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Humanization of physiotherapy care: study with patients post-stay in the intensive care unit

Humanização da assistência de fisioterapia: estudo com pacientes no período pós-internação em unidade de terapia intensiva

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ABSTRACT

Objectives: The intensive care unit emerged to improve and concentrate material and human resources for the care of critical patients, and need for constant observation and continuous assistance. However, patients in intensive care unit requires exceptional care, directed not only to the physiopathological problem, but also towards the psychosocial issue, now intimately interlinked to the physical disease. In this ambient, very demanding for capability of the multiprofessional team, presence of the physiotherapist has become more frequent. This study aims to verify if the attitude of an experienced physiotherapist in the intensive care unit is humanized.

Methods: To evaluate physiotherapy care humanization, a questionnaire was prepared and patients over 18 years of age, lucid and staying in intensive care unit for 24 hours or more were included.

Results: Forty four patients were interviewed and 95.5% of these considered the physiotherapy care as humanized. Positive association was observed between dissatisfaction with the items of dignity, communication, warranty and empathy, and a dehumannized physiotherapy care. Patients who evaluated warranty as negative had a twofold greater chance (0.7 - 5.3) of perceiving care as dehumanized. Patients who evaluated empathy as negative had a 1.6 (0.8 - 3.4) times greater chance of perceiving care as dehumanized.

Conclusion: Physiotherapy care given in the intensive care unit was marked by good assistance, attention provided to the patient and quality of treatment, characterizing humanized care.

Keywords: Physiotherapy; Humanization; Intensive care unit; Patient care; Patient satisfaction; Professional-patient relation**;** Questionnaires

INTRODUCTION

Intensive care units (ICU) emerged from the need to improve and concentrate human and material resources for care of critically ill patients, considered reversible, and from the need for constant observation and continued care thereby centralizing patients in a specialized center.[1]

In this ideal ambient for care of the critically ill, although reversible patients, that seems to be one of the more aggressive, tense and trau-

matizing environments of the hospital,[2] which is also demands so much from the multiprofessional team, presence of the physiotherapist has been increasingly frequent.

Physiotherapy has available a comprehensive arsenal of techniques that complements critical patient care. Principal indications are improvement of the pulmonary function, therapy to mitigate pain and the psychophysical symptoms, as well as prevention and rehabilitation of musculoskeletal, cardiovascular and neurological complications. The physiotherapist in the ICU seeks to preserve life with improved quality and mitigate physical symptoms, providing an opportunity for the patient's functional independence, whenever possible.

However, the patient in the IOCU needs care of excellence, not only directed to psychopathological problems, but also to psychosocial issues, that become closely interlinked with physical disease.[1] Patient fear, anxiety and distress may have a negative influence on the adjustment process in the unit as well as on the healthcare team and the recovery.[3] Thus, humanization, defined as retrieval of respect for human life, considering the social, ethical, educational, psychic and emotional circumstances existing in all relationships,[4] must be part of the physiotherapy philosophy. The physical environment, material and technological resources are important, however not more significant than the human essence. Indeed the latter must steer the actions of the physiotherapy team, enabling it to build up a more human reality, less aggressive and hostile for those experiencing a stay in the ICU.

Although literature stresses the need for humanization, little is known about implementation and outcome of measures to minimize impersonality toward the patient. As such, evaluation from the standpoint of a patient assisted by a physiotherapist in the ICU may help to build a new therapeutic relationship of respect, affection and bond to improve quality of the attention to the patient and fashion a humane hospital.

METHODS

Cross-sectional study, carried out in August 2008, with patients in the General and Cardiology ICU of the Hospital São Rafael (HSR), Salvador (BA). The General ICU has 16 beds to care for adult, clinical or surgical patients with different pathologies, while the cardiology ICU has nine beds intended for care of heart disease, clinical or surgical adult patients.

The sample was defined for convenience and comprised by 44 patients over 18 years of age, selected according to the following inclusion criteria: history for admission in the ICU for a stay of at least 24 hours or longer, be lucid and oriented, with sustained capacity of verbalization and/or writing, staying in other units of the hospital at the time of data collection and agreeing to participate in the study.

The project was approved by the Research Ethics Committee of HSR. Confidentiality of the information given by the questionnaire was warranted by using only an identification number. The right not to voluntarily participate in this study was given by signing a term of consent, stressing their agreement, in accordance with the ethical aspects shown in the resolution 196/96 of the National Health Council.

Data was collected using personal interviews by the author of the study, who in contact with the ICU, was informed about discharges and destination of patients in the hospital. Interviews were performed in the patient's room, without presence of any healthcare professional from the hospital, especially physiotherapists, to ensure security and comfort needed by the patient, keeping confidentiality of the replies and avoiding embarrassment or commitments.

Data was collected using a standardized questionnaire, structured, especially developed for the research (Attachment 1), made up of closed questions about sociodemographic data of interest for the study and pertinent to the specific part of the study (assessment of the physiotherapist-patient relationship) and procedures.

The physiotherapist-patient relationship was considered as a dependent variable, categorized as humanized when represented by five or more positive replies in the assessment of this relationship and dehumanized when represented by five or more negative replies.

The following dimensions of care were selected as independent variables:

- Dignity – have a dignified attentive and respectful care. Be identified and treated by name. Be able to identify the physiotherapists involved in his/her care. Have the privacy, individuality and respect to his/her ethical and cultural values guaranteed.

- Communication – Receive clear, objective and comprehensible information. Be attentively listened to by the physiotherapist, with sufficient time to clarify doubts.

- Autonomy – Be informed about treatment options and alternatives. Have permission to make decisions on the type of treatment, after talking it over the physiotherapist. The patient may refuse treatment.
- Reliability – Physiotherapist must fulfill the promise and be qualified to carry out the task.
- Warranty – Physiotherapist should work with both remedial practices and capable performance;
- Interpersonal aspects – How each physiotherapist interacts personally with patients, that is to say, respect, courtesy, interest, liveliness;
- Empathy – Physiotherapist should be capable of feeling him/herself in place of the patient and offer individualized care;
- Responsiveness - readiness to help and respond to the patients needs;
- Efficacy - Resolutive care, based upon risk criteria, bringing about improvement or sustaining health.

According to the patient's perception regarding care given by the physiotherapist in the ICU, these items were assessed in a positive or negative form.

Co-variables were: gender, age bracket – categorized as 18 to 59 years and ≥ 60 years of age, marital status – married and single, including in this group those divorced or widowed; education- low, incomplete primary school and high, starting from complete primary school; income – 0 to 3 and > 3 minimum wages, reason for admission to the ICU – clinical and surgical treatment; use mechanical ventilation, length of stay in ICU – 1 to 3 and ≥ 4 days; type of ICU – Genial and cardiology ;and procedure - lung expansion therapy, bronchial hygiene therapy; withdrawing of ventilation support; kinesiotherapy; stretching; positioning therapy.

The data bank was built using the (version 8.0) Excel software. Statistical analysis was carried out using the Epi Info (version 3.5.1) software. For the study, significance level was defined as 0.05.

RESULTS

Patients of this study presented a high degree of satisfaction with the physiotherapist care. It was perceived that only two (4.5%) evaluated the physiotherapist/ patient relationship as dehumanized (Table 1).

Sociodemographic characteristics of the population according to the relationship physiotherapist / patient are shown on table 1. Most patients were male (61.4%), 60 years of age or over (61.4%), married (56.8%), high level of education (63.6) and income

Table 1 – Sociodemographic characteristics of the population according to the physiotherapist/patient relation

Sociodemographic characteristics		Physiotherapist/patient relationship	
	Total	Humanized (N= 42)	Dehumanized (N= 2)
	N (%)	%	%
Gender			
Female	17 (38.6)	100.0	0.0
Male	27 (61.4)	92.6	7.4
P value		0.25	
Age bracket			
18-59	17 (38.6)	100.0	0.0
≥ 60	27 (61.4)	92.6	7.4
P value		0.37	
Marital status			
Single	19 (43.2)	100.0	0.0
Married	25 (56.8)	92.0	8.0
P value		0.31	
Education			
Low	16 (36.4)	93.8	6.3
High	28 (63.6)	96.4	3.6
P value		0.68	
Income (minimum wages)			
0-3	17 (38.6)	94.1	5.9
>3	27 (61.4)	96.3	3.7
P value		0.62	
Cause of admission			
Clinical treatment	19 (43.2)	94.7	5.3
Surgical treatment	25 (56.8)	96.0	4.0
P value		0.84	
Use of MV			
Yes	12 (27.3)	100.0	0.0
No	32 (72.7)	93.8	6.3
P value		0.38	
Length of stay (days)			
1-3	26 (59.1)	92.3	7.7
≥ 4	18 (40.9)	100.0	0.0
P value		0.34	
Type of ICU			
General	24 (54.5)	91.7	8.3
Cardiology	20 (45.5)	100.0	0.0
P value		0.19	

MV – mechanical ventilation; ICU – Intensive care unit. Results expressed in numbers (%) or only %.

more than three minimum wages (61.4%). Because the hospital has high complexity surgical services, surgical treatment was the reason for admission of most patients (56.8%), the general IOCU was the unit of origin (54.5%), mechanical ventilation was not needed (72.7%) and length of stay in the unit was less than four days (59.1%).

In relation to causes of admission, cardiovascular diseases were the primary disease for patients clinically treated (57.9%) as well as surgical (36%). In the clinical treatment group, respiratory disease ranked second (15.8%), followed by non-respiratory sepsis (5.3%) gastrointestinal/hepatic diseases (5.3%), endocrine/renal diseases (5.3%) post-cardiorespiratory arrest (CRA) (5.3%) and politrauma (5.3%). In the surgical treatment group, abdominal surgery ranked second (32%), followed by head and neck (20%), thoracic (8%), and upper/lower limbs (4%).

Regarding patient satisfaction in relation to dimension of the care according to the physiotherapist / patient relationship, most patients evaluated the items positively (Table 2). Negative evaluations were more frequent for the items autonomy (31.8%) and empathy (11.4%). Negative evaluations of the items dignity 2.3%) and communication (2.3%) were less frequent. Quantitative data analysis disclosed a positive association between dissatisfaction with the items dignity (100%), communication (100%), warranty (50%) and empathy (40%) and a dehumanized relation physiotherapist / patient (p= 0.04, p= 0.04, p= 0.00 and p= 0.01, respectively).

Patients who evaluated warranty as negative presented a twofold greater chance (0.7 – 5.3) of perceiving as dehumanized, the relation physiotherapist / patient. Those who evaluated empathy as negative presented a 1.6 (0.8 – 3.4) greater chance of perceiving this relation as dehumanized, compared to those who evaluated this item as positive (Table 3).

It was observed that when performing the physiotherapy procedures, absence of humanization was low (5%), since only the bronchial hygiene therapy with coughing stimulus was scored.

Table 2 – Satisfaction of patients regarding dimensions of care according to the physiotherapist / patient relationship

Dimensions of care		Physiotherapist/patient relationship	
	Total	Humanized (N= 42)	Dehumanized (N= 2)
	N (%)	%	%
Dignity			
Positive	43 (97.7)	97.7	2.3
Negative	1 (2.3)	00.0	100.0
P value		0.04	
Communication			
Positive	43 (97.7)	97.7	2.3
Negative	1 (2.3)	00.0	100.0
P value		0.04	
Autonomy			
Positive	30 (68.2)	100.0	0.0
Negative	14 (31.8)	85.7	14.3
pValue		0.09	
Reliability			
Positive	42 (95.5)	97.6	2.4
Negative	2 (4.5)	50.0	50.0
P value		0.08	
Warranty			
Positive	40 (90.9)	100.0	0.0
Negative	4 (9.1)	50.0	50.0
P value		0.00	
Interpersonal aspects			
Positive	42 (95.5)	97.6	2.4
Negative	2 (4.5)	50.0	50.0
P value		0.08	
Empathy			
Positive	39 (88.6)	100.0	0.0
Negative	5 (11.4)	60.0	40.0
P value		0.01	
Receptivity			
Positive	42 (95.5)	97.6	2.4
Negative	2 (4.5)	50.0	50.0
P value		0.08	
Efficacy			
Positive	42 (95.5)	97.6	2.4
Negative	2 (4.5)	50.0	50.0
P value		0.08	

Results expressed in numbers (%) or only %.

DISCUSSION

Knowledge of patients' opinion is fundamental, not only to improve quality and humanization of intensive physiotherapy but also because the team is in charge of lessening the painful process involved in ICU stay. A stay may become less stressful for the pa-

Table 3 – Prevalence of dehumanization and measurement of association according to dignity, communication, warranty and empathy

Dimensions of care	Total N (%)	Prevalence of dehumanization (N= 2) %	Ratio of prevalence (CI 95%)
Dignity			
Negative	1 (2.3)	100.0	*
Positive	43 (97.7)	2.3	
P value		0.04	
Communication			
Negative	1 (2.3)	100.0	*
Positive	43 (97.7)	2.3	
P value		0.04	
Warranty			
Negative	4 (9.1)	50.0	2.0 (0.7 – 5.3)
Positive	40 (90.9)	0.0	1.0
P value		0.00	
Empathy			
Negative	5 (11.4)	40.0	1.6 (0.8 – 3.4)
Positive	39 (88.6)	0.0	1.0
P value		0.01	

*Could not be calculated due to insufficient data. Results expressed in numbers (%) or only %.

tient, depending on the attitude towards life, of the place where he was admitted and of the team caring for the patient.[5]

In this study, a high level of satisfacti0on with the humanization of the physiotherapy care was perceived. Favorable evaluations are reasons for satisfaction, mainly because patients are generally 60 years of age or more, with high education level and socio economic conditions, which may be associated to a high level of perception of their rights and high level of requirements.

Age is an important factor to be taken into account for the physiotherapist performance because needs and expectations of persons vary according to their stage of life. This requires closer attention and adjustments of conduct to the different manifestations and behavior of each patient.

Regarding dimension of care, most patients gave a positive evaluation to the items, with dignity and communication receiving the highest indices of approval. Stressing the importance of these items, Nations and Gomes[16] emphasize the relationship with the professional as the core of humanized care.

As in literature[3,5,6] it was noted that communication is fundamental for the adequate quality of intensive care. Patients expect to be informed to minimize fear of the strange hospital world. Lack of information promotes insecurity while omission causes distrust. It is not sufficient to transmit information; terms have to be explained for patient comprehension. Use of technical language makes understanding more difficult, above all for those with a lower education level.[7]

In a study published in 2007,[5] it was noted that in the healthcare professional, the patient valued the human capability to be kind, to chat and include him/her in clinical decisions more than the technical qualification, and in this study it was observed that autonomy was rated with the highest disapproval. These results suggest that in the therapeutic relationship, in addition to capable care, autonomy and patient empowerment are required. To include patients in the clinical decisions is appreciated and patients give more credibility to the professional able to share decision making and respects his/her autonomy.[5]

A negative evaluation of empathy, warranty, communication and dignity were seen to be related to dissatisfaction with the humanization of physiotherapy care. Pereira and Azevedo[8] state that in the interpersonal relationships inherent to professional practice, it is the quality of the meeting that establishes its efficiency, and it is known that empathy is essential in this meeting.

Aiming to facilitate acceptance and effectiveness of care, courtesy and qualification in physiotherapy procedures is essential, besides explanation of objectives to the patient, inspiring the necessary confidence and warranty.

In patients evaluations, empathy and warranty are the ruling factors of satisfaction with humanization of the physiotherapy care. This may be explained by considering that patients expect the healthcare professional to create a welcome ambient that eases or alleviates suffering and may respond vigorously to the health problem.[7] Gestures that enhance uniqueness, value the patient as a human being.

The items reliability, interpersonal aspects, receptivity and efficacy, although without statistical significance are also important indices of the quality of physiotherapy care.

Data reported here substantiate that the relationship physiotherapist / patient is based up reliability that physiotherapy inspires and in the patient's understanding of the physiotherapist's reality. For the physiotherapist, selection of techniques must recog-

nize usefulness and expected results, To implement physiotherapy techniques without clear objectives brings about insecurity and undermines patients trust. Studies[5] disclose that the most relevant ability of the healthcare professional from the standpoint of an ICU patient is human capability. Ability to care for the person, not only the disease, is crucial.

Regarding physiotherapy procedures, the bronchial hygiene therapy with coughing stimulus must be highlighted because it is the only one where the patient noted lack of humanization. Coughing stimulus, also called tracheal – tic is carried out by manual stimulus and excitation of the cough receptors located in the tracheal region, by a lateral movement of the trachea during inspiration. As this is a disagreeable recourse, it must be restricted to patients in a comatose state of unconsciousness, mental confusion or those who present a reduced coughing reflex.

Considering that the experience of a hospital stay and disease obliges human beings to face a crisis situation, intervention in the ICU must truly preserve the biological and mental health of the person, supporting his/her full recovery by means of humanized care.[9] Masetti[10] detected that when working with humanization, length of stay decreases and overall wellbeing of patients improves. Granja et al.[11] suggest that neuropsychological aftermaths of an ICU stay may affect the quality of life of patients after discharge from the unit.

There are some aspects in this study that may be considered vulnerable. All forms of measuring patient satisfaction are based upon patient perception regarding his/her expectations, values, degree of demand about care and individual characteristics such as age, gender, social class and psychological condition. To still being under care may have inhibited negative replies to evaluate the physiotherapist/ patient relationship. However, improvement in the quality of information relied on interviews made without presence of a healthcare professional to provide more liberty to give his/her opinion. It is also noteworthy that the sample of patients included was small due to operational limitations making it impossible to carry out a representative study in the ICU of the city of Salvador. However, all patients admitted in the ICU who met inclusion criteria were included in the study. Therefore, data should be extrapolated to ICUs that have similar characteristics regarding the type of care and clientele. Notwithstanding, results of this study should still be considered in the context of some limitations, since all patients were conscious and data were obtained in the post-discharge from the ICU.

CONCLUSION

As observed in the results, physiotherapy care given in ICU was marked by good assistance, attention directed to the patient and quality treatment characterizing humanized care.

Negative evaluations of communication, dignity, empathy and warranty were defined in this study as the main factors for unsatisfactory quality of the relationship physiotherapist / patient. However, empathy and warranty were the ruling factors of satisfaction with humanization of the physiotherapy care.

To improve the quality of care given, acknowledgment of the most frequent factors of dissatisfaction may indicate ways to facilitate humanization of physiotherapy care in the ICU.

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RESUMO

Objetivos: As unidades de terapia intensiva surgiram a partir da necessidade de aperfeiçoamento e concentração de recursos materiais e humanos para o atendimento a pacientes graves, e da necessidade de observação constante e assistência contínua. Entretanto, o paciente internado na unidade de terapia intensiva necessita de cuidados de excelência, dirigidos não apenas aos problemas fisiopatológicos, mas também para as questões psicossociais, que se tornam intimamente interligadas à doença física. Neste local tão exigente quanto à competência da equipe multiprofissional, a presença do fisioterapeuta tem sido cada vez mais freqüente. Este estudo teve por objetivo constatar se a conduta profissional do fisioterapeuta experimentada na unidade de terapia intensiva é humanizada.

Método: Foi elaborado um questionário para avaliação da humanização da assistência de fisioterapia e incluídos pacientes maiores de 18 anos, lúcidos e que estiveram inter-

nados em unidade de terapia intensiva por período igual ou superior a 24 horas.

Resultados: Foram entrevistados 44 pacientes e 95.5% destes avaliaram a assistência de fisioterapia como humanizada. Observou-se associação positiva entre insatisfação com os itens dignidade, comunicação, garantia e empatia, e uma assistência de fisioterapia desumanizada. Pacientes que avaliaram a garantia como negativa apresentaram uma chance 2.0 (0.7 - 5.3) vezes maior de perceberem a assistência como desumanizada. Pacientes que avaliaram a empatia como negativa apresentaram uma chance 1.6 (0.8 - 3.4) vezes maior de perceberem essa assistência como desumanizada.

Conclusões: A assistência de fisioterapia prestada na unidade de terapia intensiva foi marcada pelo bom atendimento, pela atenção dada ao paciente e pelo tratamento de qualidade, caracterizando uma assistência humanizada.

Descritores: Fisioterapia; Humanização; Unidade de terapia intensiva; Assistência ao paciente; Satisfação do paciente; Relação profissional-paciente; Questionários

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Attachment 1 - Questionnaire

HOSPITAL SÃO RAFAEL
UNIVERSIDADE CASTELO BRANCO / ATUALIZA ASSOCIAÇÃO CULTURAL

N°: |__|__|

Project: **Humanization of physiotherapy care: study with patients post-stay in the intensive care unit**

A) Sociodemographic Characteristics

01. Gender: 1. ☐ F 2. ☐ M

02. Age bracket: 1. ☐ 18 to 59 years 2. ☐ >60 years

03. Marital status: 1. ☐ Single 2. ☐ Married

04. Education:
1. ☐ with no formal schooling
2. ☐ Primary school: 2.1. ☐ Incomplete 2.2. ☐ Complete
3. ☐ High school 3.1. ☐ Incomplete 3.2. ☐ Complete
4. ☐ Higher Education: 4.1. ☐ Incomplete 2.2. ☐ Complete

05. Income (Minimum Wages): 1. ☐ 0 a 3 2. ☐ >3

06. Class of primary diagnosis:

1. ☐ Clínical:
   - 1.1. ☐ Respiratory
   - 1.2. ☐ Cardiovascular
   - 1.3. ☐ Neurological
   - 1.4. ☐ Non respiratory sepsis
   - 1.5. ☐ Gastrointestinal/hepatic
   - 1.6. ☐ Endochrine/Renal
   - 1.7. ☐ Polytrauma
   - 1.8. ☐ Post cariorespiratory arrest
   - 1.9. ☐ Others: _____

2. ☐ Surgical:
   - 2.1. ☐ Cardiovascular
   - 2.2. ☐ Thoracic
   - 2.3. ☐ Abdominal
   - 2.4. ☐ Head / Neck
   - 2.5. ☐ LLM / ULM

07. Type of ICU: 1. ☐ General 2. ☐ Cardiological

08. Length of Stay in ICU (days): 1. ☐ 1 to 3 2. ☐ >4

09. Use of Mechanical Ventilation: 1. ☐ Yes 2. ☐ No

B) Physiotherapist-Patient Relationship

01. Dignity: *"Have a dignified attentive and respectful care. Be identified and treated by name. Be able to identify physiotherapists involved in his/her care. Have the privacy, individuality and respect to his/her ethical and cultural values guaranteed."*

1. ☐ Positive 2. ☐ Negative

02. Communication: *"Receive clear, objective and comprehensible information. Be attentively listened to by the physiotherapist, with sufficient time to clarify doubts."*

1. ☐ Positive 2. ☐ Negative

03. Autonomy: *" Be informed about treatment options and alternatives. Have permission to make decisions on the type of treatment, after talking it over with the physiotherapist. Be able to refuse treatment."*

1. ☐ Positive 2. ☐ Negative

04. Reliability: *"Physiotherapist must fulfill the promise and be qualified to carry out the task."*

1. ☐ Positive 2. ☐ Negative

05. Warranty: *"Physiotherapy care working with remedial practice and capable performance."*
1. ☐ Positive 2. ☐ Negative

06. Interpersonal aspects: *"How each physiotherapist interacts personally with patients, that is to say, respect, courtesy, interest, liveliness."*
1. ☐ Positive 2. ☐ Negative

07. Empathy: *"Physiotherapist should be capable of feeling him/herself in place of the patient and offer individualized care."*
1. ☐ Positive 2. ☐ Negative

08. Effcacy: *"Resolutive care, based upon risk criteria, bringing about improvement or sustaining health"*
1. ☐ Positive 2. ☐ Negative

09. Responsiveness: *"Readiness to help and respond to the patients needs."*
1. ☐ Positive 2. ☐ Negative

C) Procedures

1. During some of the physiotherapist's procedures did you perceive a lack of humanization:
1. ☐ Yes 2. ☐ No
1.1. ☐ Positioning therapy
1.2. ☐ LET
1.3. ☐ Interruption of ventilatory support
1.4. ☐ TBH: 1.4.1. ☐ Suction 1.4.2. ☐ Coughing stimulus
1.5. ☐ Kinesiotherapy
1.6. ☐ Stretching
1.7. ☐ Others: _____