



REDISCOVER OF THE SYMPATHY IN THE PRACTICE OF THE NURSE IN INTENSIVE THERAPY

REDESCOBERTA DA SIMPATIA NA PRÁTICA DO ENFERMEIRO EM TERAPIA INTENSIVA REDESCUBIERTA DE LA SIMPATÍA EN LA PRÁCTICA DEL ENFERMERO EN TERAPIA INTENSIVA

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ABSTRACT

Objective: to understand the value of the sympathy for the elaboration of nursing care in the discourse of the nurse who works at the Intensive Care Unit (ICU) and discuss it, based on some assumptions of Max Scheler and the scientific literature. **Method:** this is a descriptive-exploratory study with qualitative approach performed in an ICU in the city of Belo Horizonte/Minas Gerais, Brazil. The research participants were nine nurses. The data were obtained by interview and analyzed from Diltheynian hermeneutics. **Results:** sympathy was recognized as a foundational element for the nursing care of the critical patient in the ICU. **Conclusion:** Nursing care is an expression of technical, scientific and human competence. It must involve sympathy since it fights insensitivity, establishing the I-You relationship. The use of technology cannot move the nurse to the forgetfulness of the patient as a person. Ignoring this status, he will be perceived as an object and considered as a thing, being a paradoxical position to Being a Nurse. **Descriptors:** Nursing; Culture; Social values; Philosophy.

RESUMO

Objetivo: compreender no discurso do enfermeiro que atua na Unidade de Terapia Intensiva (UTI) o valor que assume a simpatia para a elaboração do cuidado de enfermagem e discuti-lo à luz de alguns pressupostos de Max Scheler e da literatura científica. **Método:** estudo descritivo-exploratório, com abordagem qualitativa, realizado em UTI, na cidade de Belo Horizonte/Minas Gerais, Brasil. Os sujeitos da pesquisa foram nove enfermeiros. Os dados foram obtidos por meio de entrevista e analisados a partir da hermenêutica Diltheyniana. **Resultados:** a simpatia foi reconhecida como elemento fundacional para o cuidado de enfermagem ao paciente crítico na UTI. **Conclusão:** o cuidado de enfermagem é expressão da competência técnica, científica e humana. Deve envolver simpatia, pois ela combate a insensibilidade, estabelecendo a relação Eu-Tu. O emprego da tecnologia não pode mover o enfermeiro ao esquecimento do paciente como pessoa, ignorado esse status ele será percebido enquanto objeto e coisificado, posição paradoxal ao próprio Ser-enfermeiro. **Descritores:** Enfermagem; Cultura; Valores Sociais; Filosofia.

RESUMEN

Objetivo: comprender en el discurso del enfermero que actúa en la Unidad de Terapia Intensiva (UTI), el valor que asume la simpatía para la elaboración del cuidado de enfermería y discutirlo basado en algunos presupuestos de Max Scheler y de la literatura científica. **Método:** estudio descriptivo-exploratorio, con enfoque cualitativo, realizado en UTI, en la ciudad de Belo Horizonte/Minas Gerais, Brasil. Los sujetos de la investigación fueron nueve enfermeros. Los datos fueron obtenidos por medio de entrevista y analizados a partir de la hermenéutica Diltheyniana. **Resultados:** la simpatía fue reconocida como elemento fundamental para el cuidado de enfermería al paciente crítico en la UTI. **Conclusión:** el cuidado de enfermería es una expresión de la competencia técnica, científica y humana. Debe envolver simpatía porque ella combate la insensibilidad, estableciendo la relación Yo-Tú. El empleo de la tecnología no puede mover el enfermero al olvido del paciente como persona, ignorado ese status él será percibido como objeto y cosificado, posición paradoxal al propio Ser-enfermero. **Descritores:** Enfermería; Cultura; Valores Sociales; Filosofía.

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INTRODUCTION

The Intensive Care Unit (ICU) provides assistance to severely ill patients who need complex and specialized care, requiring ongoing medical and nursing care, and appropriate technological resources for ongoing patient monitoring. These resources are fundamental to this care, contributing decisively to patients' diagnosis and prognosis. However, there should be concern about the adequate use of this technical-scientific advance and the ethical dimension that underlies human life, and especially for the pragmatics of nursing.¹

Nursing and other healthcare courses are immersed in a plot that underlies the debate of a philosophical nature between Positivism and subjectivity, understood as an exclusionary character. That is, science and subjectivity are opposite and not complementary. However, human life is given by the unicity between reason (science) and feeling (subjectivity).²⁻³

For Positivism, the science, technology, and technique constitute insurance for the construction of a civilizing framework of peace, dignified life and health for all. However, the exacerbation of the value of the logical (science) and useful (technical) can lead to elevated risk in moving the nurse who works in the ICU to the process of dehumanization against nursing care, incurring a serious ethical error of comparing the patient.²⁻³

In this way, the unequivocal credulity of the benefit of science for the construction of this civilizing framework is compromised. Therefore, it is necessary to build a mechanism that allows the nurse who works in the ICU to move to the adoption of a critical-reflexive attitude, aiming to prevent or interrupt the increased process of valuation of the logical and the useful, to the detriment of the love towards the care given to critical patients.⁴

In this sense, some provocative questions arise: how to sensitize the nurse, given the credulity attributed by him to science, technology, and technique for the full exercise of nursing care in the ICU? What is his significance about sympathy for nursing care to critical patients? Because it is not plausible to regard this care as something centered solely on objectivity (technical-scientific), ignoring that it requires the recognition of the patient as a person. These questions give rise to a reflection on nursing care in intensive care patients.

There is also a growing discussion about the humanized care in the ICU, opposed to the technician and mechanistic approach, coming from Positivism, suggesting that science, technology, and technique are not enough to ensure the recovery of the patient in his biopsychosocial dimension. This fact is evidenced in the assistance handbook, which is observed in the reports of the various members of the nursing team, showing feelings of fear and anguish, as well as ambivalent behaviors of proximity or distance from the patient. Given this situation, it can be affirmed that the practice of nursing care is based on the relational character of an expression of subjectivity, something exclusive to the Being a Nurse.⁵

The justification of the study was centered on the assertion that the nurse as a spiritual entity can submit the professional action to criticism, starting from the awakening of their feelings, arising from the relationships established before the patient and their relatives during the professional exercise in the ICU.¹

The Schelerian philosophical perspective is assumed, since it is shared by the understanding that through the feeling, the nurse becomes humanized, becoming fit to provide nursing care in his biopsychosocial dimension. Max Scheler developed an affectivity-centered anthropology, combating human brutality through love and sympathy, recognizing it as the basis of the humanization process.^{6,7}

Given these considerations, the purpose of this study is to understand, the value that the sympathy assumes for the elaboration of nursing care in the discourse of the nurse who works in the ICU and discuss it based on some assumptions of Max Scheler and the scientific literature.⁷

METHOD

This is a descriptive-exploratory study with a qualitative approach. It is capable of incorporating the question of meaning and intention as inherent in acts, relationships, and social structures being involved both in its advent and in its transformation, representing meaningful human behaviors.⁸

The research was performed in an Intensive Care Unit (ICU) of a large hospital located in the city of Belo Horizonte/Minas Gerais. It has 40 beds subdivided into three spaces, where 10 beds are intended for patients with heart disease. In this unit, there are 28 nurses, 01 (one) coordinator nurse, 01 (one) auditor nurse, 01 (one) administrative nurse and 25 nursing assistants.

Data collection took place after the participants were informed about the ethical aspects of the research and signed the Free and Informed Consent Term. The technique used was the semi-structured interview, containing questions about the demographic partner and the following guiding question: how do you evaluate the role of technology and the sympathy for the exercise of nursing care in intensive care patients? The interview was recorded on electronic media. The participants of the research were the nurses who acted in the unit scenario. The criterion of inclusion of the participants was to provide direct assistance to the patient. In the study, the sample was used for convenience.

The nurses were invited to participate by an invitation letter and, for the respondents, the face-to-face meeting was scheduled in which the content of the research was presented to them and, with their consent, the interview was scheduled. This occurred in a private room in the setting institution, with an average duration of 40 minutes with nine nurses. This number was delineated after the saturation of the data was obtained. Participants were identified by the alphanumeric system in the text by the letter E, plus Arabic numbers arranged from 1 to 9. The interviews were conducted from August to September 2013.

Diltheynian hermeneutics was used for the comprehensive analysis of the data. Its objective is, from the written text, to understand the movement of belonging to the subject to the being of what is understood. In this process, the interpreter is required to have information about the historical-social plot to begin the game of circularity. This technique is characterized by a coming and going between the whole and its parts. In it, the interpreter assumes the commitment to read and re-read the text until awareness is revealed of the elements that ground the meaning. Also, textual writing functions as a totality so the analysis of the text cannot be done once, because, with each new reading, it is understood a little more since the necessary knowledge is being incorporated.⁹

Some of the assumptions were adapted as guides to unveil the phenomenon: (1) transcription of the speeches in full of the deponents; (2) initial reading so that there was the approximation with the whole and then separately; (3) careful and minute textual reading, countless times, until the definitive character of the speeches was revealed to consciousness; (4) recording ideas and realizing their groupings, giving rise to the units of meanings. They express self-meaning

and in relation to the context, being a word, sentence or paragraph, obtaining the attitudes that characterize the sympathy in the nursing care. Finally, this material was discussed through some assumptions of Max Scheler on sympathy and scientific literature.^{6,7}

The research met the parameters established by Resolution 466/12 of the National Health Council (CNS). It was approved by the Academic Committee of Bioethics of the Universidad Del Museo Social Argentino, registered with number 002/2012.

RESULTS

Nine nurses participated in the study, 24% were male and 76% were female. The age ranged from 23 to 42 years old. As for the duration of intensive care, most had up to 10 years of service. It was possible to identify the sympathy in the nurse's speech. It was manifested in the care praxis from such attitudes as: "coming near", "having closeness", "offering a word of affection and comfort", "talking to the patient", "welcoming who is suffering", in Schelerian terms, by a relationship of sympathy and love. The deponents illustrated this consideration by saying that:

The patient is totally dependent on me to survive [...] any error, any negligence by me can lead to death. We deal with the human being, so I have to get close to take care of the patient. (E4)

Technology is important to help with my work, what is the use of technology and not being close to the human being? (E5)

[...] our role of caring, no machine ... changes the bedding, shower, medicated; Offering a word of affection, comfort. (E6)

I think that every day the professional is less valued, less recognized [...] because in the ICU, the nursing embraces, welcomes, protects, cares [...] (E7)

[...] we are a little more distant from the patient because we have to request medication, to evolve. Previously, because everything was manual, you were closer to the patient. (E8)

I think nursing care is everything. Nursing is the one who is there for 24 hours, manipulating the patient, talking to him, verifying both his evolution and his regression. Nursing is who has the patient's first glance. (E9)

It was also possible to verify the statements of the deponents the implication attributed by them to the relationship between technology and feeling. Noting that, in their understanding, technology calls for the sympathetic attitude to become more

tenuous. However, they are morally obligated to resist. The cutouts of the statements of the deponents are presented to exemplify this assertion:

[...] the time I have for the patient, I divide it with the report, computer, things that prevent me from staying with him as it was before [...] improved the technical part, part of the relationship [...] I think it is cooled down a bit. (E1)

Because professionals are often linked only to technological devices and lose focus on the patient, they lose the focus of the totality that is the human being, who has priorities and that, many times, you cannot take into account only technological devices [...] you really have to have a clinical view of the patient. (E2)

The technological resource comes to help us, but it will only help us from the moment we see it as support and complement to our work [...] sometimes, we have to be careful, not to forget the patient, because the technological resource is a working tool [...]. (E3)

DISCUSSION

The socio-demographic profile of the interviewees demonstrated the influence of the female gender as the founder of the course and also the tendency of experienced professionals in nursing care to the critical patient under specialized care in the Intensive Care Unit (ICU).¹⁰

The nurses in their care practice in the ICU should seek to exercise the fullness of life in love so that it develops and grows in a real approximation with the patient. This idea is based on the Schelerian assertion that it is through love that the nurse develops the capacity to “sympathize with” the patient and, in this way, they will recognize his longings, historicity, idiosyncrasies, perceiving him as a human person and not as an object, a position of extreme relevance for the nursing pragmatics.¹

For Scheler, sympathy and love when established in praxis enable full communication between people. They constitute an amalgam and, in this way, one cannot speak of one without referring to the other and vice versa. He is only able to “sympathize with” one who is capable of loving and, by loving, he is able to “sympathize with”. This relationship is one of implication and mutuality. Thus, the relationship that the nurse routinely elaborates to care, makes him/her able to know and attend to the patient’s need and distances him from nursing interventions based only on biological, technical and

scientific aspects. They eventually ignore their humanity because they do not know their psychosocial and psychospiritual dimension.^{5,7}

For the theorist, sympathy has two forms: “feeling with the other” and “sympathizing with the other”. First “feeling with the other”, then “sympathize with the other”. “Sympathizing with the other” brings awareness to the case of the patient and a reality equal to our own self. Being equal to this reality is the basis of the movement of spontaneous love to the patient. “Feeling with the other” is an apparition of lesser impact of the emotional life, since it moves the nurse to face the joys and sorrows aroused in the care encounter with the patient. Nevertheless, he is incapable of producing the compassion in his inner, that is, the ability to put the patient “inside”, being softened by him. This attitude, only the “sympathizing with the other” is capable of fostering, allowing nurses to move to a humanizing attitude of their professional practice.^{7,12}

Thus, the nurse who attends the ICU will cease to act with humanity, if during his action, he is not moved to growth and development in love, understanding it as the basis for its assistance praxis. When experiencing professional action, he is not able to “sympathize with the other”, and to reflect on his attitude, he will disintegrate, defer, lose consciousness and restrict the being a Nurse, since nursing care means a basic existential phenomenon.¹⁰

In love, the nurse discovers the value of himself and the patient, being able to choose the good spontaneously, free of duty, while imperative. For the theorist, the imposition of duty is unfavorable for the construction of the ethical subject, because it alienates the feeling as the fulcrum of the relational life. In this sense, the philosopher points out that love is a spontaneous act, of an inner nature, without any logical-rational element, being characteristic of human subjectivity, making it innocuous to awaken it from the Kantian categorical imperative.^{6,7,10}

The deponent explained this assertion by saying that:

[...] our role of caring, no machine ... changes the bedding, shower, medicated; Offering a word of affection, comfort. (E6)

The nurse intuitively recognized that nursing care was not an object of duty or that it was closed to the technological device, but, in the sentimental attitude in which he was moved to “sympathize with” the patient, offering him attention, affection and comfort. Through sympathy he was able to transcend

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his individuality and to participate in the patient's feelings, then "sympathizing with" him and, guided by love, to identify and direct to other human beings, and then, to carry out his humanity emotionally.

The deponents ratified this view by saying that:

The patient is totally dependent on me to survive [...] any error, any negligence by me, can lead to death. We deal with the human being, so I have to get close to take care of the patient. (E4)

I think nursing care is everything. Nursing is the one who is there for 24 hours, manipulating the patient, talking to him, verifying both his evolution and his regression. Nursing is who the patient has's first glance. (E9)

Technology is important to help with my work, what is the use of technology and not being close to the human being? (E5)

In this sense, solidarity emerged as a co-existential element of love for the patient, evidencing the importance of preserving him, from the continuity of life in his biological and social aspects. For the nurse, the patient's perception, mediated by sympathy and love, enabled the recognition of life in a comprehensive dimension and full of situations enriching the human, a fact identified by him when recognizing in the pragmatics of nursing the need to be with the patient. In this way, it is evident that only through love can one arrive at the reality of the person.^{2,13}

Continuing in the hermeneutic analysis the following reports were presented:

I think that every day the professional is less valued, less recognized [...] because in the ICU, the nursing embraces, welcomes, protects, cares [...] (E7)

[...] we are a little more distant from the patient because we have to request medication, to evolve. Previously, because everything was manual, you were closer to the patient. (E8)

It seems that the nurse who lives the care in the ICU is aware that by empirical, logical-rational methods is impossible to know the patient as a person. For example, it is known that the vital parameters express only the relevance or not for the preservation of life. However, they say nothing about the person. This only becomes known from an affective bond. In an intuitive way, the nurse recognized this condition when he said that "nursing embraces, welcomes, supports" and that it must be involved with the patient, being "closer." Moved by sympathy and love, the nurse ratified the Schelerian assumption that the person is given to us only in the act

of love, it is revealed only through this act. Thus, nursing care based on sympathy and love, favored the nurse to attend the patient in a humanized way because love brings the desire to know him and when he loves, he values him.¹⁴⁻¹⁶

It is widely debated that from the historical point of view, the courses that found the health area were based on mechanistic and Cartesian paradigms, directing the cosmovision and practices of the professionals to the optimization of the production of goods and services, accentuating the fragmentation, specialization and neglecting the complexity of human relationships, reflecting on health practices emphatically determined by the clinical, technical and biological approach.²

The roots of this evil go back to the controversies that began with Humanism and the Renaissance about the superiority of active life about reflective life. It took centuries to reach the central point of this worldview: the man forgot himself. Because of this forgetfulness, the technician-scientist with his excesses moves the nurse to the process of dehumanizing nursing care. Such a condition demands its transformation, a critical-reflexive position on the part of the professional.^{2,3}

The deponent explained this assertion by saying that:

Because professionals are often only linked to technological devices and lose their focus; they lose the focus of the totality that he is as a human being... a human being who has priorities and, often, you can not only consider... that technological device... (E2)

Thus, in the nursing care pragmatics developed in the ICU, two aspects coexist that carry with them complex and contradictory aspects, enabling to infer that this is a potentially productive transition zone. The first strand brings the remnant of the worsening of the current mechanistic, dehumanizing model, with emphasis only on the clinical, technical and biological approach. The second strand contrasts with man as a machine, in a humanizing way, centered on the otherness and expansion of the sense of the I-You.⁷

This understanding was verified in the speech of the deponents when saying that:

[...] the time I have for the patient, I divide it with the report, the computer, things that prevent me from staying with him as it was before [...]the technical part has improved, but part of the relationship [...] I think it is cooled down a bit. (E1)

The technological resource comes to help us, but it will only help us from the moment

we see it as support and complement to our work [...] sometimes, we have to be careful, not to forget the patient, because the technological resource is a working tool [...]. (E3)

These two explanatory aspects of Nursing are permeated by the disarticulation between reflexive action and practice. The nurse should be moved to develop the critical-reflexive activity because only through this exercise he will be able to suspend professional practice and judge his legitimating relevance to being a nurse. In a dynamic world of great transformation, it is seen that people are increasingly giving up this arduous and painful task and, consequently, they go to forget themselves and the other. In this ongoing process, they succumb to dehumanization. It is up to the nurse who works in the ICU to oppose this model, revisiting him praxis from a worldview centered on love, since only this one has the prerogative to make human nursing care.^{1,4,5,13}

CONCLUSION

As a conclusion, it can be stated that nurses attending ICU have identified sympathy and love as foundations for the course pragmatics, expressed through nursing care. Through love, he encountered and entered the field of ethical action. Also, the use of technology and social relationships with the patient and the family allowed him to reflect on nursing care, moving him to the recognition and rediscovery of sympathy as a founding element of patient care in critical health situations, valuing him as a person.

It is also argued that nurses must maintain a critical-reflexive attitude to combat the process of dehumanization in vogue in contemporary society, where self-forgetfulness and the other, manifested by the growing escalation of violence and social abandonment seek to impose on professional action their indelible marks. It should not be ignored that the extreme individualization advocated by contemporary society may remove it from Being a nurse.

Two limitations of this research should be noted. The first was the sample use for convenience, considering that in this modality, the selection of nurses with similar positions can occur. However, it must be considered that in this study the sampling process occurred by theoretical saturation. The second was the fact that data collection was limited to an Intensive Care Unit only. However, an important initiative related to this theme in the scenario of nursing care in

high complexity was revealed, still insipient in the literature with this approach.

Thus, the researchers recognize that other studies should be developed in this same theoretical-philosophical aspect, including discourses of nurses who work in the ICU of other institutions, whether public or private, which may reveal unnoticed situations.

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