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Original Article

AUTOBIOGRAPHY AFTER MYOCARDIAL REVASCULARIZATION SURGERIES: LIFE STORY AT A CARDIAC ICU

AUTOBIOGRAFIA APÓS AS CIRURGIAS DE REVASCULARIZAÇÃO MIOCÁRDICA: HISTÓRIA DE VIDA NA UTI CARDÍACA

DESPUÉS DE LA AUTOBIOGRAFÍA CIRUGÍA DE REVASCULARIZACIÓN MIOCÁRDICA: LA HISTORIA DE VIDA EN LA UCI CARDIACA

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ABSTRACT

Objective: to describe the life story (LS) of patients subjected to myocardial revascularization surgery (MRS), unveiling potential dogmas in their reporting of the journey from the pre- through the immediate postoperative periods at a cardiac ICU. **Methods:** In this field study with qualitative design we collected life stories. Patients were first interviewed at their homes, using a guiding script. The interview was recorded in mp3 format. All recordings were later transcribed for research purposes. **Results**: Due to sample saturation, of eight patients interviewed, only five were selected to participate in the study. Study participants were categorized according to qualitative variables: sex, age, religion, marital status, number of children and operative period. On the basis of these variables, we highlighted the most relevant information reported by each respondent. **Conclusion**: Experiencing a MRS may have a significant impact on physical and psychological aspects in the journey from the preoperative phase, to the surgical site and the immediate postoperative phase, especially anxiety, fear, apprehension, anger, revolt and sometimes even a lack of ability to accept a situation as it is.
Descriptors: Nursing research; Autobiography; Thoracic surgery; Intensive care units; Adaptation, Psychological.

RESUMO

Objetivo: descrever as histórias de vida (HV) de pacientes submetidos às CRM, desvelando os possíveis dogmas através das suas narrativas do pré ao pós-operatório imediato em uma UTI cardiológica. **Método**: pesquisa de campo de abordagem qualitativa por meio da coleta das HV. Foram iniciadas as entrevistas nas residências dos narradores, guiadas por um roteiro norteador e gravadas em MP3. Após as gravações estas foram transformadas em texto escrito para torná-los disponíveis para a pesquisa. **Resultados**: Foram entrevistados 08 pacientes, destes selecionamos 05, pois obtivemos o ponto de saturação. Os sujeitos da pesquisa foram caracterizados de acordo com as variáveis qualitativas: sexo, idade, religião, estado civil, filiação e período operatório, onde guiados por essas variáveis destacamos as narrativas mais importantes pertinentes de cada depoente. **Conclusão**: A experiência de vivenciar uma CRM pode trazer mudanças significativas nos aspectos físico e psicológico durante o período do pré-operatório, o caminho do sitio cirúrgico e do pós-operatório imediato, onde destacamos medo, ansiedade, apreensão, raiva, revolta e às vezes intolerância com as situações vivenciadas.
Descritores: Pesquisa em enfermagem; Autobiografias; Cirurgia torácica; Unidades de terapia intensiva; Adaptação psicológica.

RESUMEM

Objetivo: Describir las historias de vida (HV) de los pacientes sometidos a La CRM, revelando los posibles dogmas a través de sus narrativas de pre y postoperatorio en una UCI cardiaca. **Método**: Investigación de campo de enfoque cualitativo mediante la colecta de las HV. Se iniciaron las entrevistas en las residencias de lós deponente, guiadas por un cuestionario guía y grabados en formato MP3. Después de lãs grabaciones estos han sido transformados en texto escrito para que estén disponibles para la investigación. **Resultados**: Se entrevistaron a 08 pacientes, 05 de ellos seleccionados, porque hemos obtenido el punto de saturación. Los sujetos fueron agrupados según sus variables cualitativas: sexo, edad, religión, estado civil, filiación y el período de operación, donde los guiados por estas variables destacamos las narrativas más importantes pertinente a cada deponente. **Conclusión**: La experiencia de experimentar un CRM puede traer cambios significativos en los aspectos físico y psicológico durante el período preoperatorio, el camino de la zona quirúrgica y el postoperatorio inmediato, donde destacamos el miedo, La ansiedad, El temor, La ira, La rebeldía y a veces intolerancia con situaciones vividas.
Descriptores: Investigación en enfermeira; Autobiografía; Cirugía torácica; Unidades de cuidados intensivos; Adaptación psicológica.

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INTRODUCTION

The heart is popularly known as a vital organ, the seat of life, emotions and feelings. Culturally, any heart-related problem is seen as a threat that leads to emotional and physiological changes[1]. Heart surgery (HS) is a complex procedure that implicates in alterations of various physiological mechanisms and imposes great psychological and organic stress. HS can be classified into three types: corrective (related to defects of the ductus arteriosus, including that of the atrial and ventricular septum); reconstructive (for myocardial revascularization and aortic, mitral or tricuspid valve repair); and substitutive (corresponding to valve changes and transplants)[2].

Myocardial revascularization surgery (MRS) is defined as a process of restoration and preservation of vital capacities that aims at restoring a patient's physical, mental and social well-being. About 100 thousand heart surgeries were performed in 2012 in Brazil. Of these, more than 50% were associated with MRS, a significant percentage when compared to other underdeveloped countries[3].

The prospect of undergoing a MRS will frighten any human being because the heart has a cultural meaning as the organ responsible for the emotions and for controlling life. Thus, heart surgeries lead to the emotional wear-out of patients, friends and family members, because they represent a threat to the future and a readaptation to daily life[4]. After MRS, patients undergo recovery and rehabilitation. They are referred to a Cardiac Intensive Care Unit (CICU) for hemodynamic rehabilitation and risk reduction during this critical phase[1,3]. In most cases, it is the first time that these patients are hospitalized in an ICU and their expectations can be met by the care team. Nevertheless, in order for that to be possible, the patient should be cared for as a whole person, considering his/her singularities and pluralities[4-5].

Given the need to understand and intervene in situations where individuals or groups of people are exposed to different diseases, hospital Psychology has been requested to contribute in the approach to these problems, assisting other health care members in increasing appreciation of primary, secondary and tertiary mental health interventions to patients[5]. Some studies suggest that the best way to identify a patient’s problem is to recognize it and offer viable strategies to achieve possible solutions and have a positive impact on reality[6].

The care provided by health professionals and psychologists has been changing in the last decades, due to the recognition of the need to be closer to the patient, in a more intense interpersonal and psychotherapeutic relationship. During care delivery, patients receive direct care to create a bond between patients and their families, minimizing difficulties experienced by the former[1,5]. Nurses and their teams should show knowledge, accessibility, self-confidence and interest, exceeding patients’ expectations[6].

This paper analyzes the life story (LS) of CICU patients who have been subjected to MRS. Our interest in researching this topic was raised by two reasons. Firstly, as professionals, we always hear different complaints after a MRS. Secondly, there is a lack of knowledge about this subject in the databases.

Based on the above, the following study question was formulated: “To what do patients have to adapt when they are go to the ICU after MRS?”. Thus, this study aimed to investigate the physical and psychosocial impact of MRS on patients, unveiling potential dogmas in their reporting of the journey from the preoperative phase (PO), to the surgical site (SS), the transoperative phase (TO) and the immediate postoperative (IPO) phase at a CICU.

METHODS

In this qualitative, descriptive and exploratory field study[7] we used the LS method to investigate the physical and psychosocial impact of MRS on patients. The LS method proved adequate for making it possible that real experiences were revealed to the researchers through the speeches of participants. This made it possible to gain insight into the adaptation that patients undergo as a result of their condition.

This study was approved by the Research Ethics Committee of the Estácio University in Alagoas, through the Plataforma Brasil on June 18, 2014. Opinion number: 696.411 and CAAE: 229098014.4.0000.5012. We selected patients who underwent MRS between March 2010 and 2011 (time period when the greatest number of MRS had been performed). Data collection took place between July and August 2014. The study was conducted with patients who had been subjected to MRS and hospitalized in the CICU of a referral hospital in Alagoas that has 12 beds for hospitalization of “critical care” patients.

The inclusion criteria were: Patients aged 18 years or older, who spent the IPO phase of MRS in the CICU during the time defined by the study, accepted to participate and signed the informed consent form (ICF). Exclusion criteria were: Patients who were pregnant or had any mental pathology or disorder that may have been aggravated by participation in the study.

After analyzing medical records and collecting addresses and phone numbers, we found that 20 patients met the inclusion criteria. Of these, only eight agreed to participate in the study. The interviews were scheduled to take place at the patients' homes. The data were collected through interviews guided by a semistructured questionnaire with nominal qualitative variables (sex, religion, marital status and age) and ordinal qualitative variables (PO, SS, TO and IPO)[7].

A family member of choice by the patient and the entire research team (a social assistant, a cardiologist, an ICU nurse, a psychologist and a nurse undergraduate student) were present during the interview. All participants gave their consent to record the interviews (using a Sony[R] MP3 player).

Due to sample saturation[8], of eight patients interviewed, only five were selected to participate in the study. Saturation point was reached as no new information was being obtained. All recordings were later transcribed for research purposes. Transcription was performed in two steps: Transcription itself (written copy of spoken material) and transcreation (final version of the text, signed by the interviewees)[9].

The data were analyzed using content analysis. After the steps described above, we performed: a) a pre-analysis (we made a floating reading of all validated speeches and organized them); b) analysis (thematic analysis of the texts); and c) interpretation (the writing of the manuscript, explaining the results found and including the questions of and answers to the guiding script)[7].

RESULTS AND DISCUSSION

The qualitative analysis[7,9] of participants' LS revealed the meanings that patients gave to the experience of undergoing MRS. These meanings are shown as short text fragments of the answers given to the questions of the guiding script used in the interviews. Next, we present these fragments, their unveiled meanings and a discussion based on the literature.

Five patients were included in the study: Three females and two males. To ensure patients' confidentiality, all participants were named as PCT plus a number from one to five. The LS of patients who had undergone all three phases of MRS (PO, SS and IPO) were analyzed according to their profiles. The table below shows these results:

Table 1 – Patients' profile according to qualitative variables, Maceió, Alagoas, Brazil, 2014.

Pct	sex	age	marital status	children	religion
01	F	51	Married	02	Practicing Catholic
02	F	45	Married	01	Evangelic
03	F	35	Married	00	Spiritist
04	M	57	Widowed	03	Nonpracticing Catholic.
05	M	49	Married	02	Buddhist

Source: Research data, 2014.

MRS is a process of restoration and preservation of vital capacities that aims at restoring a patient's physical, mental and social well-being. It is also a complex procedure that involves the alteration of several physiological and psychological mechanisms[10]. It is essential that the health care team has knowledge about the feelings and reactions of patients with critical diseases who undergo surgical procedures, as this information may help these professionals provide a more humane and systematized care[11].

The LS method allows us to obtain information on the subjective essence of a person´s life, because there is no better way of obtaining information on a person´s experiences and perspectives than hearing them tell their stories with their own voice[9]. This method uses personal trajectories in human relationships, in order to get information about the personal life of one or several respondents. Consequently, it provides a wealth of detail on the subject, gives respondents the freedom to speak freely about their personal experiences and what is being asked by the interviewer[11].

For some people, having to undergo a critical surgical procedure is synonymous with receiving a death sentence, a threat of broken dreams. The whole universe of meanings and wishes that used to give sense to life starts to be subjectively questioned, creating an internal and external conflict[5]. These conflicts can only be measured through qualitative research, because it gives voice to research participants, allowing them to reveal their own LS.

How did you feel when you found out that you might be subjected to a MRS?

According to the study[12], when patients received the news that they were going to have undergo a MRS, they experienced many different feelings, such as: apprehension, fear, concern, dismay, anxiety, distrust, nervousness. This is shown in the interview fragments below:

PCT 01:"...My world fell apart, I never thought this could happen to me..." (Looks up and silences)

PCT 04:"...That was a chock and I felt numb, words failed me, then the scene going on in my head, I thought about dying and leaving my chidlren..." (Laughter and tears).

PCT 05:"...Fear, because I´ve always been the strong one, never got sick nor went to the doctor, so much so that I did not tell anyone that I was going to see a heart surgeon, I felt like a super hero and I just had to accept my fate..." (Speaks slowly, looking down).

Patients with indication for cardiac surgery react differently to the news and cope in various ways. It is important to emphasize that the sensibility and vulnerability shown by people faced with this situation differ, as well as their interpretations, reactions and evaluations[13]. As can be seen below, for the same question, we received different reactions and answers:

PCT 02:"...I was so angry with God and thought I might die and leave my family, I´ve always been a good daughter..." (Cried)

PCT 03:"...I was at the doctor's office with my husband and he took my hands and told me everything was going to be okay, at that moment I felt like I was the strongest woman in the world..." (Sighs and pauses)

The analytical and systematic course of an LS has the purpose of making possible the objectification of a type of knowledge that has as its raw material opinions, beliefs, values, representations, relationships and human and social actions from the perspective of patients' intersubjectivity[9].

We found to be of paramount importance for the multidisciplinary healthcare team to aggregate scientific and technical knowledge and understanding about the needs experienced by the patients, since it is through this that these professionals intervene and optimize the provision of systematized care, ensuring the delivery of quality care to patients in the PO, TO and IPO phases of MRS[14].

Since the MRS, in addition to being traumatic to the body, is also associated with an immediate risk of death, a patient's individual and social perception of the sequelae arising from it is also brought into relation with the cultural value of the organ that is going to be operated. Thus, the value of life and all emotional manifestations are colloquially associated with the meanings given to the heart as the seat of these functions[2, 14]. Still analyzing the PO phase, but more specifically the surgical center, we will now describe some of the thoughts of patients who underwent MRS.

What were your thoughts and feelings when you entered the surgical center?

PCT 01:"...I cried, felt a chill and was trembling, my children held my hands, comforting me, but still I felt scared of dying..." (Eyes wide open whilst speaking)

PCT 02:"...I thought about God, mu hands were shaking, my blood pressure went up, but my whole family was supporting me..."

PCT 03:"...The day has come, I thought... I was nervous and thought, If I die today God will not have been fair with me, because there were so many things I still had to do in my life and I was so young and wanted to become a mother..."

PCT 04:"...I saw my children and my parents support me, and remembered my wife who had passed away three years earlier, my whole life started flashing before my eyes, but I had to stay centered, because my parents were old and they were very worried. I looked up and called for God..."

PCT 05:"...I felt a chill in the stomach, a feeling I was going to die... My children, my wife and my siblings walked by my side up to the entrance of the surgical unit, I thought about running away, screaming and even crying, but I held everything inside, because men don´t cry..."

Some authors state that it is essential to identify the feelings and coping actions used by

patients from the preoperative phase to the surgical center, as more positive and proactive behavior can be reinforced instead of unorganized/chaotic behavior[12].

The main strategies used by patients to cope with MRS are based on the support and presence of their families, the quality of interfamilial relationships and spiritual resources[3]. We found that the presence and support of their families are very important for patients in critical situations such as MRS. This finding is ratified by the answers given by participants to the last question above.

With regard to religion, one of the spiritual ways of coping with a serious illness, we found the following answers;

Did your religion help you in any way during the preoperative phase?

PCT 01: ...A little, but at first I was angry and kept asking why me?(said energetically)

PCT 02:"...I fervently prayed to Jesus, but my anxiety was taking over me.."(interrupted her speech for a few seconds and then continued)

PCT 03:"...Yes, of course, it helped me move on, because nothing happens by chance... I confess that first I was angry, but I eventually learned to accept my fate..."

PCT 05:"...A lot, it was my foundation, my support pillar..."

The experience of having a serious disease causes suffering and leads patients to seek for a meaning to try and make sense of the situation, as it can often be confusing and exhausting for them[3, 15].

For the same question mentioned above, one of the respondents gave an answer that differed from the others, namely:

PCT 04:"...I bargained with God, told him I would donate food for the rest of my life if I didn´t have to undergo surgery, because it made no sense having to go through this situation... (Cried while talking) I stopped, thought about it and realized it was necessary, then I asked God to help me..."

Investigations in the field of health have been seeking to achieve a greater approximation with the subjects of the study, trying to listen to them, and not only treat them as mere objects of research, in an impersonal and cold relationship[14-15]. In this sense, the LS method makes it possible for researchers to learn to listen to subjects who experienced a situation that they would like to investigate. An implication of this is that study subjects are seen as partners who play an active role in the study and reflect about their own lives. Respondents' reflection, which reveal very private and intimate issues, is the most basic difference that appears in the categories of scientific analysis[9, 16].

To do science is to work simultaneously with theory, method and techniques, in a perspective in which this tripod is mutually conditioned: the "how" depends on what the object demands, and the response to the object depends on the questions, instruments and strategies used in data collection. In addition to the trilogy, the quality of an analysis also depends on the art, the experience and the capacity of in-depth analysis possessed by a researcher, who gives the tone and the "spices" to the work he/she is elaborating[5, 9].

The MRS may represent a new reality that is suddenly imposed on patients and distresses them, requiring a reorganization ability that is not always readily found and effective, leading to changes in self-image, making them fear for their future health as well as daily dependence[15].

After MRS, there is a phase of recovery and rehabilitation. The goal of cardiac rehabilitation is to improve cardiac capacity and quality of life by controlling coronary risk factors, reducing the likelihood of recurrence and decreasing morbidity and mortality[17]. The patient is referred to the ICU, which is intended to provide care to clinically severe patients, who usually go prolonged hospitalizations and invasive procedures, such as central venous catheters for serum therapy, indwelling bladder probes, chest drain, and invasive mechanical ventilation via endotracheal cannula[18].

In most cases, it is the first time that these patients are hospitalized in an ICU and their expectations can be met by the healthcare team. When they are admitted to the ICU, they are still under the effect of anesthesia. They experience a change in their way of living and understanding the health-illness-recovery process. This trinomial creates a conflict to the patient, because he has gone through a traumatic moment[5, 18].

Given the above, we asked participants about the IPO phase, as shown below:

How did you feel and what was your first thought when you woke up in the ICU after undergoing surgery?

PCT 01:"...I woke up in the ICU, a person told me to keep calm and informed me that

everything had gone well... I had terrible pain in my stomach, on the chest and on my back... I felt confused (sleepy), I could hear all the information but felt drowsy... I was extremely thirsty and missed my family..."

PCT 03:"...I thought I would not survive, but I did survive. I had terrible pain on my chest and back... Thirst... I wanted to see my relatives and my husband... I thanked God for everything..."

One of the main complaints of ICU patients after MRS (accounting for 35% of findings) is that they have to stay away from their families[19]. ICU patients and their families give a cultural meaning to this hospital unit, as it is considered by people as a unkown and scary place[14, 19].

PCT 02:"...I opened my eyes and I was in a crowded place, later I found out it was the ICU, and something was preventing me from breathing, I felt distressed, imagined I was dying, but someone told me to keep calm and that everything had gone well... I thanked Jesus and shortly after I wanted to see my family..."

PCT 04:"...I woke up and my arms were restrained, I felt like I had drank a lot and I imagined it was all just a dream after having some whisky shots (laughs)... Then someone took my hand and told me I was in the ICU, I felt safe, protected, and asked them to release my hands... I wanted to see my children, my parents and my siblings... I was so happy I forgot to thank God..."

The IPO phase of a MRS is filled with feelings of insecurity, loneliness, fear and helplessness. This and the distance from their relatives and friends lead patients to look not only for healing, but also for security, affection and solidarity in the health team[20]. This could be noted in the speeches from PCT 02 and PCT 04.

Thus, given the different emotional reactions often shown by patients at different moments of hospitalization, we found that it was important to get to know the perspective of patients with regard to their experiences during this period and what they felt as significant[20].

PCT 05:"...I woke up at the ICU with a tube in my mouth... My hands were tied, later I took those tubes off... They put me on oxygen, censured me and told me that the tube could only be taken off by medical orders... But I didn't care... I felt like a tied animal... I missed my relatives, had chest pain and felt like crying..."

Some of the goals of the multidisciplinary team in the preoperative phase are to prepare the patient for surgery and reduce his/her anxiety. Patients should always be approached and taught individually and this counseling should aim at reducing the fears that contribute to patient anxiety at this moment. These fears usually are: fear of the unknown, of death, of the anesthesia, of changes in one's body image, and of the ICU, which is seen as a synonym of death[12, 17].

A hospital ICU has a set of functionally grouped elements intended for the care of severe or hemodynamically unstable patients who require uninterrupted medical and nursing care, as well as specialized equipment and human resources [18]. The ICU environment is seen as the main triggering of fears and apprehensions in the IPO phase. The ICU is considered to be a strange and scary place, filled with many different sounds and smells, that disrupts the emotional and psychological equilibrium of the patient just by being named[20]. From this point on, patients were asked a different question, as seen below:

How did you feel when you woke up in the ICU after surgery?

PCT 01:"...I felt like a winner, but my chest and my back hurt... Having to lie on one's back is terrible, as well as going up and down with the so called CVP catheter... The best moment was when I saw my children..."

Central venous pressure (CVP) is used in the hemodynamic follow-up of critically ill patients. It is assessed and zero degrees to monitor right in zero-degree, with the patient in dorsal decubitus. CVP catheters monitor right atrial pressure and body volume[6, 18].

PCT 02:"...I felt relieved when they removed the tube from my throat... I also recall Physical Therapy, the pain I felt doing those exercises, then ...I waited for the visit ... I always thanked God, everything was going well..."

PCT 03:"...I asked for water and a young woman always answered like: you're not allowed, I wanted to kill her (laughs)... I was so thirsty... Then I was finally allowed to drink some water, but I drank too much and ended up throwing up and as I threw up, the pain got more intense ... But what always cheered me up was when I had visit from my family and I´m glad they were allowed to visit twice a day..."

In line with the speeches above, in the literature it is stated that patients see the ICU as a scary place where they often become emotionally destabilized, as they supposedly associated it with severe diseases and risk of death[1].

PCT 04:"...It´s awful to depend on others... The worst thing for me is that I even had to ask for water... The pain was so intense... The damned CVP catheter, damned gout (laughs)... There was a thing coming out of my breast and left lung, a while later I found out that that was a drain... I was feeling nervous on the second day..."

PCT 05:"...After they took out that tube from my throat everything started going well... I felt pain in my chest and on my back... Those drains hurt a lot and having to move up and down the bed to perform the CVP test... Although they told me that I was fine and should stay calm, I felt anxious and bored..."

The clinical experiences and the behavioral changes experienced by patients who go through specific treatments led to the institution of measures for the assessment of responses based on patients' profiles, since cardiovascular diseases and their surgical treatment may represent a new reality that is abruptly imposed and emotionally distresses the patient[11].

Moreover, having to stay away from their families and in this unknown environment called ICU may make patients feel helpless, and this, in turn, may be related to the loss of environmental control[5, 11]. It is worth emphasizing that nurses, psychologists and physicians play a fundamental role within the health units, because it is through the assessment of the patient that the survey of various phenomena can be carried out, either based on the external appearance or in the subjectivity of a human being's multidimensionality[21].

The life trajectory of each interviewee is therefore the gateway to the reading of their speeches, and the analysis of the latter begins when it becomes necessary to interpret the report provided by the interviewee and its importance to society[22].

We found that experiencing a MRS modifies the life process of cardiac patients, whereas the strategies used to cope with this process make their experience less traumatic and provide a theoretical basis for health care[3]. Knowing how patients react to MRS in the ICU is essential for the multidisciplinary healthcare team, because this knowledge can give professionals a basis to support their actions in providing a humanized assistance, based on a care planning approach[13].

Nurses' care plan are extremely important, since it is geared towards the care of patients who underwent critical procedures, and is a measure for the prevention and control of complications/problems that may contribute to safe nursing practices, based on the individual needs of each patient[23]. For this to be possible, patients should be cared for holistically, respecting their uniqueness. In addition, the delivery of care should incorporate the values, hopes, cultural aspects and concerns of each patient, because each individual is unique and has his/her own specific needs, expectations, values and beliefs[23].

When a subject constructs or reconstructs his/her narratives through their LS, he/she makes a self-analysis, enabling the creation of new bases of understanding. The researcher, on the other hand, needs to build complicity to facilitate the dialogical relationship, so that it is possible to perceive a double discovery as "the others" are revealed by their speeches, and the phenomena are automatically being discovered and unfolded in ourselves[16,24].

CONCLUSION

The analysis of respondents' speeches showed that experiencing a MRS may have a significant impact on physical and psychological aspects in the journey from the preoperative phase, to the surgical site and the immediate postoperative phase, which answers the guiding question of the study.

The situations reported by the patients as significant in the PO phase were: the surgical procedure, family support, fear of death, anxiety, revolt, social dependence and the fact of living a new experience. On their way to the SC, patients report the same feelings, but also emphasize the emergence of their faith and the fear of death. In the IPO phase, patients reported the following feelings/behaviors: suffering, anxiety, anger, helplessness, loneliness and fear. Of note, the study participants were unaware of some facts that are inherent to the IPO phase, such as the fact that they have to fast for about six hours after the endotracheal cannula is removed, which explains their complaints of thirst; others reported drains emerging from their bodies or that they had to move up and down to have their central venous pressure measured every hour, i.e., they did not know how the IPO phase in the CICU would be like. It is important to stress, though, that, for personal reasons, these patients did not participate in the MRS preparation group offered in the referred hospital.

Teams who work in the ICU should be prepared to identify situations that may cause conflicts to the patients, not only during hospitalization but also after hospital discharge, because, as we found in this study, these patients rely on the support provided by these healthcare teams, and especially on that provided by nurses.

Moreover, we believe that it is important to conduct other studies to assess how well prepared ICU team members are to assist patients and families, focusing not only on surgery from a biological point of view, but also on the experience of living this situation from the perspective of the people involved, i.e, the patients and their families.

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