

THE MORAL DIMENSION OF CARE IN INTENSIVE THERAPY¹

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ABSTRACT

The Intensive Care Unit (ICU) is considered the unit of most technical complexity in the hospital, taking into account the type of activity it develops. As it's a restrict sector, the workers remain closer to each other, which may strengthen exchange of experiences, dialogues and conflicts. Thus, we aimed to analyze the moral dimension of care in intensive therapy. The research, based in Leininger's proposal of Ethno Nursing, was carried out with health workers, being 40 general informants, which of 15 were built up as key informants. The method includes four steps of observation, one of interview and four steps of analysis of data, covering specific and congruent criteria with the qualitative paradigm. The denial of care as value proved to be present in the daily work in ICU, expressed by activities performed in a mechanic, routinely and often uncompromised way. However, the idea that the health care has to be impregnated of moral values and ethical attitudes is valued by the majority of the workers who act in this complex environment. By the analysis of the ethical dimension of care in intensive care, it was possible to comprehend that the existent relationships in the actions of the workers have to be transformed in order to contemplate the indispensable ethical questions to an effective car.

Keywords: Nursing. Moral development. Intensive Care Units. Intensive Care. Workers.

INTRODUCTION

The Intensive Care Unit (ICU) is considered the unit of most technical complexity in the hospital, taking into account the type of activity it develops: the care for critical users, the instability of one or more physiological systems, the possible risks to health and even death. As it's a restrict sector, the workers remain closer to each other, which may strengthen exchange of experiences, dialogues and conflicts. Thus, in the daily work in the ICU, the health workers experience specificities in the relationship among themselves, with the users and the family members. One of the aspects to be considered by the worker are the moral values, essential for the development of the best practices of care, thus demonstrating responsibility to be present.

As important as being present, redeem the sensibility and place yourself in the other's place, moral commitment is necessary to assure an effective care. Carefully observe the respiratory pattern, detect alterations, experience the user's discomfort, the agony and suffer, are attitude, which require knowledge and technical competence. Thus, the moral and clinical perception is committed as more than knowledge about pathologies, theories and principles, requiring receptivity and availability for the experience to look after, by which the worker, in addition to observing the clinical conditions, behaves guided by a moral action.

In this direction, knowledge and intellectual dimensions are necessary for a moral action. Moral is an object of knowledge, "says things that the person must know", these are provisions that enable to decide what to do, how and when

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to do to, by thinking and judging values. The moral “talks about principles or maxims [...] it speaks on behalf of what rules shall be followed [...] talks about values”, reveals that “affective investments are derived from principles”^(1:72).

Intellectual dimensions, rules, principles and values are necessary for a moral act, “but are not sufficient: it is necessary to know how to make them move, relate them in between, give them life, make them produce sense and actions for each situation faced”^(1:80).

Thus, the worker has the moral commitment to protect the user, look after him with sensibility and dignity, i.e., be attentive to his position in the bed; the areas of hyperaemia; the need to change his laying position and clean him are never only observations of problems and affected needs; they are fundamentally ethical observations, because observing constantly and early possible alterations, enables avoiding the user’s complications and suffering, which involves knowledge as an inseparable value of an affective evaluation.

However, it can be seen that at the same time while some workers develop their actions with care as a value and recognize their importance, others, during their activities, may be denying or neglecting care. If the workers get accommodated, either by habit, lack of commitment, personal and professional dissatisfaction, it becomes necessary to provide conditions to modify their attitudes, in order to impede their mechanical and routine immersion in the job context⁽²⁾.

In health, such conditions bring a thought about the ethical foundations upon us, which are the base for the care enforcement. Thus, the performance of this research is justified before the possibility to analyze the relations present in the workers’ daily life, aiming the necessary transformations for the enforceability of a process, which contemplates the indispensable ethic questions for an effective care in the intensive therapy environment.

From the comprehension of the moral commitment for the efficiency of the care, a question comes: how does the care link to the moral values? Based on the assumptions mentioned above, the purpose was to analyze the moral dimension of care in intensive therapy.

METHODOLOGY

This research was developed with ICU health workers from a University Hospital in the South of the country, with the approval by the Ethics Committee of the Federal University of Santa Catarina (UFSC), opinion 269/05. Reference theoretical-methodological foundations were used in the conception of Leininger’s ethnography and ethno nursing⁽³⁾, which consider ways to obtain facts, the people’s feelings, visions about the world to comprehend beliefs and values and mode of life.

Ethno nursing includes nine stages, namely: four observation stages, one interview stage and four data analysis stages⁽⁴⁾. Despite of this apparent fragmentation, these stages link to a come and go movement in an interlinked way, occurring concomitantly, since the beginning of the process till its end⁽⁵⁾.

First, the signature is obtained on two copies of the participants’ Free and Clarified Consent, assuring their privacy, anonymous information and requesting authorization to disclose the results. Then, data collection was started, considering that the observations started in September 2005 and ended in December of the same year, passing through 24 work shifts, a total of 83 hours. The permanence period varied from two to six hours of observation, with the data recorded in a field diary. In the first stage, the daily work was observed, identifying how the workers performed their activities, in the relationship with the users, among themselves, with family members and with the administration, with some questions emerging: what care actions implemented by the team were performed by the nurse, by the technician or by the nurse assistant? In ICU, how does the decision making process occur in relation to the implementation of care and treatments? The number of general informants was forty health workers.

In the second stage, the observation continued being prioritized, starting the informal conversations in order to comprehend how the workers exercised their actions and decision making⁽⁴⁾. Gradually, the approximation to the workers was intensified, with moments of participation in discussions and actions, paying attention to their comments. The first analysis stage occurred simultaneously with the data

collection and the documentation. This process included what was said and observed, postures, gestures, feelings, the comprehension of values, which guided the individuals actions, gathered to obtain a total vision about the phenomenon, with the purpose to recognize the content of the collected information, provide interpretations and attribute meanings⁽⁵⁾.

After the first stage of analysis of the observations, fifteen key informants were selected⁽³⁾, using the following criteria: at least one worker from each professional category and the selection of workers representing all work shifts. Thus, the following were selected: four nurses; two nursing technicians; three nursing assistants; four physicians, one physiotherapist and one nutrition technician.

In the third observation stage, the researchers became more active participants, developing group actions with the workers, keeping attentive to their condition of observers. Concomitantly, the second stage of analysis was started, studying the data to identify differences and similarities in the way the ICU workers expressed their actions, visions about the world, values and decision making to develop the care.

In this stage, a script was elaborated with common questions to all interviewed, and contemplating specific situations for each key-informant, according to the prompt observations recorded in the field diary, starting the interviews individually. The interviews were scheduled in advance, started in December 2005, and were finalized in April 2006, with average duration of 1 hour and 30 minutes, most of them carried out at the proper work place. In order to guarantee the data fairness, the interviews were recorded on a cassette, upon the participants' authorization and, immediately after that, transcribed, starting their analysis process.

During these interviews, new questions were constituted, aiming to catch the perceptions and meanings attributed to the validation of the previously observed data, a qualitative research was adequate, because it favored the "study of subtle nuances" based "on a carefully built approach" through personal approximation and trust relationship, which was established between the researchers and the informants^(6:1062). Thus, each worker was interviewed,

considering the record of his actions and the mode he exercises them, being stimulated to express how he build his mode to act, what he thought about his attitudes, which values he supported on to make decisions and act, how he made the transition between what he valued and what was done, how he realized his actions and his work colleagues' actions. In the third analysis stage, the intent was to evidence the most significant subjects in order to recover them and get deeper into them with the informants.

In the forth observation stage, these were carried out in a reflective mode, reviewing situations and re-evaluating the informants' behavior and global actions, as well as the possible influence of the researchers. The forth analysis stage was constituted of the data synthesis, the extraction of sub-categories and categories and theoretical formulations.

RESULTS AND DISCUSSION

From the whole analysis process, two big categories were elaborated: "Care as a moral value" and "Denial of care as a value"; presented below:

Care as a Moral Value

In this category, two sub-categories were identified: "Commitment as expression of care" and "Respect to the individuality as expression of care".

Commitment as expression of care

In the observations and the interviews carried out, it was possible to identify the workers' commitment with the patients, their involvement and responsibility in their job as expression of the moral values, which seem to sustain their practice in the health area:

What I value more is the observation [...] observe early the alterations, the abnormalities, which might be happening [...] the need to be close, even he being in comma, and provide him with basic care: for hygiene, keep a comfortable position, observe for how long he is that position [...] I think oral hygiene, the nasal hygiene are very important (Worker 4).

The patient is one whole, he is not the nurse's, the physician's. When I see there is a need, I have to call the responsible and talk, I become anxious.

His mouth is dry, I called, he didn't come, I wet, I will not leave the patient waiting [...] I need the exam, the R-ray fast, I will not keep waiting the secretary. I am the responsible for the patient (Worker 3).

I think that it is really my moral education indeed, it's the commitment to the patient, this is the most important, the world might be falling down outside, but I will not go out and leave the patient (Worker 5).

In the health workers' group job they can find a conception of what is prioritized as moral value, as moral sensitivity. The feasibility of constitution of a hospital environment permeated by an ethical atmosphere and the respective comprehension of the purpose and the content of the good values ⁽⁷⁾ enable the composition of a myriad of small good care acts. In this perspective, the values are indispensable to guide the comprehension and the vision about the world and can serve as parameters for choices, guiding actions and attitudes, influencing care and health ⁽⁸⁾.

The values are socially shared concepts of the desirable. They can be related to beliefs about the existential objectives, i.e., to seek for happiness, knowledge, as well as to desirable forms of behavior for a purpose ⁽⁹⁾.

Care as a moral value is the manifestation since the constant observation of the user, the capacity to detect alterations, needs and establish basic actions; as well as the ability to "be present" and be committed. And, while the worker becomes aware about the user's needs, he can detect physio-pathological phenomena in the act to care.

Respect to the individuality as expression of care

Predominantly empathic relations, features by sensitivity, concern about the other, about his values, mode of living and taking care, the respect to his privacy and modesty, and the necessary emphasis on dialogue and interaction as an instrument of approximation, knowledge and exchange with the patients, expressed a moral dimension of care:

In addition to the theoretical-practical knowledge, good sense, good character are also needed, not to do to others, what you wouldn't like them to do to you [...] you will treat differently for sure. Not letting care become a routine and treat as an

object, do things more like mechanically, in any way. I like very much giving bath in bed, take care of the patient's hygiene (Worker 14).

If the patient is awake, comprehend, try to talk, explain. Sometimes, he cries, you have to listen; he asks for a family member, you have to make an exception and let in; see the reason for fear, explain the issues like devices, tubes, even those of the patient beside, many times they don't understand why the patient is in that state. Many times it takes to understand these needs (Worker 4).

The attentions to the needs of care are also moral observations, because they require knowledge, sensitivity, engagement and affectivity. Observe the alterations early is simultaneously the possibility to avoid complications and situations of discomfort, which involves knowledge as an inseparable value of an affective evaluation. Yet integrating knowledge and technical ability to the ethical dimension of care enables the workers to think and act "from the identification of moral values from experiences; the interpreting of experiences; the mode to relate and establish communicative process" ^(10:161).

In the same way the workers seek a scientific base and technical competence to sustain their actions, they need to redeem their sensibility to face possible difficulties existing in the care to critical patients ⁽¹⁰⁾. They also need to practice the "human sensibility that manifests in the interest, respect, attention, comprehension, consideration and affection to the other", reinforcing the link between the scientific base and the ethical reasons ^(11:2).

Care as a moral value requires looking to the user as a human being, with different presentations, which do not dissociate him from the social groups he is a part of, with no way to isolate him, fragment him. Thus, it is necessary to know his singularity, his values, his beliefs, which requires deep respect to his condition, including his feelings of suffering due to the present risks, the distancing from the family, the fear of a permanent incapacity, the possibility not to be able to provide for his family anymore and also solitude and death.

The decision making according to these evidenced needs of care can be understood as a manifestation of responsibility, consisting in an obligation to perform basic diagnostic and

therapeutic functions in a competent way. In this context, the responsibility is linked to values and interests of a society to privilege the health market, facts, which lead to ambivalence between the “*responsibility of shall be and the independence with capacity to choose*”.^(12:877)

Thus, behaviors developed in care and the way the workers express their actions are related to cultural patterns⁽⁸⁾. In this direction, the organization of the care environment requires an attentive look to the organizational culture, which continuously gets instituted and transforms from the relations among the workers and with the users: practices, which get normalized and become acceptable, such as the identification of the user as a clinical case or the acceptance of changing gloves only, without washing your hands first.

The Denial of Care as a Value

In this category, two subcategories were identified: “(Lack of)care for the other and for himself” and “(lack of) care for himself and for the other”.

(Lack of)care for the other and for himself

The recognition of certain practices as incoherent and inadequate as actions of care, and their manifestation despite of this affirmation, enable considering the understanding of the denial to care as a value for some workers. Thus, the identification of the users by their name as expression of respect and care to the other can be replaced by their identification according to the number of their bed or their diagnosis, showing their depersonalization and apparent denial of their humanity, as well as the humanity of the proper worker:

I have never thought about this attitude. Certainly, if I say Mrs. 4, I have the habit to do so, many times I change the names, it seems lack of respect! It's because the patient is in comma and we depersonalize a bit, but this doesn't influence my attitude to him. In the faculty, there is always someone guiding and many times we lose [...] When I call an awake patient, I him by his name (Worker 12).

It is isolation of affection. We are not treating the sick person, we are treating the disease, this is already the first problem. It is a behavior and humanization exercise (Worker 11).

Many times, the job routine is associated to

the denial of the emotional and the human dimension of the relations among the health workers and their clientele, in the name of a knowledge and therapeutic responsibility, which sees a disease to be overcome and not a sick person to be comprehended and taken care of, not visualizing “the patient as a human being, but as an addition to his job routine, depersonalizing him”. However, it is impossible to deny the unconditional respect and the patient's right to be called by his name, because it is necessary to establish a respectful interpersonal relationship, when someone undertakes to take care in an ethical and humanized way^(13:340).

The situations approached herein strongly reflect what can be detected as a habit in the ICU environment. Some workers say that initially they used to identify the users by their names, which, with the time passing, became neglected in the professional actions. Others express that this attitude in relation to the health users is common in any hospital.

(Lack of)care for himself and for the other

The practice of washing hands before and after the performance of procedures, expression of the worker's care first for himself and also for the users he assists, doesn't seem to be a routine incorporated in all worker's job. Regardless of the professional education, it was perceived that several workers don't wash their hands routinely, with an apparent “naturalness” before this (lack of)care, favoring the dissemination of microorganisms, depriving themselves and the user from the right to be taken care of safely and with quality:

I say this {laugh} to my students daily. So, it is terrible you say something and you don't do it. You cannot take from one patient to another, you cannot take the belongings from one patient and take to another, you have to wash your hands, this is my theory when I enter the ICU with my students (Worker 1).

And, the small details sometimes, mainly for me, pass a bit left behind in this story. We are totally free, the hands hygiene is a primordial care (Worker 5).

Everyone decides on his own. They even try, comment, but that's it; there is no one to inspect, but it shouldn't be inspected (Worker 4).

It's lack of care and it is a consequence. I have already observed and sometimes I catch myself in not going to wash my hands [...] I empty the diuresis of a patient, while I am emptying one, I go and empty another one [...] I think the routines should be checked again (Worker 15).

The practice of washing hands doesn't seem to be recognized as a moral value to be incorporated in the workers' routine as well. For this purpose, it is necessary to intervene, discuss norms and routines, so that everyone, as a part of the group, can work preventively, assume responsibility for their attitudes, their contribution to the necessary change in behavior to incorporate the norms to their working process, aiming not only the determination by the Ministry of Health for prevention and control of hospital infection, but recognizing the users' right to be taken care of safely and with dignity, rebuilding the "care process, which has been fragmented along the time" and redeeming the "essence of care subjectivity"^(14-15:71).

However, despite of the distinction of the importance of this care, some workers seem to naturalize this non-fulfillment as something which a part of their daily life, exposing themselves and exposing the users to preventable risks, regardless of the existing and stipulated measures and norms for infection control. Considering the exposed, even with the information and the knowledge about the content and the importance of this job, denial of care is seen as a valor, i.e., denial of care seems to be a value as well. The (lack of)care seems to be a value, perpetuating the performance of an automatic job, not thinking about what being an ICU worker represents and how much his actions can reflect on inadequate care for himself and on the care for the others, requiring the capacity of value judgment and formulation of other modes to conceive the everyday life⁽¹⁶⁾.

CONCLUSION

The care process involves will, interests and moral values. In the same way the workers value

the moral dimension of care, in other moments, they seem to perform their job not carefully, mechanically, without considering commitment and responsibility, necessary factors for health workers.

Knowledge about what has to be done and believe in its reinforcement is not simply enough, if the worker's attitudes are apathetic and indifferent before the commitment to the care for user as a unique subject. More than that, the workers need to have sense of duty, responsibility and commitment, to immerse in a process of (un)constitute themselves for a moral job. For this purpose, it is necessary to face values, norms, principles and ethic knowledge to sustain their mode of being, working, relating one to the other, involving affectively, being responsible and morally committed.

From the analysis of the moral dimension of care made effective in an Intensive Care Unit, it was possible to see that the moral implications pursuant to the health workers' decision making, to the non-fulfillment of the moral obligations and to the lack of professional recognition, can generate suffering and dissatisfaction either to the users, or to the workers, compromising the ethical dimension of the nursing job.

In this perspective, it seems that internalization of moral values by the workers is indispensable to serve as parameters to evaluate, judge the actions considering what is may be done, what shall be done, what cannot be done and what shall not be done, thus sustaining decision making and ethical actions in relation to care.

It is possible that from the exposure of these issues to the workers, some reflection processes have already started regarding their mode of being, thinking and acting in their work environment. In this perspective, it is up to the ICU workers to make a group debate as an attempt to review and mobilize themselves to transform this reality.

A DIMENSÃO MORAL DO CUIDADO EM TERAPIA INTENSIVA

RESUMO

A Unidade de Terapia Intensiva (UTI) é considerada a unidade de maior complexidade técnica do hospital, tendo em vista o tipo de atividade desenvolvida. Por ser um setor fechado, os trabalhadores permanecem mais próximos uns dos outros, o que pode intensificar trocas, relações, comunicações e conflitos. Assim, objetivou-se analisar a dimensão moral do cuidado em terapia intensiva. A pesquisa, fundamentada na proposta de

Etnoenfermagem de Leininger, foi realizada com trabalhadores da saúde, sendo 40 informantes gerais, dos quais, 15 constituíram-se como informantes-chaves. O método incluiu quatro fases de observação, uma de entrevista e quatro fases de análise dos dados, contemplando critérios específicos e congruentes com o paradigma qualitativo. A negação do cuidado como valor mostrou-se presente no cotidiano do trabalho na UTI, manifestado por um fazer mecânico, rotineiro e, muitas vezes, descompromissado. No entanto, a compreensão de que o cuidado em saúde necessita estar impregnado de valores morais e de atitudes éticas, é valorizada pela maioria dos trabalhadores que atuam neste ambiente complexo. Na análise da dimensão ética do cuidado em terapia intensiva foi possível compreender que as relações presentes no fazer dos trabalhadores necessitam ser transformadas de modo a contemplar as indispensáveis questões éticas para um cuidado efetivo.

Palavras-chave: Enfermagem. Desenvolvimento Moral. Unidades de Terapia Intensiva. Terapia Intensiva. Trabalhadores.

LA DIMENSIÓN MORAL DEL CARE EN INTENSIVE THERAPY

RESUMEN

La Unidad de Cuidados Intensivos (UCI) es considerada la unidad de mayor complejidad técnica del hospital, llevando en cuenta el tipo de actividad desarrollada. Por ser un sector cerrado, los trabajadores permanecen más próximos unos de los otros, lo que puede intensificar cambios, relaciones, comunicaciones y conflictos. Así, se ha tenido el objetivo de analizar la dimensión moral del cuidado en terapia intensiva. La investigación, fundamentada en la propuesta de Etnoenfermería de Leininger, fue realizada con trabajadores de la salud, siendo 40 informantes generales, de los cuales 15 se constituyeron como informantes clave. El método incluye cuatro fases de observación, una de investigación y cuatro fases de análisis de datos, abarcando criterios específicos y congruentes con el paradigma cualitativo. La negación del cuidado como valor se ha demostrado presente en el cotidiano del trabajo en la UCI, que se ha manifestado por un hacer mecánico, rutinario y, a menudo, sin compromisos. Sin embargo, la comprensión de que el cuidado en salud necesita estar impregnado de valores morales y de actitudes éticas es valorada por la mayoría de los trabajadores que actúan en este ambiente complejo. En el análisis de la dimensión ética de la atención en cuidados intensivos fue posible comprender que las relaciones presentes en el hacer de los trabajadores necesitan ser transformadas con el fin de contemplar las indispensables cuestiones éticas para un cuidado efectivo.

Palabras clave: Enfermería. Desarrollo Moral. Unidades de Cuidados Intensivos. Cuidados Intensivos. Trabajadores.

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