

Hospitalization from the traffic victims' and their family caregivers' points of view*

HOSPITALIZAÇÃO NA ÓPTICA DO ACIDENTADO DE TRÂNSITO E DE SEU FAMILIAR-ACOMPANHANTE[†]

LA HOSPITALIZACIÓN BAJO EL ENFOQUE DEL ACCIDENTADO DE TRÁNSITO Y DE SU FAMILIAR ACOMPAÑANTE

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ABSTRACT

This study describes the context of hospitalization experienced by traffic accident victims and their family caregivers. Using a qualitative approach and orientated by the convergent analysis, the investigation took place at an emergency hospital, in Fortaleza, Ceará, in 2004, with 14 people - seven patients with skeletal muscle trauma and seven relatives accompanying them. In the participants' standpoint, the hospitalization moment is permeated by depression, anxiety, sadness, fear, concern, unawareness, affront from the health team to the patient and family, being exacerbated by the physical traumas, economical difficulties, social and legal implications. According to the integral principle, care to traffic victims should be extended to their relatives, because the latter also suffer *injuries* when they come across sudden death, serious traumas and sequels in significant persons.

KEY WORDS

Accidents, traffic.
Family.
Hospitalization.

RESUMO

O trabalho descreve o contexto da hospitalização vivenciado pelo acidentado no trânsito e por seu familiar-acompanhante. Com abordagem qualitativa e norteada pela pesquisa convergente assistencial, a investigação realizou-se em um hospital de emergência em Fortaleza, Ceará, em 2004, com 14 pessoas - sete pacientes com trauma musculoesquelético e sete familiares acompanhantes. Na visão dos participantes, o momento da hospitalização é permeado pela depressão, ansiedade, tristeza, medo, preocupação, desinformação, destrato da equipe de saúde ao paciente e família, sendo exacerbado pelo trauma físico, dificuldades econômicas, sociais e implicações legais. De acordo com o princípio da integralidade, o cuidado ao vitimado no trânsito deve ser ampliado aos familiares, pois esses também sofrem danos quando deparam com morte súbita, traumas graves e seqüelas em pessoas significativas.

DESCRIPTORES

Acidentes de trânsito.
Família.
Hospitalização.

RESUMEN

El trabajo describe el contexto de la hospitalización vivenciado por el acidentado de tránsito y por su familiar acompañante. Con abordaje cualitativo y orientado por la investigación convergente asistencial, la investigación se realizó en un hospital de emergencia, en Fortaleza, Ceará, en 2004, con 14 personas - siete pacientes con trauma músculo esquelético y siete familiares acompañantes. En la visión de los participantes, el momento de la hospitalización está permeado por la depresión, ansiedad, tristeza, miedo, preocupación, desinformación, maltrato del equipo de salud al paciente y familia, siendo exacerbado por el trauma físico, las dificultades económicas, sociales y las implicancias legales. De acuerdo con el principio de integralidad, el cuidado a la víctima de accidente de tránsito debe ser extendido a los familiares, ya que éstos también sufren daños cuando enfrentan una muerte súbita, traumas graves o secuelas de las personas significativas.

DESCRIPTORES

Acidentes de tránsito.
Familia.
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INTRODUÇÃO

Traffic violence repercussions are directly influencing on family and social harmony and appearing in the national and local world population. Statistics demonstrate that traffic accidents are an increasing reality, transforming Brazil into one of the world champions in this external human health problem⁽¹⁾.

Traffic accidents (TA) cause serious problems to human beings, ending lives prematurely, contributing to children and teenage orphanhood, mutilating people, increasing the number of individuals with personal and professional disabilities. The consequences of traffic violence are seen to lead to problems, which are extended to families, health systems and societies. Corroborating the complexity of the problem, the literature argues that the traffic risk is a phenomenon that ought to be studied in an organizational and social context. Preventive measures appropriate to social, cultural and economic reality of the country in question should be adopted⁽²⁾.

According to DATASUS data, 127,633 deaths from external causes (ICD-10) were reported in Brazil, in all group ages, in 2005. Among them, 36,611 (28.70%) deaths were related to traffic accidents, which rated them as the second place. Between 5 to 39 years old, traffic accidents totaled 21,309 deaths (58.20%); when this interval is extended to 59 years old, the total reaches 30,884 (84.36%). There were 29,798 (81.40%) deaths among males and 6,805 (18.60%) among females⁽³⁾.

Reducing these figures and the subsequent repercussions is one of the world concerns. Hence, public policies cannot affect an effective TA prevention, reducing rates that contribute to increasing human loss statistics on a daily basis. Comparing health actions, experts highlight that

social commotion and health system actions to prevent such situations are limited. [...] Making the care and prevention of traffic accidents comparable to those dedicated to AIDS [...] is the challenge to be overcome by public administrators⁽⁴⁾.

These deaths, resulting from preventable and predictable situations, cause exorbitant costs to the Nation, loss of human lives, family and social imbalances. As the family is directly and indirectly stricken by TA consequences, there is the assumption that the family is a functional unit. Thus, it is represented by the supporting values among relatives. In this context, there is shared responsibility, facilitating the identification of individual difficulties and optimizing abilities to satisfy basic needs that emerge out of these relationships⁽⁵⁾.

In accordance with what was said before, the family poses a challenge to the health administrators. The family ought to be included in the healthcare plan designed to

assist the victim. The family is a systemic unit that requires balance and harmony for everyone's well-being. When a given relative is found in a crisis, the family core is unbalanced. In this context, the TA repercussions are complex. They eventually reach the family, which is a strong ally regarding the victim's recovery.

In this study, family is regarded as something pleasurable and based on affection. It is seen as a good feeling among the loved ones, exceeding the blood relations. In this perspective, family can be seen as a system that is part of a larger whole, composed by many subsystems⁽⁶⁾.

Hence, by describing the circumstances experienced by the relative who accompanies the TA victim during hospitalization, the authors address the importance of debating immeasurable problems that stem from traffic accidents. This debate originates reflection and mobilization of an interdisciplinary field, with articulation of the political and social dimensions, in favor of human life.

The contributions of these relatives' experiences, when accompanying the victims, allow the deconstruction and construction of attitudes that guide an effective reorientation of professional practices. Based on these assumptions, the study aimed at describing hospitalization, under the perspective of the traffic victims and their accompanying relatives, in an emergency hospital.

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METHOD

This is a qualitative study, with the aid of Convergent Assistential Research⁽⁷⁾. This type of research maintains a close relationship with social situations, with the purpose of finding solutions for problems, causing changes and introducing innovations. The study was carried out in an emergency hospital in the city of Fortaleza, CE, in 2004. Overall, 14 subjects participated in the study. Seven were traffic accident victims with muscle-skeletal trauma and seven were accompanying relatives.

The inclusion criteria were: (1) patient was a traffic accident victim with muscle-skeletal trauma requiring at least a two-month hospitalization to ensure the research feasibility; (2) accompanying individuals were relatives, with or without blood ties; (3) significant person for the victim, as indicated by the family; and (4) being accompanied in the study period.

Data were collected during 22 meetings with one of the authors and the research subjects. There was participative observation and informal and open interviews, with orientation, identification, exploration and resolution phases⁽⁷⁾.

The first meeting anteceded the orientation phase and its goal was to introduce the research objectives and request full consent of all the participants. In the orientation phase,

there were two meetings with the purpose of intensifying the relationship between the researcher and the participants, strengthening friendship and being trusted by these people. In this phase, the observation was focused on the attitudes shown by the patients and their accompanying relatives and the conflicts mentioned. They were given some explanations regarding hospital routines.

In order to run a strict methodological approach, two types of diary were used: field diary, in which the researcher registered the perceptions and events that happened throughout the 22 meetings; and the family diary, in which the relatives could register, as carefully as possible, the events that were worth mentioning, perceived conflicts, ideas, uncertainty during the hospitalization and future life.

The identification and exploration phase lasted for 16 meetings. The participants showed their feelings, desires, ideas, experiences and conflicts. As the meetings and interviews were performed, assistential care was provided to the participants. Biological, emotional, economic and social needs were observed.

When it comes to the biological aspects, care was focused on the application of dressings, offering or supervising food intake, body hygiene, helping with the repositioning of the skeletal tractions, performing and/or helping with bed mobilization, among other required needs.

During care of the emotional needs, there was special attention to the complaints, uncertainties, inquietude, and orientation on how to solve problems with the other team members. Thus, patients' and relatives' anguish and anxiety were minimized.

Regarding economic and social needs, the participants were advised about: (i) the obtention of documents, medical leave and retirement; (ii) the existence of DPVAT – Compulsory Insurance of Personal Injuries Caused by Vehicles in Terrestrial Roads; (iii) the orthotics and prosthetics program; (iv) other benefits dispensed by the National Institute of Social Welfare. The participants were also sent to the protocol and social service of the institution.

The resolution phase was started after one of the authors perceived changes and maturity in the participants. Furthermore, the collected information converged into data saturation. This phase took place during the three final meetings. This time was characterized by gradual distancing between the researcher and the study participants. The objective was to undo the dependency bond.

The result analysis and the collection were performed simultaneously. Some authors⁽⁷⁾ argue that in the assistential processes, the information collection and its analysis take place simultaneously. It favors the researcher's gradual immersion in the reports. The reflection leads to interpretation

and voids that can eventually be filled throughout the process. The analysis steps are: (1) apprehension, (2) synthesis, (3) theorization and (4) contextualization.

In the apprehension phase, the information is registered, organized and identified. The data describe the family stories and circumstances experienced following TA occurrence, during hospitalization. In the theorization phase, from the relationships perceived during the synthesis processes, the results were in conjunction with the literature. The transference phase identified the meaning of the findings and the possibility of replicating them in similar situations. The process was not regarded as generalization but as socialization of the results. Hence, categories that converged into the context description were identified, both in the patients' and family caregiver's standpoints. The aspects related to emotion, family, economy and society were highlighted.

The study followed aspects related to ethical issues involving human beings, according to resolution no. 196/96 of the National Health Council⁽⁸⁾, and was approved by the Committee of Ethics of Universidade de Fortaleza - UNIFOR, and by the Ethics Committee of the institution being investigated (Report 212/2004).

RESULTS AND DISCUSSION

Subject characterization

The seven patients were in the age group of 20-80 years old. The seven caregivers were between 21 and 60 years old. Five caregivers had blood ties and two were spouses. Three patients and caregivers lived in the city of Fortaleza. Four lived with the caregivers in the countryside. Three patients were single and four were married. All the caregivers were married. One patient was a registered worker, two were retired and four were unregistered workers. One caregiver was an unregistered worker, two were public servants and four were housemaids. Three patients were breadwinners and four were the sole breadwinner. Four caregivers did not contribute to home expenses. Two patients were passengers at the moment of the accident. Three were driving and two were hit by vehicles. Of the seven patients participating in the research, two were young, four were young adults and one was elderly. Two were intoxicated at the moment of the accident and only three had the care of the accident *causers*.

In the TA-related complexity, the victim (or victims) may become politraumatized, with multiple injuries, with a prolonged hospital stay, similar to a chronic disease treatment. Besides the subject with the *chronic problem*, everyone who accompanies the victim is also victimized by the trauma, sharing suffering and conflicts.

In accordance with the findings in this study⁽⁹⁾, when dealing with caregivers of severe cranioencephalic trau-

In the TA-related complexity, the victim (or victims) may become multitraumatized, with multiple injuries, with a prolonged hospital stay, similar to a chronic disease treatment.

ma, some authors identified an increased number of depression cases, difficulty in expressing feelings, less time and willingness to participate in recreational activities. Also, caregivers tend to show a domination behavior.

Studies addressing the caregivers' reality (belonging to family, affective or social milieu) and how they experience this process should compose the interest of investigators towards this theme. Another study⁽¹⁰⁾ emphasizes that the process of caring is permeated by suffering and privation, which is often accompanied by guilt and religiosity. There is affection ambiguity and demanding socioeconomic changes, which symbolizes the resume of personal projects in the caregivers' lives.

The literature reports that studies with family caregivers have been raising interest in many researchers. It is a growing field in healthcare. Despite the development, the publications that look at this topic are not many⁽¹¹⁾.

After the occurrence of a traffic accident, the victims and their relatives face problems which were apparently hidden in the care perspective of most healthcare professionals. There are alterations in these patients' and caregivers' life styles. There is apparent sadness and even verbalizations of dismay. The gravity of physical injuries is not mentioned. There are body limitations and limb amputations or even death of a loved one. Among the situations made evident by the participants, the victims and their relatives, those related to the emotional, family, economic and social aspects deserve attention.

Besides premature death, physical and emotional problems and family conflicts caused by traffic accidents, there are other apparently obscure but important difficulties such as material and social damages⁽¹⁰⁾.

In the emotional aspects, the subjects attribute their anxiety to surgery cancellation, delays in scheduling them, delays in health recovery and prolonged hospital treatment. In this perspective, it is important for the healthcare team to understand the victims' and families' anxiety, in order to intervene appropriately. The literature shows that anxiety is multidimensional. It manifests in the cognitive sphere, which is evidenced by concern, obsession and self-confidence. In the affective sphere, it is evidenced by embarrassment and sadness. In the behavioral sphere, by constraining attitudes, escape and compulsive repetition. In the physical sphere, by the manifestation and exacerbation of several signals and symptoms, interfering in the recovery⁽¹²⁾.

... I'm too anxious because of a surgery which is delayed. Now, to make things worse, a secretion has appeared in the wound. (FA1). See, doctor, it's the second time my surgery has been suspended. I can't take it anymore (pointing to the skeletal traction). And now? When is it due? (P-1).

I've got to get well soon. I have a life outside here and I've got things to do (P-2).

When investigating emergency care of violent acts, the literature describes that the medical work is focused on the wounds that require procedures, no matter what caused these wounds. [...] Any problem that exceeds this acting sphere is not seen as a medical problem⁽¹³⁾.

Another category mentioned was depression/sadness, which is constant in people's routine. It is exacerbated by the loss of loved ones, and the distancing of family, friends, work and uncertainty about the future. The impotence and incapacity to provide care to children also contribute to this melancholic mood. The limb amputation was another reason related to such *depression*, and contributes to emotional instability.

Death as a TA consequence occurs suddenly, subtracting dear people from the family core. The victims were apparently healthy, productive and often the only working person in the family. Here are some reports:

I had everything, I had a structured life, a house, children, job and my husband. And now? He's dead (tears) (P-1).

In the family sphere, besides worrying about the hospitalized person and missing other family members, the lack of financial and/or emotional resources maximize dissatisfactions and conflicts inherent to traffic victims' hospitalization and their caregivers. In the participants' speeches, their activity overload is clear:

I intend to go back there because a lot of things depend on me, both my children and my job. My grown-up children need me while they're under my roof (FA-7)

I'm the one who has to solve everything by myself. Everything is on me because my daughter works all day long. There's no one else (FA-4).

A research that characterized the caregivers of cranioencephalic trauma victims in ambulatorial care reports that it is important to know the victim's and caregiver's characteristics. Also, their individual needs, in order to design forms to provide them with the necessary support⁽¹¹⁾. In this complex network, it is indispensable for the healthcare professionals to rethink their practice and consider family as an evolving system when it comes to possibilities of solving crises and conflicts. The objective is the search of new ways.

Being unaware of the current pathology, its gravity, the treatment to be performed and prognosis, was referred to as an instability source, both in the emotional aspect and in the interpersonal relationships of the people involved. It evidences a cycle of sadness, anxiety, anguish, anger, fear and despair negatively interfering in the treatment and recovery.

Some authors⁽¹⁴⁾ who studied the effects of behavioral alterations in victims of cranioencephalic trauma from the caregivers' standpoint found that the patients became more aggressive, anxious, dependent, depressed, irritable, forgetful, impulsive, had higher social inadequacy and mood changes.

Thus, the participation of the healthcare team is fundamental. Likewise, it is complex because there is the need of a sustenance base to favor healthcare management.

It should be pointed out that even though there are higher levels of overload, stress and psychological symptoms evidenced in relatives with traumatic brain injury patients compared with those with orthopedic patients, the groups do not differ regarding the feeling of anguish of the relatives⁽¹⁵⁾. Thus, the higher the social support provided to the family, the lower the level of depression shown by the members. The impact is hard when they receive the news, stay in hospital, and return with pain to their homes⁽¹⁶⁻¹⁷⁾.

Communicating, informing and listening are extremely important to make the professional-patient-family relationship more effective and affective. The establishment of dialogue is often capable of extinguishing or soothing despair for a long period. The patients' and relatives' lack of information and lack of attachment with the healthcare professionals are evidenced in the participants' discourses.

I've been here for a month and nothing has been done. Nobody says anything (P-3).

[...] they always seem to be in a hurry. They don't have any time (FA-7).

None of the doctors explains about the treatment. I know he'll stay here for many days. I just don't know how his leg is. Could you tell me something? (FA-5).

I told doctor X that I didn't have enough flesh for grafting, but he said I did. I was anesthetized when the surgery was called off (P-3).

Information, support and more professional proximity to patients and families are indispensable for treatment success. No one examines, talks, or is responsible for patients. This is the practice model shown to students during academic education⁽¹⁸⁾. It can be inferred that doctors are the ones who provide information, in the perception of patients and relatives. Such assumption is the fruit of a biomedical model rooted in popular culture and in the opinion of healthcare professionals. Knowledge is a dichotomy, care is fragmented and interdisciplinary practice is incipient, favoring the care, which is said to be full of errors and conflicts.

When looking at the doctor-patient duo, the literature reports that the fragmented view of attention implied the absence of attachment construction or a weak construction. It caused a professional de(responsibility) in relation to the patients' general health status. The patients, in turn, are dissatisfied with the attention received⁽¹⁸⁾.

In the participants' discourses, there was the identification of information about medical leave and consultations, acquisition of accident insurance, prosthetic and orthotic devices, among other benefits dispensed by the National Institute of Social Welfare. This fact characterizes the frag-

ile view of integrality when providing care to TA victims and their relatives. Such inquietude is found:

Doctor, how do I get a leg prosthetics? I happened to read a magazine and I saw they're expensive (P-3).

I wanted to get the insurance, but a caregiver said that this is possible only after discharge. Is it true? (FA-2).

"Doctor, I wanted to get the motorbike insurance, but I don't know which documents I need. Should I get a lawyer? (FA-7).

The professionals, who are unprepared and untrained to inform this unaware clientele, deviate from the humanized care policies, and evidence the absence of integration among the responsible sectors. In this perspective, the literature reports that all the individuals who were victims of traffic accidents have the right to insurance compensation. However, even though this guarantee has existed for more than thirty years, many victims or beneficiaries do not receive the benefit because of lack of information⁽¹⁹⁾. It should be pointed out that

the participation of several professionals in healthcare care leads to involvement of all the team components with assistance, and favors greater availability of professionals towards clients⁽²⁰⁾.

Regarding economic and social dimensions, they unfold on legal, judicial and labor matters, detected in the subjects' verbalizations.

[...] he was a freelancer, he wasn't hired. He's in a bad situation. It's bad for him, it's bad for me. We all are in a bad situation (FA-4).

Our lives will change 100%. His salary was three times the minimum wage a month, commission included. Now, we'll have to live with a minimum wage. It'll be hard to pay our debts (FA-3).

[...] he'd drunk and drove along the wrong lane (FA-2).

[...] he just wants to drink (FA-6).

[...] he turned left and it was prohibited (FA-7).

A study performed with university students⁽²¹⁾ describes that only 4% of people acknowledge that alcohol is a factor leading to accidents. However, drivers (both genders) who drive intoxicated show a 184% higher risk to get involved in TA.

It was shown that the unregistered workers endure the consequences posed by labor justice. The law does not assist this economically active population. Some discourses show the description:

He did not want to hire me officially. Now, he comes to ask me to transfer the possession of the motorbike he bought from my husband. I'll transfer it only when I leave here and when he pays the rest of it (P-1).

My husband has been working for him almost three years. Always, without documentation. Now, after the accident, he came and asked to hire him. But on minimum wage (FA-3).

Studies have identified a high participation of people on motorcycles being TA victims. This group should be considered absolute priority in terms of accident prevention. In a study carried out in the city of Pelotas, RS, the motorcycle riders were mostly unemployed males, working for delivery and transportation services. Without training and proper inspection, the motorcycle riders are a high-risk group for themselves and for other people, especially pedestrians⁽²²⁾.

Contributing to the anguish and fears of these study participants regarding the prognosis of returning to their routine, it is known that even after the hospital discharge, the victimized person remains incapable of returning to work in the short term. Treatment demands ambulatorial accompanying, rehabilitation, compliance with medication therapy, transportation expenses and so on. These are expensive and reinforce concerns and uncertainties.

The fears surrounding the trauma victims are extended to their relatives. They seek further explanation about the disease, outcomes, therapy with medication, diet and physical exercises. In order to face reality, health education may allow the interested people in this process to manifest their real needs. They may resort to dialogues with the professionals and enable suitable actions⁽²³⁾.

Researches show that for each person killed in traffic accidents, four others are severely injured, causing a legion of mutilated people who are incapable of working, originating high costs to the government and unsupported families^(2,24). Regarding this aspect, it is important to point out the need of supporting measures toward families. They are struggling to overcome the difficulties that threaten attachment⁽²⁵⁾.

It is worth mentioning in this study that favorable situations were perceived during hospitalization, according to patients and their family caregivers. They referred to the existence of solidarity among patients and caregivers during hospitalization. They emphasized the moments when they could share experiences. They mentioned that many professionals explained that society ought to improve traffic education and responsibility. There was also allusion to the availability of the healthcare team to solve the patients' and caregivers' immediate needs. Another point to be considered, in the participants' standpoint, was the possibility of reflecting about the importance of family and existence, as reported:

Doctor, some things happen to us so as to unite the family (FA-3).

I've often been in desperation. I wish I had died. But that's life. Sometimes you get desperate, but, since I haven't died, there must have a mission (P-4).

Concerning TA gravity and the importance of Health Education programs, the literature argues that only with continued traffic education many lives will be saved. Public hospitals will economize and will have more beds available. Social welfare will not spend on premature, unnecessary and perfectly avoidable costs⁽²¹⁾. Another study reinforces the idea of developing awareness of life valuation with current and future drivers, passengers, bicyclers and Brazilian pedestrians, and respect to other people's lives is a challenge that should be faced with priority, by both public administration and society⁽²⁶⁾.

By visualizing the problem dimension, there is reflection about the implementation of assistance, given that human complexity understanding is involved. Without fragmentation, the victims' voice and wishes are completely heard, with emphasis on subjectivity. In this perspective, the literature expresses that the reductionist paradigm cannot remain. Emphasis on biological aspects, a fragmented perspective and hidden hierarchies of knowledge are concepts which are the opposite of integrality⁽²⁷⁾.

Reinforcing the importance of Health Education in the violence thematic, some authors argue that it requires knowledge of several disciplines to reach the goal, that is, awareness of the human being and search of quality of life with autonomy⁽²⁰⁾. The healthcare team, with an interdisciplinary attitude, should conduct the patient, family and community to the best healthcare assistance, through strategies that use dialogue and effective interaction, which are made of several expert healthcare professionals. However, they cooperate and maintain their specificities when assisting the patient⁽²⁸⁾.

CONCLUSION

Hospitalization for the TA victims and their caregivers synthesizes an array of problems that reach the emotional, family, economic and social dimensions. Nevertheless, favorable situations were reported during hospitalization, such as solidarity among patients and caregivers, experience sharing, traffic education and responsibility, availability of the health team, reflection about the importance of family and existence itself.

In the participants' speeches, hospitalization is experienced with depression, anxiety, sadness, fear, concern, lack of information about the gravity of the case, prognosis, rights and duties related to traffic accidents, legal, economic and social implications. To this problematic, there is the addition of imbalances in family relationships by the loss of a loved one, financial difficulties, overload of activities, role inversion and uncertainty.

The context described by patients and caregivers leads the professionals to reflect about the care provided to this clientele. There is the need of transcending the perspective beyond bodily care, rediscovering the person's magnitude, being aware of family and social dimension and being willing to provide

full assistance. The challenge to proceed with the health-care actions is the inclusion of patients and caregivers in

the planning and actual care. Caregivers should not be regarded as action objects, but as real action subjects.

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