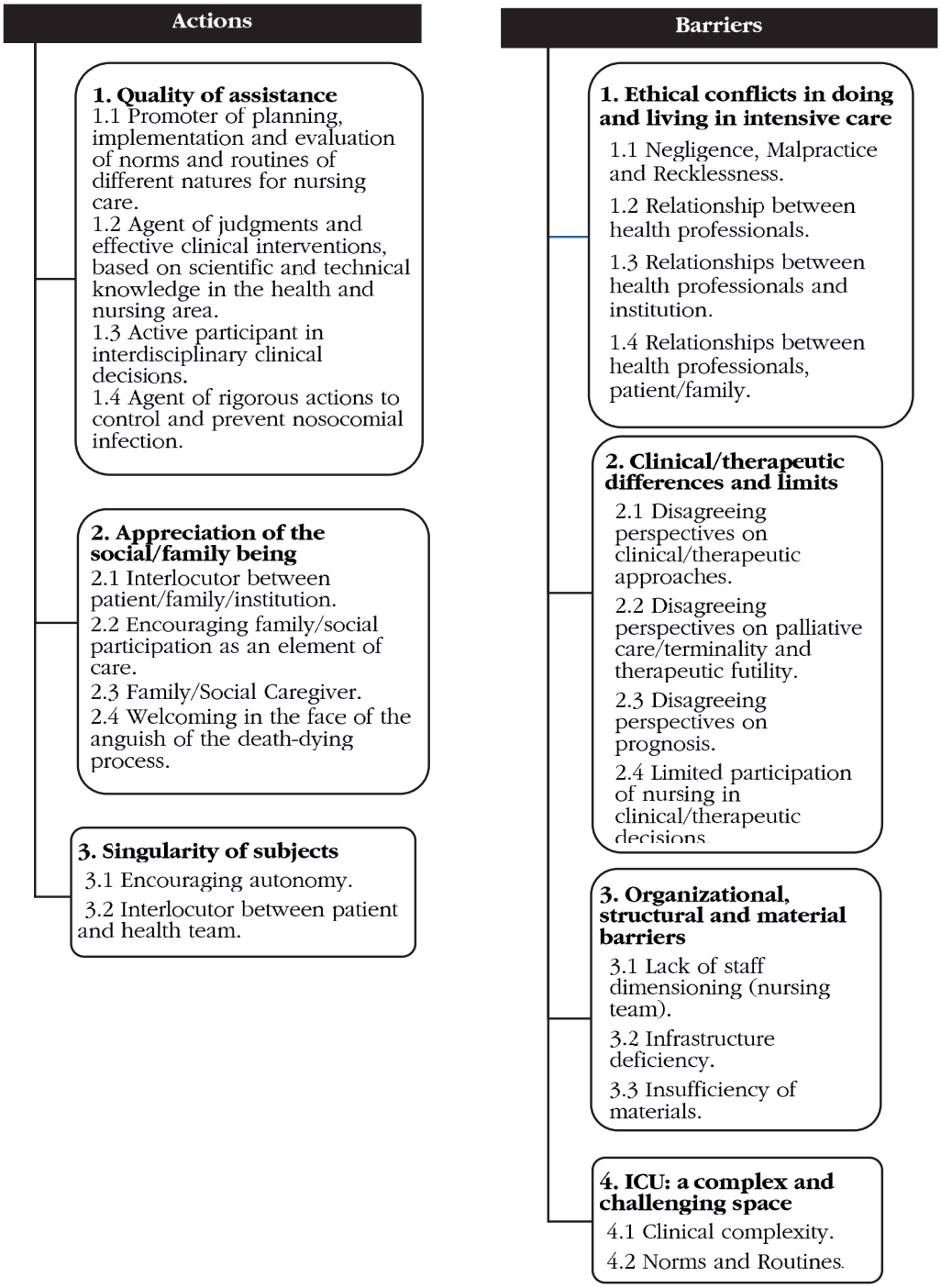
Source: Created by the author.

According to data presented in Table 1, the participating intensive care nurses were from all Brazilian regions, with predominance of the South, Southeast and North regions. Among the respondents, women prevailed and with an employment relationship. Although most participants have a specialization in intensive care, the percentage of participants with master's and doctorate degrees was relevant. A significant number of them reported the existence of an ethics committee in the institution of employment.

We obtained 166 positive situations related to the actions of defense of the patient, experienced in the daily care of critically ill patients. Among the 75 nurses, 48 (64%) mentioned 106 negative situations regarding the patient's defense. It is indicated that, of this total of 106 responses, 17 were excluded, because they were not categorized as negative situations, thus obtaining a total of 89 valid answers for analysis of the results.

The actions of nurses in the defense of the patient are presented in 3 categories, subdivided into 10 subcategories. The barriers identified by intensive care nurses in the practice of law are listed in 4 categories, subdivided into 13 subcategories (Figure 1).

Figure 1 – Actions and barriers found for the practice of patient advocacy by intensive care nurses



Source: Created by the author.

The three categories of the patient's advocacy actions performed by the intensive nurse are presented in the sections: Quality of care, Valorization of the social/family being and Singularity of the subjects.

Quality of Assistance

There were reports of the nurses who denoted the thinking and making of the clinical role of the professional based on scientific knowledge. Nurses conceived their role of defense of patients in all nursing care situations, provided that they were based on clinically recognized criteria for the quality of care.

> [...] *user was demoted and could not maintain saturation and I asked the intensivist to review if he was able to stay only in CMN* [continuous macro nebulization] *support. He returned to the MV* [mechanical ventilation]. (15).

> *Nurse defends* [advocate for the patient], *when requesting deep venous access to the medical team for vasopressor infusion*. (1).

The role of defender of quality care was also expressed in the participation of nurses in the evaluations and clinical decision-making of multidisciplinary teams and in the daily situations of divergent judgments between procedures prescribed by colleagues.

> *The physiotherapist tried to wean the patient from mechanical ventilation and asked only the doctor's opinion. I questioned it because it was not hemodynamically stable and, therefore, I asked to reassess whether it would be possible by the clinic and MV parameters* [mechanical ventilation]. (15).

> *Requested further evaluation of a RLL extremity* [right lower limb] *by the nurse of the vascular surgery team, to discuss the indication of amputation of this extremity. This new evaluation did not indicate amputation. The RLL has been preserved.* (7).

> *At one point, I realized that a terminal patient had pain and that the sedation used (only simple fentanyl at 10ml/h) was no longer effective. In addition, the patient had Rass -2, and the doctors classified it as -5 and thought it was comfortable. The resident argued with me because she didn't want to associate any more medication. I had to call the on-call doctor who evaluated the patient and agreed that he was uncomfortable, progressing fentanyl and associating midazolam.* (21).

Other reported situations characterized the patient's defense, when nurses were strict agents in performing and monitoring actions to control and prevent hospital infections.

> *When I request the interruption of procedure, by breaking sterile technique.* (48).

> *A nurse defends the patient, when questioning the need to stay a long-term bladder tube for a patient who had no indication and the permanence of the vesical probe of delay would increase the risk of infection.* (2).

Appreciation of the social/family being

The role of nurses, to preserve the uniqueness of people as social beings, especially the affective/emotional aspect of patients, ranges from the flexibilization of visiting hours and length of stay to the permanent reception to doubts and anxieties exposed by family and friends who seek information, especially about clinical status and prognosis. Preserved all institutional, professional and patient safety limits, the valorization of the social identity of those in the ICU constitutes an important advocacy action by intensive care nurses.

> *When the nurse takes into account the biopsychoemotional need of the patient and breaks with rules imposed by the institution. For example, allowing a family member to stay longer in an ICU* [Intensive Care Unit] *who has no extended visit.* (12).

> *Emotional support, through flexibility in visiting hours, with increased length of stay of family members, reducing anxiety, sadness, anguish,* delirium *and psychomotor agitation.* (17).

> *Elderly patient, with septic shock of pulmonary origin, extremely anxious and agitated, with hyperactive delirium. I performed an intervention together with the multidisciplinary team about the presence of a family member with her. After the presence of the full-time family member for approximately 24 hours, the patient progressed with reduced anxiety and improvement until the disappearance of hyperactive delirium.* (5).

The nurses described situations in which they advocated the participation of family members in the face of the impending terminality of the patients.

> *In the presence of the family at the time of death.* (16).

Singularity of subjects

Although limited, there are possibilities of patient choices that can be respected. Therefore, nurses act as lawyers at times when patients are able to express their wishes, after receiving all technical and rights information.

> *Patient would do an arteriography and knew nothing about the exam, neither did the family. At the time, many complications occurred consequently to the examination, including death. I explained to the family about the exam and that they should make the decision aware of the benefits and risks. The doctor in charge knew my guidance and came to take satisfaction. I replied that I would always do this, if they didn't, that it was a right of the patient and family members to know about the treatment.* (45).

> *Guidance regarding the information that was being passed on by the doctor, where the patient and the family were not understanding the need for a procedure, and it would benefit the patient.* (5).

> *I guide patients on the rights and our obligations. I emphasize to the patient about the right to public health and quality. And when the patient is underage or elderly, I advise family members that these patients have the right to follow up, even if they have to go against colleagues who do not agree. I believe in this defense, and patients and family members can exercise their citizenship.* (68).

The four categories related to the barriers encountered by intensive care nurses for the practice of the patient's advocacy will be presented in the sections: Ethical conflicts in doing and living in intensive care; Divergences

and clinical/therapeutic limits; Organizational, structural and material barriers; and ICU: a complex and challenging space.

Ethical conflicts in doing and living in intensive care

The first category includes elements related to the situations translated by the participants, such as actions of negligence, malpractice and recklessness of professionals, in addition to limits generated by relational ethical conflicts between health team professionals, between professionals and users/families and between professionals and institution.

> *Elective procedures performed by medical residents without success over and over again*. (38).

> *Failure in the conference/administration of blood products performed by the nurse, generating complications to the patient*. (55).

> *Nurse calls the doctor a patient with tachycardia and pain, the doctor does not give importance, and the patient makes a CRP* [cardiorespiratory arrest] *and progresses to death*. (58).

> *Surgeon had pericardial puncture without analgesia. When I spoke to the medical coordination, the surgeon was called attention, but he never spoke to me again*. (50).

> *When I guide nursing colleagues on the importance of dialogue with family members about nursing care, and the answer I have is that the doctor has to give more information. With this, the patient/nursing/family relationship is distant*. (68).

> *When the nurse aims at the well-being of the patient, but the private institution only aims at profit, the nurse, by showing evidence on this topic, becomes known as the "black sheep" of the group*. (12).

Clinical/therapeutic differences and limits

This category consists of data that evidenced divergent clinical/therapeutic perspectives among health team professionals. Aspects of care in intensive care were listed, mainly related to clinical management, prognosis, palliative care and terminality and therapeutic futility.

> *Terminality situation, a patient with pathology in oncology with a poor prognosis, futile measures were made, which prolonged the patient's suffering. Feeling of impotence in the face of the situation experienced, because the conduct was medical, even though the information about the severity of the diagnosis and descriptions of palliative in the medical records is clear*. (39).

> *A nurse did not authorize a aspersion bath for the ICU* [Intensive Care Unit]*, the doctor authorized it, and the patient died. (46)*.

> *Cancer patient, with severe pain, requested analgesia for the nurse, but there was only prescribed dipyrone, which had already been administered. The nurse asked the doctor for a reassessment, who refused to do so*. (67).

> *Not respecting the autonomy of the nurse in the daily rounds*. (16).

> *Lack of autonomy of nurses in emergency situations, in cases of CRP* [cardiorespiratory arrest]. (72).

Organizational, structural and material barriers

This category expresses that the experiences contextualized by the participants denounced a series of deficiencies that compromised the work process of health professionals for intensive care with better conditions for the development of advocacy.

> *Lack of adequate materials for procedures and lack of multiprofessional communication*. (51).

> *Family to have to buy pyramidal mattress because it has no available*. (75).

> *Insufficient nursing professionals dimensioned in an emergency. When I received two patients on CRP* [cardiorespiratory arrest]*, I could not provide assistance to both*. (15).

> *Bureaucratic sectoral demands undermine care and even if doing, nurses always believe they could have done more. However, even without being able to do so, the nurse unfolds so that everything is better for the patient, although this costs him lunch time, for example*. (3).

> *Slow support services, unwillingness, closed pharmacy and need for insums*. (51).

ICU: a complex and challenging space

Finally, in this category, the ICU's own characteristics, such as differentiated norms and routines, high complexity and regulated and centralized communication process, could potentiate the barriers to the practice of the patient's advocacy, as reported.

> *By determination of the Hospital Direction, the visiting hours were reduced to 30 minutes/day, with the entrance of only 2 family members. Even after several attempts at change, the Board proved irreducible*. (7).

> *Do not allow the family to come in to say goodbye to the patient at the time of death*. (16).

> *Lack of adherence to the new routines, making it difficult to improve the reality of the ICU service* [Intensive Care Unit]. (54).
>
> *Patient and family without information. Nurses tried to reverse, but could not contact physicians and family members.* (24).

Discussion

The finding that 75% of the participants had a specialist title reports to the assertion that the ICU is a place of high specificity, where professionals need constant updating[11].

Regarding the categorization of the data in the results, in the aspects related to the actions of intensive care nurses in the practice of the patient's advocacy, in the category "quality of care", actions were presented for planning, implementation, evaluation of norms and routines for nursing care, judgments and effective clinical interventions, based on scientific and technical knowledge, participation in interdisciplinary clinical decisions. That is, the nurse represented numerous roles in the multidisciplinary team, through direct patient care, interaction with the family and also management and autonomy in decision making.

Thus, the literature agrees with the arguments brought by nurses, emphasizing the importance of interprofessional collaboration in creating equal opportunities for each member of the health team to act, in order to coexist the sharing of knowledge and experiences[12].

It is noteworthy, then, that the nursing work process, by presuping evidence-based knowledge, would enable the organization and structuring of services and, consequently, the construction of autonomy. In this sense, autonomy is understood as a condition for the development of professional competence, assisting in the making of agile and mandatory decisions, enabling workers to perform their activities with empowerment and quality[13].

However, there are actions in everyday situations that present divergent judgments, such as those in those where nurses with organizational training, longer time of clinical experience and training, have a higher level of autonomy, interacting empowered in multidisciplinary decisions[14].

A the category called "valorization of the social/family being", the descriptions of the participants contextualized the nurse as an interlocutor between the patient/family/institution, acting as an incentive for family/social participation in the care process, family/social caregiver and welcoming in the face of the anguish experienced in the process of dying patients. However, a study reports that previous experiences and cultural norms influence perceptions, communication, behaviors and choices[15].

Therefore, although it is clear how communication should be performed, most of the time, nurses only have access to family members during visiting hours, in which the time is usually reduced. Therefore, this situation can constitute tension between patient/family/institution, because it is in these moments that family members end up overflowing their fears, their anguish and doubts. Therefore, the interaction between nurses/patients/family is a priority in the practice of professional practice and becomes the articulating axis of care[6].

Finally, the family can promote the patient's well-being by supporting them and providing the team with the necessary information. Thus, consistent and routine communication can positively impact the resilience of the family[16].

In cases of end-of-life experiences, typically associated with ICU admissions, an effort was found by the participants of this research to integrate the family into the care of their family members. Thus, by allowing the presence of the family member next to the critically ill patient, or even facilitating communication between the patient and family members, and still accepting the choices of both, the nurse was strengthening good relationship practices, strengthening ties and reducing suffering. Thus, closer relationships are an important support not only in the most difficult times for family members, but also in decision-making, treatment choices and at the time of decision not to prolong the suffering of the patient, the main agent of care[17-18].

In the category entitled "singularity of the subjects", the participating nurses reported advocacy actions, as they encouraged the autonomy of patients and participated in the

communication process between the team and the patient.

In this sense, by understanding and respecting the specificities and needs of each patient, in addition to guiding their rights and clarifying doubts about therapies, the nurse acts as a representative of the patient before the team, defending their wills and assisting in shared decision-making, in order to facilitate the conduct of therapies and strengthen the autonomy of the patient-family[19].

However, it is noteworthy that the valorization of the singularity of the subjects should not be treated only in end-of-life situations. On the contrary, on a daily basis, patients have simple wills that often cannot be welcomed due to the harsh routines to which they are submitted. Thus, advocacy actions are expressed through the fulfillment of a simple will, such as the postponement of a bath.

In the aspects related to barriers for intensive care nurses to practice the patient's advocacy, the "ethical conflicts in doing and living in intensive care" that constituted a category were the most expressive limits. In this sense, the daily routine of nursing is permeated by stressful situations that require decision-making, which often lead to differences of opinion, exacerbation of ethical-moral problems[5] and, consequently, feelings of anguish and professional exhaustion[6]. These feelings may justify the non-exercise of advocacy as a self-protective strategy, in order to avoid situations that accentuate ethical conflicts[20].

In this study, the reports related to ethical conflicts arising from situations of negligence, malpractice and recklessness attributed to nursing team colleagues, as well as to other health team professionals, constituted explanations used to inhibit defense actions. However, they can configure conniving postures of those who identify and do not act, because situations of negligence, malpractice and recklessness, when verified, require defense. This fact may indicate a stagnation characteristic of moral suffering, when professionals perceive ethical conflicts, but feel prevented from acting[20].

Regarding the relationship between health team professionals, there was emphasis on conflicts experienced between nursing professionals and medical professionals, especially in established work relationships with high hierarchy appreciation. There is a distinction between the epistemological object of professions in the health area, because sometimes, while nurses prioritize patient-centered care, in order to maintain the best possible well-being with the minimum of futile treatments, the medical team centralizes its action in interventional biomedical culture, focused on the disease[21].

It is important to clarify that, among nursing professionals, ethical conflicts are derived from differences of opinion and stressful situations that need to be mediated by nurses. These relational confrontations, among other challenges, are pointed out as factors that do not stimulate the role of defense, in view of the excess of demands to manage. Finally, the different relational conflicts can remove nurses from their beliefs and values and, thus, not foster defense attitudes[20].

Also in the context of relationships, in intensive care, health professionals are often aggressively and disrespectfully held accountable by patients and family members, with accusations related to resistance and difficulty in understanding all the complexity that health-disease processes involve. Although the legislation guarantees the patient the right to make decisions about treatment and interventions, especially in critically ill patients, these decisions are problematic situations, since they involve the possibility of whether or not to comply with the will of the patient and family members as opposed to clinical criteria[20].

In the category "divergences and clinical/therapeutic limits", the reported situations expressed barriers to the defense of the patient that went beyond the scope of the relationships. That is, although the processing of these limits happened in a relational way among the professionals of the health teams, there was an intensified interface with the respective corpus of knowledge and competencies of each professional of the interprofessional team. There was a paradox, since the assumption of the integrality of patient health care should require a multidisciplinary team, interdisciplinary actions

and decision-making in a shared way between the different fields of knowledge[12].

However, also in the ICU, a fragmented and hierarchical organization may predominate, reflecting in a planned and implemented attention, in part, in a little articulate and, often, conflicting way[12,21]. Thus, for nursing, there are persistent clashes against the devaluation of the profession in clinical decision-making processes. This occurs in some contexts, which denounce the low influence of the clinical perspective of intensive care nurses and have repercussions on frustrated defense expressions in the face of shielded postures, especially from medical colleagues[22]. Thus, in this dissonance, there are, on the one hand, nurses in defense of autonomy and holistic well-being and quality life and, on the other, physicians, rooted in the biomedical model, obstinate therapeutically, guided by procedures sometimes futile, under the clinical criterion[23].

In the third category "organizational, structural and material barriers", institutional aspects were classified as barriers to the defense of patients, in addition to relationships. In this sense, in work environments limited by material issues or the overload of activities, the results are the mental and physical illness of the worker and dissatisfaction with work. In these cases, attention is focused on taking care of the minimum resources available, with the best possible quality, but unable to advance defense issues that could provide better patient care[24].

In this context, there are serious situations, in which minimum conditions for essential care are lacking, some to guarantee the survival of patients, such as lack of basic medications and equipment, revealing that the patient's defense is exercised not as an advance in care, but as a primary action of nurses[1]. It is important to highlight the insufficient dimensioning of nursing professionals, as well as the daily work, with reduced health teams in the ICU, themes discussed in a study that indicate the deleterious effects of these realities for workers' health and for the quality of care[25].

Another aspect that deserves reflection is the fact that nurses live with the reality of low wages, which lead them to maintain at least two employment bonds. Again, these contexts are permeated by stressors, and the consequences are a high rate of absenteeism in the units, due to the illness of workers, without substitution and, consequently, a reduction in the health team, with an increase in the demand for professionals[26].

The descriptions, in this study, reported the slowness of support services and the lack of beds and technological equipment essential for the maintenance of life, such as mechanical fans and monitors. This reality becomes dangerous, especially in hospitals with reference in urgency and emergency, which keep their doors open, even without beds available for the continuity of care provided to patients. Thus, they often remain hospitalized in the emergency unit itself or, if they need care in the operating room, in the postoperative period, await hospitalization in the ICU bed[27].

The category, entitled, "ICU: a complex and challenging space", shows that too rigid or inflexible norms and routines have negative repercussions. Among the consequences are the delayed transmission of the patient's clinical information to family members, the postponement of hospitalization or discharge of patients and the restriction of the permanence of companions and visits to hospitalized patients[23].

The research's limitation indicates the aspect that the sample was more representative of nursing professionals from the South, Southeast and North regions of Brazil.

The contribution of this study is the reflection about what can be considered as potential actions already used and those that can be implemented in the daily lives of intensive care nurses to practice the advocacy of their patients, as well as the barriers faced by them to implement these actions.

Final Considerations

The study demonstrated the actions that visualized the performance of intensive care nurses in an autonomous way and evidenced the importance of effective communication.

The intensive care nurses of the research defended the quality of care by acting as promoters of planning actions, implementation and evaluation of norms and routines, agents of trials and effective clinical interventions.

The preservation of the social, affective and emotional role of patients was shown in actions, such as interlocution between patient/family/institution, and as an incentive for family participation in decision-making, through the elucidation of doubts and the reception in the death/dying process. There was also the appreciation of singularity as an individual, when listening to the patients' wishes, explaining about rights, transmitting technical reports and promoting the autonomy of customers.

The study also allowed the discussion and reflection on the barriers faced by intensive care nurses in the daily defense of their patients. It evidenced the ethical conflicts in doing and living, the divergences and clinical or therapeutic limits, the organizational, structural and material barriers and even the ICU itself as a complex and challenging space. Unfortunately, reality shows that the daily clash with obstacles to the execution of advocacy lead to moral distress. As a course, professionals are exhausted and discouraged; as a result, they get sick and do not perform the patient's defense.

Although the scenario is discouraging and the barriers are faced daily by intensive nurses, the exercise of advocating by the patient should seek to overcome the imposition of barriers, because the act of advocating constitutes an ethical and political positioning of nurses, capable of impacting on the quality of care of patients who are extremely vulnerable.

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