Representational structure of intensive care for professionals working in mobile intensive care units*

A ESTRUTURA REPRESENTACIONAL DO CUIDADO INTENSIVO PARA PROFISSIONAIS DE UNIDADE DE TERAPIA INTENSIVA MÓVEL

ESTRUCTURA REPRESENTACIONAL DEL CUIDADO INTENSIVO PARA PROFESIONALES DE UNIDAD DE TERAPIA INTENSIVA MÓVIL

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ABSTRACT

This qualitative study was performed based on the Social Representations Theory, using a structured approach. The objective was to analyze the social representations of intensive care for professionals who work in mobile intensive care units, given the determination of the central nucleus and the peripheral system. This study included 73 health care professionals from an emergency mobile care service. Data collection was performed through free association with the inducing term *care for people in a life-threatening situation* and was analyzed using EVOC software. It was observed that a nucleus is structured in knowledge and responsibility, while contrasting elements present lexicons such as agility, care, stress and humanization. The representational structure revealed by participants in this study refers particularly to the functionality of intensive care, which distinguishes itself by the challenges and encouragements provided to individuals working in this area.

DESCRIPTORS
Nursing care
Emergencies
Intensive care
Intensive Care Units
Health personnel

RESUMO

O presente trabalho trata-se de pesquisa qualitativa baseada na Teoria das Representações Sociais em sua abordagem estrutural, que objetivou analisar as representações sociais do cuidado intensivo para profissionais que atuam em Unidade de Terapia intensiva móvel mediante a determinação do núcleo central e do sistema periférico. Envolveu 73 profissionais de saúde de um Serviço de Atendimento Móvel de Urgência. Os dados foram coletados através de evocações livres ao termo indutor cuidado a pessoa em risco de vida e tratados pelo software EVOC. Observa-se um núcleo estruturado no conhecimento e na responsabilidade, ao mesmo tempo que os elementos de contraste apresentam léxicos como agilidade, atenção, estresse e humanização. A estrutura representacional revelada pelos participantes refere-se especialmente à funcionalidade do cuidado intensivo, distinguindo-o pelos desafios e estímulos que proporciona a quem desempenha funções nessa área.

DESCRITORES
Cuidados de enfermagem
Emergências
Terapia intensiva
Unidades de Terapia Intensiva
Pessoal de saúde

RESUMEN

Investigación cualitativa basada en la Teoría de las Representaciones Sociales en su abordaje estructural, que objetivó analizar las representaciones sociales del cuidado intensivo para profesionales que se desempeñan en unidades de terapia intensiva móviles, mediante la determinación del núcleo central y del sistema periférico. Involucró a 73 profesionales de salud de un Servicio de Atención Móvil de Urgencias. Datos recolectados mediante evocaciones libres al término inductor cuidado a la persona en riesgo de vida y tratados con software EVOC. Se observa un núcleo estructurado en el conocimiento y en la responsabilidad, al mismo tiempo en que los elementos de contraste presentan vocablos como agilidad, atención, estrés y humanización. La estructura representacional revelada por los participantes se refiere especialmente a la funcionalidad del cuidado intensivo, distinguiéndolo por los desafíos y estímulos que proporciona a quienes desempeñan funciones en dicha área.

DESCRIPTORES
Atención de enfermería
Urgencias médicas
Cuidados intensivos
Unidades de Cuidados Intensivos
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INTRODUCTION

The work of doctors and nurses in mobile intensive care units (ICU) has special characteristics due to the demands of care and involves both technical and human factors. In ICU, health professionals provide care in more complex cases, that is, to individuals with more severe illnesses through the provision of advanced life support (ALS).

ICU is defined as a place

consisting of a set of functionally grouped elements, aimed at the care of severely ill or high-risk patients who require uninterrupted healthcare in addition to specialized resources and equipment[1].

These units thus concentrate specialized personnel and materials to assist the patient uninterruptedly through advanced and precise technologies aimed to provide continuous observation that may support decisions and interventions in situations of decompensation[2].

Due to the constant sense of expectation in emergency situations, frequency of severely ill patients, possibilities of sudden changes in general condition, decompensation of severely ill patients and the complexity of the work inherent in the concentration of advanced technology, the environment and work at mobile ICU is very complex. This complexity, in addition to the accumulation of emotional components derived from the social interaction, constitute a stressing factor in social interactions due to the unpredictability of the environment.

The notion of priority in care, which is stronger in the intensive care subsystem, is associated with the constant risk to life, which oscillates between real-hidden, certainty-uncertainty and truth-mistake, in which possibilities, probabilities and opportunities are at risk in the recognized or routine elected priorities, and uncertainty may arise as the awareness of the risk is acquired[3]. In this diversity-permeated social context, representations of the care provided to the person whose life is at risk may emerge, conceived by the individual or group in their work relations in the mobile ICU.

Social representations are a form of socially organized and shared knowledge with a practical purpose, and these representations contribute to the constitution of a common reality of a social group[4]. Thus, it is a method to comprehend the dimensions and processes of knowledge shared by a certain group regarding a common reality. In the intensive care dynamics of a mobile ICU, the social communications and interactions experienced by team members are complex, and professionals are frequently close to contingency and/or limiting situations because the patients may experience sudden changes in health. This fact may trigger diverging behaviors and attitudes in response to the work conditions, such as continuously addressing the limits of life, difficulty in accepting death, scarcity of materials and personnel while addressing the need for personnel to be constantly available and on duty, quick logical thinking and assertive decision-making.

Studying social representation is an attempt to comprehend the methods that individuals create, transform and to interpret feelings, perceptions and life experiences within a social group. Social representations consist of beliefs, opinions, attitudes and values regarding a given social object[5].

Therefore, the study of intensive care in mobile ICUs viewed through the structure of representations may determine the interactions experienced in the professional environment with a global focus. This approach may allow the recognition of concrete work attitudes and processes that articulate the relationship between the work objectivity and subjectivity of each professional inserted in this group[6].

Representational elements may be deduced from the meanings that are contained in speeches and studied through a structural approach[7] that is specific to the field of social representations—a theoretical-methodological proposition that is complementary to the study of Moscovici. This complementary approach aims to identify and analyze the processes that determine social representations as socio-cognitive sets that are organized and structured into two subsystems: a central system and a peripheral system[8].

The central nucleus consists of a group of elements around which social representations are organized. It contains the determination of the meaning, that is, the structure or element that organizes and subsidizes the fundamental and inflexible meaning of the social representation[8-9]. The central nucleus is characterized as rigid, stable and composed of elements that elucidate other more flexible nuclei, namely the peripheral elements. The peripheral system is organized around the central system. Its elements are flexible and allow greater interaction within the context, providing accessibility to the reality and developing, regulating and defending the central nucleus[7].

The identification of the central nucleus and peripheral elements regarding intensive care for mobile ICU professionals may demonstrate the cognitive, emotional and symbolic components built into the routine of personal relationships. Therefore, it is necessary to determine the nature of intensive care behind the work process in the ICU because the manner in which care is provided reflects behaviors and attitudes of the subjects and social groups in a shared, meaningful way.

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To understand the theme of care provided to the person whose life is at risk and considering care to be the essence of nursing because it is vital to life, this study aimed at answering the following question: *How do health professionals in the routine of personal interactions / providing professional care in mobile ICU represent the care of the person at risk of losing their life?* Thus, the study aimed to analyze the representational structure of intensive care provided to the person who is at risk of losing his/her life as seen from the experience of health professionals who work in mobile ICUs.

METHODS

This study was developed according to the Theory of Social Representations in terms of structural approach and used EVOC 2003 software (*Ensemble de Programmes Permettant L´analyse des Evocations* – version 2003) for data analysis.

The study setting was the Mobile Emergency Care Service (Serviço de Atendimento Móvel de Urgência - SAMU) of Santa Catarina state, which is divided into seven macroregions to facilitate SAMU coordination. The macroregion selected for this study was the metropolitan area of Florianópolis, which includes 21 other municipalities in addition to being the state capital. Opened on November 5th of 2005, the SAMU unit of the macroregion of Florianópolis has four Advanced Support Units to cover a population of 933,560 inhabitants. To treat this population, the advanced support of the SAMU of Florianópolis employs approximately 90 professionals, including doctors, nurses and paramedics.

The study included 73 professionals as subjects (49 doctors and 24 nurses). The number of subjects was considered to be sufficient because the subjects represent approximately 81% of the total number of professionals working in this unit. The following inclusion criteria were adopted for data collection: completed higher education of at least two years; professional experience in a mobile/hospital ICU of at least one year, agreeing to participate in the study and signing the free and clarified consent term. Regarding the professionals' duration of experience, a minimum of one year was established because it was considered to be sufficient for expressing views concerning their experiences in providing care at the mobile ICU.

To meet ethical requirements and according to Resolution 196/96 of the National Health Council[10], the study project was evaluated and approved by the state coordinator of the SAMU of Santa Catarina and later evaluated and approved by the Research Ethics Committee of the UFSC under protocol no. 112/2008.

Data collection was performed in the period between May and October of 2008. The technique of free association or evocation was employed for data collection, considering the qualitative and quantitative properties in determining central and peripheral elements of a representation. We used the expression *care provided to a person whose life is at risk* as the inducing term. The technique application consisted of asking the subjects to say five words or expressions that came to their minds immediately when given the referred term, and these terms were immediately registered by the researcher, in addition to the sociocultural characteristics of each subject.

Evocations were grouped by meaning to homogenize the semantic content and achieve a more consistent analysis, which constituted the stage of standardization of the evoked words and terms, also known as the standardization dictionary. The material was then treated using the EVOC 2003 software that calculated the simple frequency for each evoked word, the mean order of evocation of each word and the mean of the mean order of evocation for the corpus set.

Data were analyzed based on their distribution in the four-house board technique[11]. This technique allows the distribution of produced terms according to the importance attributed by the subjects by combining two attributes related to the evoked words or expressions, namely the frequency and order in which they were evoked. The four-house board discriminates central elements (most frequent and most important elements) situated in the upper left quadrant; intermediate or 1st periphery elements (most important peripheral elements) situated in the upper right quadrant; contrast elements (presenting at low frequency but regarded as important by the subjects) situated in the bottom left quadrant; and representation peripheral or 2nd periphery elements (less frequent and less important) located in the bottom right quadrant[12].

It is worth highlighting that when integrated by computation, this technique becomes an important facilitating instrument for the analysis of the structure and organization of a social representation[11]. Moreover, the terms present in the central nucleus have a higher frequency of evocation and lower *range*, which as previously mentioned, refers to the mean of the mean order of evocation. Among the peripheral elements, the opposite occurs with words that are evoked less frequently but have a higher *range*.

Contrast and first periphery elements present variations in these values, as the words contained in the bottom left quadrant have a lower frequency of evocation than the mean frequency of words and a lower *range* than the mean *range*, whereas the upper right quadrant presents a higher frequency than the mean and a higher *range*[13]. After the previous organization of the evoked elements, they were constituted into the corpus for data analysis.

RESULTS AND DISCUSSION

The characterization of the study subject profiles contributes to a better understanding of the representational structures of their thoughts. The data showed that 32% of the professionals were male, and 68% were female. Most

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of the subjects were professionals over the age of 30 years (94%) and married (57.1%), with 29.8% being single, 7.3% divorced, 2.1% widowed and 3.7% in a stable union. Regarding their professional categories, 67.2% were doctors, and 32.8% were nurses. Regarding the time working in the mobile/hospital ICU, 43.4% had between two and five years of experience, and 17.4%, had between six and ten years of experience; 39.2% had over ten years of experience, with a good balance between those who were considered to be beginners and those with more experience.

The corpus for the analysis of the social representations was formed by the evocations of all subjects. In total, 365 words were spoken, of which 201 were repeated words and only 164 were different, and these words were grouped into 74 standardized words.

The mean of the mean order of evocation (OME) or *range* was 2.95, whereas the mean frequency was established as 14 and the minimum as 8. In the four-house board, which was constructed based on the EVOC 2003, with the evocations stemming from the inducing term *care provided to the person whose life is at risk*, it is possible to observe the content of the social representations and the structure and hierarchy of the elements within their cognitive systems (Chart1).

Chart 1 – Four-house board of the evocations stemming from the inducing term *care provided to the person whose life is at risk* – Florianópolis, SC, 2009

Mean Frequency	Rang < 2.95			Rang > = 2.95		
	Evoked term	Freq	O.M.E	Evoked term	Freq	O.M.E
	Upper left quadrant			Upper Right Quadrant		
	Central Nucleus			First Periphery		
> = 14.0	Emergency/ Urgency	39	2.40	Severe Cases	18	3.18
	Responsibility	21	2.30	I.C.U.	20	3.30
	Knowledge	16	2.17			
	Lower Left Quadrant			Lower Right Quadrante		
	Contrast or Intermediate Elements			Second Periphery		
	Agility	13	2.38	Suffering	08	3.00
	Attention	08	2.00	Dedication	08	3.50
	Care	09	2.85	Death	10	4.20
< 14	Humanization	11	2.33			
	Saving lives	13	2.46			
	Saving lives	09	1.77			
	Stress	10	2.20			

In the upper left quadrant, it is possible to observe the *emergency/urgency, knowledge* and *responsibility* elements, which represent the most frequently evoked words, that is, the words with a lower mean order of evocation (OME) and higher frequency that may constitute the central nucleus, because they characterize the ontological meaning of the representation. Hence, it is possible to perceive the presence of three dimensions that appear to organize the representational structure, namely the imagery dimension, which is communicated via the expressions made referring to situations that require this type of care and the units that implement it; the attitudinal dimension, which is achieved in the responsibility lexicon; and the knowledge dimension, which is inherent to the analogical term present in the semantic universe of the studied group.

These tangible dimensions in the expressions *emergency/urgency, knowledge* and *responsibility,* as possible constituting elements of the central nucleus of this study, emphasize the essential structure of the meaning of care at the extreme limits of life. These expressions refer to the descriptive characteristics and object registration in the social practices of the subjects in this study. Intensive care, due to its complexity, demands from executors constant and direct contact with high-risk situations and the continuous threat of death[6].

The salient element among these expressions is *emergency/urgency*, with an evocation frequency of 39 and OME of 2.40. These elements are intimately associated with the role developed by professionals of mobile ICU who initiate life-saving care measures within a limited amount of time. These elements were homogenized due to inaccuracy, confusion and polysemy about these concepts. Therefore, urgency is defined as a situation that cannot be postponed and must be solved quickly because delays increase the risk of death. Emergency is defined as a critical situation with imminent danger or risk to life[1].

These concepts have a nearly imperceptible limit, as the clinical condition of the patient is susceptible to rapid change at any moment, thus opening the possibility for several interpretations that justify the nearly synonymous use by health professionals in their work routine. It is also inferred that the term urgency is more comprehensive and makes more sense than emergency, which results in more common usage. Emergency has a meaning that is understood in its totality by health professionals who specialize

in urgent situations and concerns the maintenance of the fine line between life and death[14]. Therefore, the distinction between urgency and emergency has no meaning from the point of view of severity, time to act or care priority.

Emergency situations are generally considered to be moments that demand a comprehensive and rapid examination of the patient from the involved professionals to observe and understand how to handle numerous situations. Thus, it configures an element that is present in the care of a person whose life is at risk.

The second salient element in the central nucleus is *responsibility*, with a frequency of 21 and OME of 2.30. In intensive care situations, responsibility as a professional attitude is inherent to the work of preserving life in these conditions and is intrinsic to the care of health professionals in the daily routine of a mobile ICU. Therefore, health professionals who work in this area are responsible for the direct care of critical and severely ill victims. Moreover, the responsibility of the team involves the organization, preparation and restoration of the equipment after each mobile service is provided, direct service to the victims and training and development of studies, in addition to acting within the pillars of care, education, management and research.

The term responsibility also suggests the awareness of the need for care in terms of health and life in other, more comprehensive contexts, including society and professional policies[15]. In the context of their responsibilities, they present a commitment to knowing and conducting their daily routine, which shows the representation of this attitude towards human care in society by these professionals. In this sense, responsibility is associated with the knowledge appropriated by the professionals throughout their lives, at work, and even through the manner in which they update their professional knowledge/actions in face of frequent transformations in the world of science, thus becoming products of the interaction and communication process.

The element *knowledge* presented with a frequency of 16 and OME of 2.17. *Knowledge* provides meaning to the knowledge dimension that, as highlighted in the previous paragraph, has an intimate association with the attitudinal dimension. Health professionals who experience intensive care, despite working against time, require the ability to conduct a critical and rapid observation of situations to administer care based on scientific principles. Therefore, from these subjects' perspective, the word knowledge may mean scientific knowledge, possibly as a consequence of a behavior that they consider to be relevant for professional improvement and care development. Knowledge in caring for the patient whose life is at risk must stimulate the professional's critical sensibilities and spirit of citizenship and encourage them to seek new horizons[16].

Outlined in the technical-scientific knowledge, qualified care must be provided while service education is performed. It is thus necessary to provide health professionals with specific qualifications for the development of their activities; that is, they must be allowed and encouraged to search for information according to the real needs identified and aimed to improve and update the capabilities of health professionals, providing an opportunity for their development and involvement in the care they provide to others[16]. The maintenance of technical competence encompasses not only the domains of theoretical and technical knowledge but also must take into account the fact that the professionals are attentive to the meaning of care within the limits of life.

In this representational structure, intensive care is based on a tripod: severely ill patients experiencing emergency/urgency situations (images that support the representation); responsibility for the care and specialized multidisciplinary team (attitudes that offer dynamics to the representation); and knowledge and experience to provide care and assist the patient (knowledge dimension that provides an acceptable base for care and the socio-cognitive reconstructions of this phenomenon in extreme situations). In this sense, an integration of knowledge must occur among professionals so that appropriate care is offered to patients requiring intensive care.

The elements *agility, care, attention, humanization, saving lives, stress* and *abilities* are found in the *quadrant of contrast elements*; that is, they complement and argue against the central nucleus or peripheral elements and represent elements of tension regarding the study object. These elements may be also characterized as a new subgroup that may begin to present a more critical examination of the *intensive care* object, which may result in modifications to the identified central nucleus.

The contrast zone reveals the presence of the three dimensions that comprise the studied social representation. Imagery is constituted in the care triad that, on the one hand, aims at saving lives, but on the other hand, is a permanent source of stress for professionals. The attitudinal dimension is organized by the elements of attention and humanization, whereas the knowledge dimension is associated with ability and agility. It is not possible to highlight the presence of an element that demonstrates a representational subgroup among the studied subjects, but it is essentially the unfolding and consolidation of the dimensions that are present in its possible central nucleus that grants it the organization character of the representation. The element *agility* is also related to the scientific and empiric knowledge developed in the professional activity, which reinforces the characteristics of the actions developed in the ICU/mobile ICU. *Agility* influences the term *emergency/urgency* present in the central nucleus, marking the professionals' acknowledgement of the need for more concise and rapid care in which services must be rendered quickly and the fundamental importance of early recognition of clinical signs by the team. *Agility* is also related to the term *ability*, evoked by the mobile ICU professionals as an admittedly necessary aspect in intensive care.

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Clinical and logical thinking skills for making decisions and agility and the ability to execute the correct interventions are some of the important competencies for the delivery of urgent care service[2]. In this sense, initiative and perception also stand out in addition to the ability to make quick decisions as crucial factors for care service[6].

The positive image of care is associated with all of the terms present in the central nucleus. Intensive care through this action requires *responsibility* and *knowledge*, just as the terms *emergency/urgency* demand care to save lives or stabilize a clinical condition. However, the term *saving lives* restates all of the elements present in the central nucleus as an essential function to be developed by the professionals in intensive care. The ability to save lives appears as a factor that integrates these professionals into a group with certain social rights. Concerning these benefits, the work of *saving lives* may be regarded as an occupation that brings social rewards, such as gratitude and admiration, to these professionals and an image that characterizes their knowing/doing. However, this can only take place when there is an existence of *abilities* that enable the act of bringing individuals back to life, a prerogative that attributes competencies to the studied health professionals in face of the challenges that they face in saving lives.

It was observed that the elements ability, agility and care form a subgroup inside the representations, influencing each other mutually and accurately demonstrating the nature of the work of mobile ICU professionals. The ability and agility elements influence the care element present in this quadrant, considering that both agility and ability must be complementary for the provided care to be successful. This occurs due to the effective and continuous intensive care that the entire team must provide to people at risk of losing their lives and who require mobile ICU assistance.

The evoked lexicon *attention* precisely evidences the meaning of the work of mobile ICU professionals according to the professionals in this sector. These perceptions may have a connection to the collective memory or history of the group[8] and the intensive treatment units that have been spaces reserved for the care of critical patients since their conception[6]. This requires that the team working in this sector remain in a constant state of alert, which is needed to identify small changes in condition that may indicate complications in the clinical state of the patient to more severe and complex changes in condition that may often culminate in death.

The attitude of *humanization* present in the representation structure relates to two different processes, the first comprising the personal wish of the professionals to provide care that contains the presuppositions of this principle. The second process may be related to the campaign of the Humanization National Policy (HNP) present in the network of health services of the SHS. It is possible that this demand for professionals of the mobile ICU service to provide a more humanized intensive care service is actually expressing a difficulty of the urgency service to provide more humanized care.

The urgent care service is characterized by the absence of bonding because all patients are simply passing through this unit. Emergency service units constitute a privileged space that manifests the intense processes of exclusion, social violence, trivialization of others' suffering, and especially of indifference regarding disenfranchised individuals that mark our society and the healthcare professionals[18]. Intensive care may also generate conflicts. This is because the professionals live with the dilemma of treating urgent cases in strict character, relieving the suffering of patients and families, addressing the pressure of taking care of individuals in situations that put their lives at risk and addressing urban violence, among other factors[18].

Working with emergency/urgent situations in mobile ICUs also means coming face-to-face with maltreatment[18], with unbearable situations for many health professionals and even impossible situations that must be represented and in a positive manner. This complicates the bonding and defining of the limits and possibilities of solidarity, cooperation and care within the service[18]. To exist, the process of care humanization requires the creation of means to modify the work process and conditions for these health professionals in providing the intensive care aspects of emergency service.

The element of *stress* present in the quadrant of contrast elements incorporates an expressive meaning of the care provided to the person whose life is at risk. This element, along with humanization, is seen as a great need in this sector. It is directly associated with the confrontations experienced by professionals involved in intensive care. Stressful situations are inherent to work in the ICU and may interfere in the daily routine of the professionals involved, as highlighted by a study regarding the emotional states of nurses in terms of their professional activity in critical units[19]. Intensive care, identified as stressful, may transform the work in this unit into moments of difficult confrontation, creating a negative understanding of the work in mobile ICUs.

These elements show opposite meanings because on one hand, they represent intensive care as stressful, while on the other hand, they represent saving lives. This duality appears to be a compensatory process, as the stressful work is seen as negative. This is particularly true for experiences that produce feelings of tension, anxiety and/or fear[2]. Saving lives, however, is a source of gratification for these professionals. It is in this service that the professionals see the result of the care provided to the patient in all of its dimensions[6].

Returning to the four-house board (Figure 1), the upper right quadrant (regarding the *first periphery*) presents the words that had a high frequency but whose mean position in the order of evocation was not sufficient to be considered

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part of the central nucleus. This quadrant essentially consists of the imagery dimension that encompasses the situations present in the care process (severe cases) and the health units that are kept in the imagination of the subjects, especially the ICU.

The words *severe cases* and *ICU* restate and reinforce the intensive care that occurs in the ICU in general and the mobile ICU in particular. In intensive care practice, the term emergency is equated with severe cases; that is, cases that lead to the suspicion of the need for quick intervention[14]. The evoked words *severe cases* have the following standardized terms: severe patients, severe cases, severity and other terms that denote this meaning, demonstrating the experiences of mobile ICU professionals in caring for individuals at risk of dying.

The element ICU is signified through the following selected evoked words: ICU, mobile ICU, intensive treatment and high complexity procedures. Mobile ICU care is rooted in intensive therapy and based upon the existence of severely ill patients, highly technical equipment and a specialized professional team. Many treated patients are critically/ severely ill and demand direct and dependent care.

Because severely ill patients must be treated by a specialized multidisciplinary team, SAMU as a mobile ICU is modeled after pre-hospital care service. This service's procedures decrease mortality and mitigate the possibilities of long-term complications in severely ill patients[17]. The mobile ICU aims to provide early critical healthcare to the population to reduce the number of deaths and health complications/morbidity. Therefore, a positive attitude is observed in this service, as demonstrated by the participants. The attitude especially concerns its functionality, restating the role of *emergency* and *urgency* care present in the central nucleus.

The words located in the bottom right quadrant are those that presented lower evocation frequency and were evoked later, composing the elements of the *second periphery of the representation*. This periphery comprises the attitudinal (*dedication*) and imagery (*suffering* and *death*) dimensions. In this space of the representation of care provided to individuals at risk of dying, it is possible to observe a positive attitude towards this service. Professionals acknowledge this by their use of the word dedication regarding the care service they provide. Negative attributes are assigned to the care of persons at risk of dying and who are seen as suffering and most likely to die. The element dedication reinforces those present in the contrast zone and central nucleus, and the elements suffering and death direct questioning regarding the intensive care function. This is even true with those elements previously recognized as efficient in the central nucleus.

The element *suffering*, which is present in the second periphery, leads to a discussion regarding intensive care that is seen by some professionals as a very distressing task.

This is because they perceive their activity as ineffective once realizing that there are many human and technological limitations in providing care to people at risk of losing their lives. These limitations generate suffering because the actions represent intense situations of intellectual and physical stresses for the individuals being treated and the professionals themselves. This nearly daily experience with critical and limiting situations contributes to the suffering of these professionals. Inevitably, this feeling has different intensities and meanings in the individual, social and cognitive scenario of this unit at different times. Along the same lines, the suffering of patients and families requires ability, humanization and dedication from these professionals. These attributes become necessary to the professional activity in the mobile ICU and are a differential in the provision of intensive care services.

The term *death* influenced the element of saving lives present in the contrast zone. Health professionals are unprepared to deal with questions related to death and the process of dying[20]. In general, health professionals do not speak about death because death is evidence of our limitations, weakness and mortality as human beings. The process of dying generates pain because professionals do not accept death naturally and perform countless procedures in the attempt to *save* the patient. However, the results may extend the length of time it takes for the patient to die, which influences the suffering of the patient and his/her family[20].

The daily experience with situations of life and death, situations dealing with death or situations that generate a high level of stress may trigger processes of suffering and anxiety, among other processes. It is part of the professionals' job to cope with death and learn how to face it. Remaining indifferent to the patients or the families of the victims is not in the script. Hence, the authors consider it important for the administrators of these institutions to become more sensitive and adopt a more humanized look at this question.

Finally, the element *dedication* influences the element *care* in the bottom left quadrant. *Dedication* reinforces the term *responsibility* present in the central nucleus. Dedication is a professional attitude permeated by concern, responsibility and affection for one another. This professional attitude also has roots in a comprehension of reality that prioritizes the possibility of helping human beings in several stages characterizing their existence, especially those in which pain, suffering and death are present[12].

In intensive care units, professionals are expected to have the knowledge and competency to identify and intervene in the patients' physiological alterations, to relieve the suffering and anxiety of their relatives, and to skillfully use the technological resources that compose this environment[16]. Providing care to a person at risk of losing their life constitutes an activity that demands responsibility and dedication from the involved professionals.

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CONCLUSION

The methodological strategy employed in this study allowed the organization of the evocations in the four-house board. Using this board, it is possible to determine and identify the social representations of the professionals from the Mobile Intensive Care Unit of the SAMU (doctors and nurses) regarding the care that they provide to persons at risk of losing their lives. In the central nucleus, the elements constituting the social representation structure of intensive care in the mobile ICU is evidenced through the words emergency/urgency, knowledge and responsibility. These words reflect the images, knowledge and attitudes involved in providing care to persons at risk of dying. In the first periphery, the elements *severe cases* and *ICU* are found, which restate and reinforce the central nucleus and consequently, the nature of intensive care in the emergency and urgency care service.

Therefore, the care provided to the person at risk of losing their life is represented by professionals of the mobile intensive care units of the SAMU as the intensive care provided in situations of emergency and urgency that require knowledge and responsibility and predict care services of quick actions with skill and attention aimed to save lives. The terms agility, ability, attention and saving lives influence the entire central nucleus positively and reinforce intensive care functions. The element humanization argues against the type of care provided, whereas the term stress reinforces the situations experienced by these professionals. Stress and humanization are directly connected to the confrontations assumed and experienced in providing this type of care.

The element dedication reinforces the elements of the central nucleus, and the elements suffering and death question the appreciations presented in the other elements. Thus, intensive care may be characterized by the challenges and stimuli provided to the person who develops functions in this area. Moreover, the mobile ICU, as a space of decision and interrelationships in emergency services, must be constantly improved. To accomplish this, it is important to consider the discussion regarding intensive care and contribute to the practices of the professionals involved in it.

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