

Humanistic Care in the Intensive Care Unit: A Qualitative Study

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Research article

Keywords: Nursing, Humanistic Care, Intensive Care Units, Qualitative Research

Posted Date: September 10th, 2020

DOI: <https://doi.org/10.21203/rs.3.rs-56266/v1>

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Abstract

Background: Nurses working in intensive care units do their main part of the job using medical equipment. Scholars have long debated the impact of technology on nursing. Those on the negative side perceive technologies as obtrusive to comprehensive humanistic care. Up to now, there has been little investigation of the nurses' perceptions of this phenomenon. The aim of the study was, therefore, to explore the perceptions of nurses and attendants of humanistic care in the intensive care unit.

Methods: The present study was a qualitative conventional content analysis conducted in an intensive care unit in a hospital in Qazvin, Iran, in 2019. Data was collected using unstructured interviews and field notes and then analyzed using the Elo-Kyngäs method in 2008.

Results: Continuous and comparative analysis of the data led to the extraction of 4 main themes as follows: 1) Insufficient understanding of nurses and patients' families of each other's roles, needs, and expectations; 2) The use of personal and situational reasoning rather than ethical principles; 3) Caring stagnation, and 4) Satisfaction with care.

Conclusion: The findings of the study indicated that due to lack of equipment, high workloads, and anxieties, nurses and attendants might not be able to understand each other's roles and expectations. If it is not resolved properly, this situation will end in conflicts and stagnation in healthcare. Patients admitted to an intensive care unit are usually in critical health conditions. However, nurses feel satisfied with the outcome of their jobs when those patients are discharged from the hospital with a stable health condition. Shedding more light on the humanistic care status in intensive care units in Iran, the results of this research can be applied to health professionals and nursing managers.

Background

Nursing is a complex and systematic profession that has wide applications in healthcare. The human essence is important in traditional medicine and focuses on the care and comfort of individuals [1].

Human caring in nursing is not considered solely as a feeling, approach, or even what one kindly desires to possess. From the moral point of view, caring in nursing is an ideal whose aim is to protect, enhance, and preserve decency. It is, therefore, an ethical and philosophical enterprise defining nurses and individuals over time and in various conditions [2].

Humanism in health care is not an ideology, but it is related to the individuals' interactions and their lifestyles and includes the moral quality and commitment that individuals consider as a whole [3]. The utilization of humanism in clinical medicine leads to the potential evolution of patients' care, workplace culture, and clinical education [4].

In contrast, dehumanization implies depersonalization, in which the illness treatment is viewed as the sole target of therapeutic care. A few out of many causes of dehumanization are the "dictatorship of

technology”, which ends in considering patients as “things”, super-specialization, the application of economic value-based criteria to healthcare administration, and the refutation of the idea that the endurance and death of patients can affect relatives and experts equally[3].

Dehumanization versus humanistic health care can be realized best in intensive care units (ICU). Patients admitted to the ICU have critical conditions and vulnerabilities. The ICUs with high-tech equipment can cause job burnout for nurses and as a result, the nurses working in highly technological environments might abandon the humanistic aspects of their patients’ care[5].

Recent scientific advances, coupled with increased awareness of cultural and social diversity, have led to a range of available treatment options; however, such developments sometimes lead to an adverse imbalance between science, technology, and humanism in the clinical practice and has made humanistic excellence a major challenge in nursing [6] [7].

Khademi (2013), the analysis of theoretical and research evidence indicates an urgent need for refocusing attention on human care and strengthening the humanism in healthcare systems, especially in nursing, as the largest health profession which plays a leading role in healthcare systems. Therefore, preserving and promoting human values in nursing can be a step towards strengthening these values and humanizing the whole healthcare system in a country [8].

Martos et al. (2017) believe that humanism demands a holistic approach. Patients are not the only ones suffering from a disease in the intensive care unit, but their families and healthcare providers are also affected by their conditions. In this case, healthcare providers are seen as the centerpiece of the deteriorating process of human care [3].

Due to the technical nature of the intensive care unit, the concept of patient-centered nursing cannot be applied in its true sense in the field of intensive care. Technology strongly affects the patients' physiological status and violates patient-centered caring [9] [10].

In a study by Martinez et al. (2012), good interpersonal relationships, the recognition of colleagues, institution and its employees, effective communication, and personal values were promoting factors. On the other hand, the lack of job recognition and the individualistic attitude were factors that impeded humanism among employees [11].

Research has found that structural elements of nursing care management which focus on the users’ needs should be aligned with public policies and the principles of comprehensiveness and humanization. This way the humanized nursing care can potentially transform health practices[12].

What makes humanistic excellence a major challenge in nursing is the inconsistency of some aspects of modern healthcare and human guidelines. Nursing experts have attempted to resolve this challenge by presenting human-centered theories [7].

Numerous theories have been proposed and even applied with a patient-centered and humanistic approach (e.g. Watson [2], Paterson and Zderad[13]) influenced by philosophical approaches to humanism from other disciplines, but less attention has been paid to the role of nurses. Nurses will have greater professional development when they become aware of the importance of proper presence in their development and positive developments in their patients. [14].

In this regard, Chiovitti (2008, p. 205) wrote: "In line with the status of nursing knowledge, early theorizing about nursing care was based on two principles according to knowledge about theoretical nursing measures: 1) experience, observation, and self-theorist training, and 2) theoretical knowledge translation of other fields to nursing[15]. "

Evidence shows that most patients experience non-human behaviors such as lack of compassion, concern, and affection while they need to be cared for [16]. It indicates that the wellbeing framework is itself a source of suffering[17].

An attempt has been made to develop an intermediary theory on human nursing in Iran using grounded theory. Nursing in Iran also suffers from some global challenges. Lack of manpower, job turnover due to poor social image of nursing, low wages, and ambiguity of duties with high pressure among nurses have created a challenging job condition for nurses. It is unclear how nurses can overcome these problems and how and under what conditions nursing becomes humanistic[18].

Despite these findings and the mentioned research results, it is important to understand the importance of humanistic care in every field by taking into account the cultural and structural differences to enable and contribute to better humanistic care. To this purpose, this study attempts to explain perceptions of nurses and patient's families of humanistic care in intensive care units.

Methods

A conventional qualitative content analysis approach was used in the present study. As naturalistic paradigms and qualitative methods take into account the dynamic and multiple nature of the reality under investigation and consider multiple constructs of a phenomenon as possible, they are believed to be useful to study the lesser-known domains [19, 20].

Setting and Participants

Data was collected using unstructured face to face interviews with 17 nurses and 4 attendants and 4 patients who were selected through purposive sampling. The key characteristics of the participants are displayed in Table 1. Field note observations were also recorded in the intensive care unit of a healthcare teaching center from November 2018 to May 2019 in Qazvin city in Iran.

Table1: Characteristics of the participants

Number of participants:25 Interview duration:25-120 minutes
Family:4 Age:41.25(21-53) Gender:1 female and 3 males Education:illiterate:1, High school diploma:2, Student:1
Patient:4 Age:35.7(17-53) Gender:2 females and 2 males Education: High School:1, High school diploma: 2, Bachelor:1
Nurse:17 Age:33.68 (21-45) Clinical experience:10.31(1-21) Education:Bachelor:14; Master: 3 Position:Nurse:13, Head Nurse:1, Staff:1, Supervisor:1, Faculty member:1

Data collection

Unstructured interviews were conducted with nurses and patients and families to collect the data. All the interviews started asking an open-ended and general question from the participants. The questions of the interview guide were general (Box 1). Interviews continued until data saturation was reached and no new theme could be identified. The interviews were all recorded and transcribed verbatim. Field note observations were also recorded in the intensive care unit to complete and deepen the interview data. They are intended as objective evidence that gives meaning and aid in the understanding of the humanistic care phenomenon. Fieldnotes allowed us to access the perceptions of the subjects and record what they observed unobtrusively.

Box 1: Interview guide

Nurse	Patient/Family
Please, explain how your took care of your patient in this unite?	Please, explain the behavior of ward nurses in caring for you/your patient?
Based on your daily experience, how do you try to provide these care in a humane way?	Please explain how you felt about these nurses' behaviors?
In what situations did you feel these Humanistic behaviors were lessened?	In what circumstances these humanistic behaviors improved?
For probing;	In what circumstances did you feel these human behaviors are decreased?
Can you give an example?	For probing;
Explain more about this?	Can you give an example?
What does this mean and what do you mean?	Explain more about this?
	What does this mean and what do you mean?

Data Analysis

The data obtained from the interviews were analyzed after they were recorded and transcribed word by word according to the Elo-Kyngäs method [21]. This method of transcription includes three steps. During the preparation stage, the whole interview, which could be a good context for semantic units, was selected as the most appropriate unit of analysis. Each interview was repeated several times so that the researcher could go deeply into the participants' opinions. At the organization stage, open coding was performed by re-reading the interviews, taking notes, and writing titles on the margins. The titles were then recorded on coded papers. Grouping began after several interviews were read. Additional titles and categories evolved by repeating the abovementioned stages for each new interview. After comparing and merging categories belonging to a group, the number of initial categories was reduced. The sub-categories with similar themes were grouped as one category. Each category was then named by words representing its content characteristics. The abstraction process continued until four main themes were extracted (Table 2).

Table 2: An example of theme extraction process

Quotation /Field notes	Initial codes	categories	Theme
Bed 9 as a bradycardia patient and attracted my attention. I informed the nurse and I said you were doing nothing for Bed 9. The nurse said he was expired. His family had a wedding today and we injected him atropine to get him alive until the end of wedding. They demanded the nursing office not to ruin the wedding if possible...(Field note 28)	The nurse's attempt to save a patient at the request of the family and the nursing office for a longer period of time	Facing moral contradictions in saving life	Replacing ethics with personal and situational reasoning
Taking care of patients with a low level of consciousness is useless and only takes our time and energy. Our colleagues say if he is sent to the ward, he will be soon expired (Nurse Ms. N)	Helping the expedition of deaths of irreversible patients and the final stage		
An internist came to the ward today and the head nurse said: Doctor, you should send the bed 10 patient, who is in a bad condition, to general ward where they should decide what to do. They insisted, but the physician did not accept to send the patient to ward. The patient had severe rectal bleeding...The doctor said how I could send the patient...The head nurse said: He would waste a lot of money and energy. They are too skinny, and we have nothing to give them, so they become thin, and catch sore. (Field note10)	The physician's refusal to comply with the nurse's request to expedite the death of an irreversible patient		
We didn't care about old patients or those who had lower levels of consciousness. I spend my time and energy for those who are more likely to be recovered.(Nurse, Ms.Kh)	More care for patients with a high likelihood of recovery and higher level of consciousness	Caring preference in young and conscious patients	
If a patient is more conscious, younger, or entered unwanted to this ward, like the suicide patients, and it is the main cause of their death, when they are put under the ventilated machine, they say please save us, we want to live, I am regretful, so the caring is done further. These cases give us the motivation to provide care to treat them (Nurse Ms. Gh)	More human attention to regretful and young suicide patients		

Rigor

Long-term engagement of the researchers for a year in the field and spending enough time communicating with participants during data collection helped the researchers to build trust and understanding in participants and enabled deep data collection. According to Lincoln and Guba's criteria [22], maximum variance sampling is based on features such as age, work experience, and the position was used to confirm the transferability of the findings. To ensure that the analysis accurately reflected the participants' experiences, the codes extracted from each interview were controlled and reviewed by the

participants during data collection and analysis, and necessary changes were made in data interpretations based on participants' suggestions. To provide dependability and confirmability of data, two nurses who were experts in conducting research and had working experience in the intensive care unit reviewed parts of the raw data including interviews and analytical products, namely initial codes and categories.

Results

Analysis of the data yielded 367 initial codes, 16 categories and 4 main themes including “insufficient understanding of nurses and attendants of each other's roles, needs, and expectations”, “the use of personal and situational reasoning rather than ethical principles”, “caring stagnation” and “satisfaction with care”. The extracted themes indicated that nurses and attendants did not have sufficient understanding of each other's roles, needs, and expectations due to the existing conditions in the ward and that the nurses neglected the professional ethics in caring and employed personal reasoning. Caring stagnation was found in the observations of caring behaviors and their interpretations. However, under the critical conditions of the patients and the ward, the nurses sought to provide humanistic care and satisfied the patients and themselves and they felt satisfied when being in and out of the ward.

1. Insufficient understanding of nurses and attendants of each other's roles, needs, and expectations

The findings revealed that the attendants insisted on tracking the status and treatment of their patients, and were willing to be present at their patients' bedside and cooperate in the care procedure. However, the attendants were neglected by the personnel and their presence was considered unnecessary and obtrusive to patients' care. The nurses were unable or unwilling to communicate and inform them (attendants). It was indicated that nurses did not understand the needs and desires of attendants, and the attendants did not understand the nurses' working conditions, measures, constraints, and needs. This theme has five attributes including “persistence by attendants in follow-up and treatment”, “neglect of attendants”, “unnecessary presence and their disturbance”, “lack of skill and willingness to interact and guide”, and “voluntary participation in care”.

1-1- Families' insistence on follow-up of situation and treatment

The important findings were follow-up and insistence on knowing the patients' status in various forms, such as visiting the patients at visiting hours, watching the patient briefly from behind the window, and waiting behind closed doors for a doctor's visit. Limiting the visiting hours to two days a week for a quarter of an hour in the intensive care unit was a major challenge for the families. Visitation restriction was a major challenge not only for the families but also for the nurses, as it was opposed to the family's willingness to meet the patient. The families were allowed to visit the patient due to their persistence, but the insistence led to the nurses' frustration.

“The attendant was looking from the glass door. I asked “What do you want?”, he said “Nothing I just want to see my son.” ...I said “It's not the visiting time.” He said “I can see through the window if possible.”

He could see his son through the window with the coordination of ward nurses and happiness could be seen on his face” (male 72-year-old family 2).

1-2- Ignoring families

During the patients' care, their attendants are often forgotten. It was found that the attendants' needs are forgotten and they are left without any support, education and caring programs.

“A patient's attendant came to see her patient and started crying. The service guard shouted and told her not to cry there. She took her cry with herself and went to the nursing station to ask a question. The nurse did not look at her and said “I do not have time” ...and then the attendant left the ward” (Field note 1).

1-3- Unnecessary and disturbing presence of families

The participants' experiences revealed many events, beliefs and attitudes affecting the nurses' humanistic performance, such as the belief in the uselessness and harmful presence of family members at the patient bedside, the consideration of family members as those with low health literacy, requiring them to spend extra energy to justify the attendants, and disturbance in care processes due to the presence of families.

“Unfortunately, the level of our people's culture is low, and they lack health literacy and if we want to tell them what is going on, you have to spend your time and energy” (Nurse Ms.A).

In fact, this complaint about the lack of understanding is mutual. In other words, the attendants complain about being ignored, and the nurses complain that the attendants do not understand their professional roles and responsibilities, and thus they consider their presence disruptive to their professional duties.

1-4- Lack of skills and willingness to interact and guide

Communicating with and informing the attendants about the patients' conditions in the intensive care unit is a highly important issue that is often overlooked. Some nurses are unable to provide appropriate care or are reluctant to perform their professional duties owing to their inability and lack of interactive and educational qualifications. This can cause major problems such as conflicts, complaints, fears and doubts about decision-making for families and attendants.

“The ward nurse asked for the consent of tracheotomy from the attendant of bed 3. The attendant was confused and did not know what the tracheotomy was. The more the nurse tried to explain, the little she understood. There was no one in the ward to have the tracheotomy, therefore, the attendant scared and said that “I must consult with my family and I could not decide alone”. (Field note 2).

1-5- Voluntary participation in care

Contrary to the previous characteristic, many attendants frequently visit the care unit and query the staff in order to help with the patients' care. The field observations indicated that some attendants asked the

nurses if they could cooperate in caring. Some nurses also said that attendants had a strong desire to improve their patient status; therefore, they were more alert and could attend the ward whenever needed.

“A young girl was suffering from hypoxia following a cardiac arrest. The patient's husband, who was also very young, was trying to use the olive oil to make her skin greasy to prevent scarring. He frequently asked questions from nurses what you need to prepare for the patient and was often present in the hospital” (Field note 3).

2. Replacing ethics with personal and situational reasoning

Some findings indicated that ethical decision-making is challenging in complex conditions of the patients in the ICU. Factors such as complexity of situation, tendency to save energy and time in difficult working conditions, nurses' emotions and feelings, demands of patients' families and the supervisors orders complicate the process of reasoning and ethical decision-making by nurses. Replacing ethics with personal and situational reasoning was experienced in two ways explained in (Table 2).

3. Caring stagnation

This theme indicates that the variety and intensity of work stresses in the intensive care unit and neglect of nurses' roles and rights lead to insufficient efforts by the nurses to meet all the needs of patients in the intensive care unit, nurses' fatigue and mistrust. In fact, many nurses try to do many caring affairs negligently as their working routines. When nurses realize that there is no difference between them and other nurses who deliberately or undeliberately do clinical affairs carelessly, they change their attitudes to their job. This issue sometimes leads to care stagnation.

- Insufficient nurse care to meet all patients' needs in the intensive care unit

There is an inadequate attempt of nurses to meet all the needs of patients in the intensive care unit such as nutrition and skin care so that the insufficient supervision was exercised after delegating authority to the unprofessional staff.

A patient was saddened by seeing the death of others.

“Well, everybody here is dying every day, and they cover the patients and take them; and I think they are waiting in line. It is ordinary for very ordinary nurses, but it is difficult for me, and it affects my spirit. I am not used to it like them” (Patient, 43-year-old man with Guillain-Barré syndrome).

- Patients' mistrust in nurse's sayings

Some patients, who are hospitalized for a long time in the ward, lose their trust in nurses, and insist and repeat their demands.

“It was the last hour of my shift, when I visited bed 9 for saying goodbye. The patient was under tracheotomy and was conscious. She said “I want sweet tea”. I prepared tea with the help of a service

worker and nurse. She said "Give it to me, but it was too hot". The nurse told her let it to become cold, and then we take it. She said "No, just now". I told her that it was hot and showed it. The nurse saw that she was upset and poured some tea with a syringe into her mouth and gavaged the remaining" (Fieldnote7).

- Neglect of the nurses' roles and rights

Cases such as stressful and difficult working conditions in the intensive care unit, lack of staff, and overwork cause nurses to feel that managers neglect their rights.

"The shifts are better now, but fewer working hours are effective. Nurses should have a regular program of entertainment. The shortcomings should be overcome. When for example, there is the lack of drug, no devices and doctors take our time for calling and finding a physician. If you come home late at night, I cause much stress; you have left the kids, and your life and had these tensions; or the number of beds for nurses should be decreased, and the routine of ICU should be adhered" (Nurse Ms.D.).

- Diversity and intensity of work stresses in the intensive care unit

Some nurses pointed out the impact of environmental stressors on patients' care.

"For example, my personal experience is that when stress comes to life, my whole day collapses, everything is messed up, my patient work and everything gets messed up, but on days with more energy for patients, I'll feel that the patient's clinical situation would become better" (Nurse Ms.M).

- Focus on the unconscious patient's body

Most nurses focus on physical care of patients and forget communication with non-conscious patients.

"We had a mental patient, we were asked to talk to her quietly, have good behavior, and explain what we were going to do for her, but we don't give an explanation for the unconscious patient, because we think it is unnecessary" (Nurse Ms.N.).

4. Satisfaction with care

Although nurses work with high pressure and are overworked in the intensive care unit, they become satisfied with patients whose care is successful and in case of patients' improvement as well as positive reactions such as patient and family appreciation.

- Gratitude and spiritual excellence from receiving internal and external feedback

Nurses believe that patient care is accompanied by spiritual rewards and benefits for themselves and their families.

"When you take care of a patient who is not conscious, you provide care and know God knows, but if a patient is conscious and prays for you, you become so happy. For example, the patient says God bless

you and protect your children, and patients become happy with you..., all these things affect your life and are useful for your children and family” (Staff Ms.N.).

4.2 Answer to the call of conscience

Nurses noted a feeling of torment after failing to perform clinical measures for patients.

“In fact, I had no special thought before, even when I was a student, I studied indifferently, but I thought what happened if one of my beloved ones became ill, so I found that the Karma exists. It is easy to abdicate the responsibilities, but the sense of responsibility does not allow doing everything” (Nurse Ms.Kha).

- Patient-nurse mutual consideration and appreciation

Apology to patients after performing aggressive procedures and the patients’ appreciation of care provided by nurses led to the creation of this category.

“Since I was long working in the intensive unit, for example, when a patient was in sleep mode, I put my hand on her shoulder and say dear mother I am putting your suction; dear mother I am doing the venipuncture. Additionally, when I search for an arterial blood vessel and cannot find it, I’ll apologize for being annoyed...”(Nurse Ms.Agh.).

- Sensitivity to patients' needs and vulnerabilities

Nurses complain about inability to resolve the patients' problems.

“There was a young woman who had the breast cancer. She had the worst possible expire. She was in my mind due to her chemotherapy and septicemia. She was conscious until the last moment, and the tracheotomy was totally performed for her. We had a lot of sympathy for her. She had reflux and could eat nothing. She was thirsty and we could give her nothing, and we saw his gradual death” (Nurse Ms.N.).

Discussion

The findings indicated that the nurses and attendants insufficient understanding of each other's roles, needs, and expectations, replacing ethical principles with personal and situational reasoning, stagnation of care, and satisfaction with care as perceptions of nurses and attendants of humanistic healthcare. Researchers in other studies considered the perceptions of care providers and recipients mostly in cases where patients had sufficient consciousness, but it was less performed in the intensive care unit, and particularly with patients with insufficient consciousness.

In line with the inadequate understanding of nurse's and attendants' roles, needs, and expectations, one study by Martos et al. (2017) in Spain indicated that specialization in medicine and intensive care work improved the communication among not only caregivers but also other caregivers in other hospital departments. Furthermore, patients and their families promoted caring motivation by caring tools and

helped to promote the humanistic care in the intensive care unit [3]. The results contradicted the findings of the present study as there was a lack of skills and willingness to interact and guide in the intensive care unit.

Moreover, Wong et al. (2015) conducted a grounded theory study indicating that the families of patients in the ICUs primarily sought information and awareness in their interactions with the nurses. Employees sought supportive ways to interact with families owing to interpersonal communication and skills [23]. Although the two studies by Martos et al. and Wong et al. achieved notable success in understanding and responding to the needs of families in the ICUs, different changes can be made in any environment depending on organizational and cultural conditions. It is necessary to use the experience of others, including these studies, and perform appropriate interventions to resolve the problem according to organizational and cultural conditions.

One of the findings of the present study was “Unnecessary presence of families due to disturbances” and “Ignoring families” relating to the following theme, “nurses and families insufficient understanding of roles, needs, and expectations of each other”. Unlike the present study, other studies emphasized that health is based on a patient-centered and family-centered system [24, 25]. Spreen et al. (2011) explained the principles and standards of visiting in the intensive care unit, stating that the “open visit” policy was an urgent need for patients and families in the intensive care unit. Clinical guidelines in many countries recommend open care policy in the intensive care unit in line with family-centered care [26] [27]. Other studies also indicated that families needed participation, and their presence was not only a nuisance but also useful and effective [20] [28].

Despite these standards and valid findings and evidence, in Iran, there are still restrictions on open visiting that need to be standardized by training or removing organizational barriers.

As related to the theme, “The use of personal and situational reasoning rather than ethical principles”, the findings indicated that nurses were sometimes influenced by emotional or cross-sectional demands of families and, in ethical conflicts, they acted personally with outcome-centered and emotional reasoning.

It is always emphasized that in the adherence to professional ethics, patients have rights in the healthcare system that must be respected and protected, and this cannot depend on providers' personal preference and desire [29].

Consistent with the findings of the present study, “Facing moral contradictions in saving the life” in one study by Falcó-Pegueroles et al. (2016) found ethical conflict is an intrinsic problem, but it is strongly influenced by specific variables and environmental conditions. Nurses' participation in decision-making when patients have critical conditions appears to be a protective factor against ethical conflicts [30]. It is important to note why nurses sometimes like the earlier death of patients, or in some cases, make the patients alive with medical interventions due to the family requests; why they are more inclined to serve the youth, and, on the contrary, the elderly are less considered. These two concepts seem to be particularly internalized in intensive care. Although it creates apparent logical reasoning for nurses, it

causes ethical challenges and internal conflicts, and thus makes nursing less humanistic and without the purpose of being good and peaceful death. Chamberlin (2019) found that useless or potentially inappropriate care was associated with neglecting patients, relatives, and colleagues, and burnout-related behavior [31]. Since, in some cases, nurses are confronted with irrational demands of the patient's family, understanding the concept of humanistic care [5] helps them make appropriate clinical decisions.

Another theme found in this study was “caring preference in young and conscious patients over other patients”. We can address one study by Khademi et al. [18] indicating the severity of disease threat, vulnerability, and weakness of supportive resources. Such conditions (age groups, such as children and the elderly, and the absence of family members at patients' beside) mean the need for careful and long-term care. Unlike the present study, this may vary based on the nurses' personality traits that are nurse-related factors in human care delivery, namely care definition, differentiation, absent nurses, analysis orientation, routine orientation, restriction, and invisibility in the hourglass model [32].

Consistent with the findings of the present study, “care preference in young and conscious patients”, one study by Laerkner et al. (2015) [33] Indicated that despite the complexity of care, nurses preferred taking care of conscious patients.

Consistent with our findings, insufficient care by nurses to meet the needs of all patients in the ICUs is a characteristic of caring stagnation. One study by Khademi et al. (2012) indicated that claims and unsuccessful self-compensation for rights occur overtime after the right violation [7]. The violation has three main dimensions, namely “caring stagnation”, “mechanical care” and “disrespect”; and patients' rights - as social rights - determine the quality and access to healthcare [34]. The rights violated in hospital settings can lead to patient/ family rights violations and care stagnation. Salazar (2016) states that many factors can lead to impersonal care in organizational or personal contexts based on the hourglass model. Humanistic care can be changed to impersonal care or vice versa depending on the orientation of nurses in caring practice and some elements in the organizational context [32].

Another finding of our study was “satisfaction with care”, which was aligned with the findings of Khademi et al. (2012). In some cases, nurses are involved with the process of unsparing responses to situations that are influenced by the synergy of education/learning and situation. In addition to satisfaction, especially receiving care benefits and rewards, it also means achieving an aspect of spiritual rights and satisfaction [18].

In line with the findings of our study about the “patient-nurse mutual respect and appreciation”, an ethnographical study by Laerkner et al. (2017) found three main themes including “a sense of ability”, familiarity with unknown situations”, and “ being conscious of their surroundings” [35]. The patients were able to interact and gain a sense of ability since the early days of the disease. They appreciated the compassionate and caring nurses who cared for them and involved them in affairs. The patients were aware of the activities around them, felt unable while being neglected by staff, and were affected by the sufferings of other patients. They were interconnected as they woke up to their inability and lack of power

alongside conflicting factors such as physical weakness, technology, location, and communication aspects.

Limitations

Since qualitative studies are dependent on the field case of study, and participants were only from a special unit, and also due to the patients' poor conditions, they could not be interviewed; hence, the researcher sought to validate the data by observing and attending the unit.

Implications and recommendations for practice

Findings and their review in the discussion section show that issues and barriers to humanization in care are situational and can vary in each society. Inadequate understanding of the patient / family and nurses of each other's needs, expectations and tasks, careing stagnation and emotional ethical decisions are the most important issues and barriers in human care in the intensive care unit.

These findings apply to health professionals and nursing managers, and can provide a good understanding of the humanistic care in the intensive care unit and will help them to determine where to start and what issues to focus on if they aim to improve the situation to improve the quality of care.

Conclusion

The findings of the present study, especially the concept of care stagnation, indicated that the humanistic care in the intensive care unit did not emerge and was not provided with its true essence and meaning. An underlying cause of this issue was the nurses and families inadequate understanding of their mutual roles, needs, expectations and even limitations of each other since it allowed nurses to consider personal and situational reasoning based on the limitations rather than on ethics and patients and attendants' needs and preferences, resulting in feeling and understanding the care stagnation. Despite this result, nurses feel an unexpected feeling contrary to the nature of care, which is satisfaction, due to experience and observation of patients' health improvement. Although this paradoxical feeling is the outcome and implication of the care process, it may be the result of changes in conditions of ICU patients.

Abbreviations

ICU: Intensive Care Unit

Declarations

Ethics approval and consent to participate

Code of ethics (IR.TMU.REC.1397.182.) was obtained from Tarbiat Modares University, and the research environment license was received. The importance, purpose and method of research was explained. The

interviews were recorded. Participants' informed consent obtained was written. Confidentiality and anonymity at all stages were met and the time and place of interviews were mutually decided. The participants were free to participate in or to withdraw from the attendance. The researcher' characteristics, and the way of access to results were explained to the participants.

Consent to publish

Not applicable.

Availability of data and materials

The datasets used and analyzed during the current study are available from corresponding author on reasonable request.

Competing interests

The authors declared no potential conflicts of interest with respect to the research, Authorship and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

Authors' contributions

All of authors initially developed the concepts with contributions. 'FH'. interacted with the participants, performed interviews, carried out transcriptions, and the initial analysis. 'EM'. & 'Mk'. conception of the study and supervised the interviews and with 'MS'. they assisted in the reviewing of the coding scheme. 'FH'. wrote the initial draft with contributions from all authors during the editing procedure. All authors have read and approved the manuscript.

Acknowledgements

The present paper was derived from a Ph.D. dissertation on nursing. We are grateful to all authorities of Faculty of Medical Sciences of Tarbiat Modares University and Qazvin Medical Sciences University, Bouali Medical Teaching Center of Qazvin, and the Intensive Care Unit Ward where the participants attended in this study.

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