



Original Article

UNDERSTANDING THE MEANING OF OLD HUMAN BEINGS LIVING THEIR AUTONOMY IN HOSPITALIZATION*

COMPREENENDO O SIGNIFICADO DO SER IDOSO VIVENCIANDO SUA AUTONOMIA NA HOSPITALIZAÇÃO

COMPRENDIENDO EL SIGNIFICADO DEL SER ANCIANO VIVENCIANDO SU AUTONOMÍA EN LA HOSPITALIZACIÓN

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The aging population is a challenge to society and health professionals. This qualitative study aimed to understand the experiences of the elderly in relation to their autonomy during hospitalization. We interviewed eleven seniors, who were hospitalized in two hospitals in the northern Rio Grande do Sul between April and October, 2010. Data were collected through interviews and analyzed based on the phenomenological reference. The results highlighted the experiences and meanings of hospitalization, and built the categories: experiencing vulnerability, living with professional paternalism and becoming aware of the relative autonomy. From the categories, a phenomenon emerged: Emerging vulnerability and dependence on professionals as limiting the autonomy of the elderly hospitalized. The results encourage professionals to seek new care strategies in order to allow the elderly to exercise their autonomy during hospitalization.

Descriptors: Aged; Frail elderly ; Vulnerability; Hospitalization; Nursing.

O envelhecimento populacional é um desafio para a sociedade e os profissionais da saúde. Estudo qualitativo com o objetivo de compreender as experiências do idoso em relação a sua autonomia durante a hospitalização. Foram entrevistados onze idosos que estiveram hospitalizados em dois hospitais do norte do Rio Grande do Sul entre abril-outubro de 2010. Os dados foram coletados por meio de entrevistas e analisados com base no referencial fenomenológico. Os resultados destacaram as experiências e significados da hospitalização, sendo construídas as categorias: vivenciando a vulnerabilidade, convivendo com o paternalismo profissional e conscientizando-se da autonomia relativa. A partir das categorias, originou-se o fenômeno: Emergindo a vulnerabilidade e dependência dos profissionais como limitante da autonomia do idoso hospitalizado. Os resultados estimulam os profissionais a buscarem novas estratégias de cuidado, a fim de permitir que o idoso exerça a sua autonomia durante a hospitalização.

Descritores: Idoso; Idoso fragilizado; Vulnerabilidade; Hospitalização; Enfermagem.

El envejecimiento poblacional es un reto para los profesionales de salud y la sociedad. Estudio cualitativo, cuyo objetivo fue comprender las experiencias de ancianos en relación a su autonomía durante la hospitalización. Se entrevistaron once ancianos internados en dos hospitales en el norte del estado de Rio Grande do Sul, Brasil, de abril/octubre del 2010. Los datos fueron recogidos mediante entrevistas y analizados por medio del referencial fenomenológico. Los resultados revelaron las experiencias y los significados de la hospitalización para los ancianos, y surgieron las categorías: experimentando vulnerabilidad, conviviendo con el paternalismo profesional y autoconscientizándose de la autonomía relativa. Se destacaron la vulnerabilidad y dependencia como limitantes en la autonomía del anciano hospitalizado. Los datos obtenidos en este estudio instan a los profesionales a buscar nuevas estrategias de atención para que ancianos hospitalizados se empoderen de su autonomía.

Descritores: Anciano; Anciano frágil; Vulnerabilidad; Hospitalización; Enfermería.

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INTRODUCTION

Since 1950, in most of the world, the life expectancy of people has increased in two decades, that is, from 48 years in 1950-55 to 68 in 2005-10. During the first half of the century, the United Nations projects that the global life expectancy will increase to 76 years⁽¹⁾. In this sense, the population's aging is a triumph and, at the same time, a challenge for society and for health professionals who have the opportunity to socialize and share experiences with older people.

Rio Grande do Sul, the state with the highest life expectancy in Brazil, has a tendency to increased longevity, since the average life expectancy at birth rose from 63.6 years in 1971 to 69.2 in 2004, for men, and from 70 in 1971 to 77.4 in 2004 for women. Regarding indicators of mortality in the elderly, we found an increase of 45.4% in 1980 to 66.0% in 2005⁽²⁾.

With the growth of the elderly population, there were specific health policies for this age group. In 1994, the National Health Policy for the Elderly was enacted, which aims to ensure the social rights of the elderly, including the promotion of autonomy, especially in the context of health services. Subsequently, this document was updated in 2006 and named National Health Policy for the Old Person. It expanded the scope of the promotion, integrated care, provision of resources, social participation and control, and training of professionals aimed at achieving a comprehensive care to the elderly⁽³⁾.

Older people can be affected by diseases and non-communicable chronic diseases, which require monitoring by a multidisciplinary group on health services and often hospitalization. During hospitalization, the autonomy of the elderly may become narrower due to the rules and routines governing the conduct of care

in hospitals. The vulnerability and fragility associated with the highly technological hospital environment, and the insecurity due to the disease process, restricts the elderly in their activities, reducing even more their judgment ability.

It is understood as vulnerability the chance of exposing people to illnesses as a result of a number of biological/individual, collective and programmatic/institutional aspects which bring greater susceptibility to infection and disease and so inherently greater or lesser availability of resources of all orders to protect themselves from both⁽⁴⁾.

The frailty among seniors has multidimensional character, since it is known that it is related to age, but not uniformly present in all subjects. It is due to biological, psychological, cognitive and social factors arising from the physiological aging process (senescence) and pathological (senility), as well as adverse conditions such as functional dependency, institutionalization and falls. The vulnerability and fragility that lies in elderly patients may lead to loss of individuality, hindering even more the exercise of autonomy and decision-making about their care and treatment. However, the frail elderly may have their autonomy and independence encouraged at an early stage, preventing disabilities⁽⁵⁾.

It starts from the perspective that there are two essential conditions for autonomy: freedom and action. The freedom is related to the independence of control of influences and, the action refers to the ability to act intentionally. An autonomous individual acts freely in accordance with a plan of their own. A person with diminished autonomy, on the other hand, is at least in some respect, controlled by others or is unable to deliberate or act on their desires and plans⁽⁶⁾.

Therefore, the need to discuss professional practices and relationships of care present in hospitals in relation to the autonomy of the elderly arises. So, the question is: what is the significance for the elderly of their autonomy experienced during hospitalization?

From the overview presented, the objective of the study was to understand the experiences of the elderly in relation to their autonomy during hospitalization.

METHODS

The method chosen was the phenomenology which allows the understanding of the human being, from their life experience, and how it shows in their relationships⁽⁷⁾. Understanding the meaning of autonomy for hospitalized elderly patients should not come from preconceived ideas or assumptions established. The professional, after entering the world of the subjects who face this experience, can uncover hidden meanings and, these are not recognized in daily hospital care.

Phenomenology is an approach that significantly enables our understanding of the phenomena that pervade the human living. So, thinking about the human being and the existence under this approach allows, therefore, expanding knowledge construction. A phenomenological research is directed to the discovery of the meanings of experience and from the revelations coming from the perception that participants have about living.

One used the existential phenomenology⁽⁷⁾ whose objective is the perception of the subject who faces the experience. This method seeks to understand the meaning of the object of experience to the consciousness and the intentionality of the other to reposition it in the world⁽⁸⁾. The unveiling of the sensations that involve the whole body-soul reveals what is unknown, and this revelation leads to a better

understanding of the human being and his existence. The human being externalizes actions, gestures, expressions that act as mediators between experience and consciousness. Also, one has to consider that the silences and gaps say something too⁽⁷⁾.

In the method, one can highlight the perception that describes the world experienced by the subject exactly as it appears, without the desire to offer abusive explanations. At this point, the description of the conscious experience lived becomes real. From this perspective, every consciousness is consciousness of something, so that everything that is perceived by consciousness is understood by phenomenology as a phenomenon, to which is given a meaning at a certain moment by the consciousness that generates meaning⁽⁷⁻⁸⁾. The second phase, description, seeks to understand the perceptions previously experienced. And the last, intentionality, existential phenomenology comprises conscious experience as a worldview. So it is not simply a passive description of the situations encountered, but a description given to understand how they happen and unite the human being to the world⁽⁷⁻⁸⁾.

One interviewed eleven seniors who were admitted to two hospitals in the northern state of Rio Grande do Sul, and the data collection period was from April to July, 2010. The first scenario was a large general hospital, reference at SUS and highly complex which serves a population of approximately two million inhabitants, totaling 580 beds for admission. The second was developed into a medium-sized hospital, regional referral center which meets a demand of patients from the city and the north region of Rio Grande do Sul and Santa Catarina, with a capacity of 364 beds.

The initial approach occurred during the hospitalization of the elderly, which could not be less than five days. It was determined that this time of

admission would be enough to give the elderly the opportunity to maintain an interaction with professionals who work in this context, learning the routines, rules, forms of care, and make a choice.

The interviews were conducted in the homes of patients after discharge, and date and time were agreed by the parties involved in this process. Before the interview, which had an average duration of around 60 minutes, there was the signing of the consent form, in two copies, staying one with the researchers and the other with the participant. The development project was approved by the Ethics Committee on Human Research of the Universidade de Passo Fundo with the opinion No. 258/2009. The confidentiality of the depositions of the study participants was preserved through codes composed by the letter "P" for "Participant", followed by an ordinal number corresponding to the interviews (P1, P2, ..., P11).

From the participants' permission, the interviews were recorded, decoded and validated by the study subjects. The data analysis was performed by integrating reading, identification of possible meanings, detection of thematic elements, rereading of significant expressions, extraction of meanings and unveiling of the phenomenon. The process of understanding the phenomenon was undertaken based on the analysis of the speeches and on the light of phenomenology⁽⁷⁻⁸⁾, which allowed the revealing of the meaning of the experience of autonomy in the hospital from the perception of older people, bringing up the meaning of lived experience.

RESULTS

The study included 11 subjects aged between 62 and 78 years, seven were male and four were retired. They were hospitalized due to demands of clinical and/or surgical care. Figure 1 summarizes the main sociodemographic characteristics of the study participants.

Participant	Gender	Age	Profession	Reason for hospitalization
P. 1	F	78 years	Retired	Metabolic disorder
P. 2	M	62 years	Retired	Arterial Occlusion
P. 3	M	66 years	Retired	Surgery radical gastrectomy
P.4	M	66 years	Farmer	Valve insufficiency
P. 5	F	74 years	Housewife	Thyroidectomy surgery
P. 6	M	66 years	Civil servant	Chronic renal failure
P. 7	M	72 years	Retired police officer	Pneumonia.
P. 8	M	69 years	Civil servant	Pneumonia.
P. 9	M	62 years	Lawyer	Prostatectomy
P. 10	F	68 years	Housewife	Cholecystectomy
P. 11	M	64 years	Farmer	Cardiopathy

Figure 1 – Characteristics of study participants in relation to sex, age, occupation and reason for admission. Passo Fundo, 2012.

Upon rereading the speeches of the participants, one found three categories and eleven subcategories.

The phenomenon was entitled: being aware of the condition of vulnerability and dependence on

professional paternalism, as limiting the exercise of autonomy in hospitalization. The following categories

were found in the study:

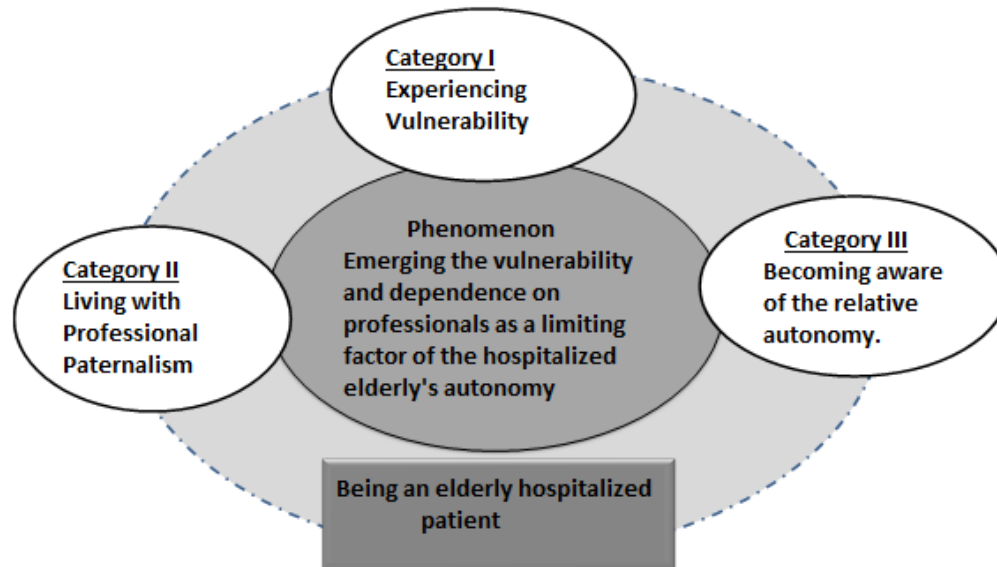


Figure 1 - Categories and phenomenon: Emerging vulnerability and dependence on professionals as limiting the autonomy of the hospitalized elderly. Passo Fundo, Brazil, 2012.

In the first category, **experiencing vulnerability**, one could grasp on several sentences said by the hospitalized elderly, the appearance of vulnerability associated with frailty, arising from ignorance of the process and insecurity experienced, and little autonomy during hospitalization, as it can be seen in the following statements: *We cannot decide. The patients feel more incapable alone, more fragile, they are always depending, they know the nurses are there, but they also do not want to be totally dependent* (P2). *At the hospital, they do to us whatever they want, our life is nothing. We have to accept, because we depend on others and still more in this moment of weakness and frailty because of the illness. I have no desire to ask for and decide about things* (P6).

In the second category, **living with professional paternalism**, the place designed for care provides the excessive appreciation of technical aspects, which promotes paternalism to the patient, because many times, the elderly are not consulted on decisions

and care provided. The professional paternalism refers to the failure to provide the patients with basic information about the disease process that involves their being: *No, I was not given any options. He said he would not do a biopsy for not hurting me and that the situation there was to do surgery. When he said that, I said, 'Again!'. And I started crying. I asked if there was time for my children to come. But they know what they do* (P6).

In the passage above, the unilateral decision exercised by the health professionals in hospitals, strengthening paternalism: *At the time of hospitalization, I was not notified, my daughter was. Although I'm aware, they did not tell me anything. They never told me why I was hospitalized, I do not remember that* (P4).

In the category **becoming aware of the relative autonomy**, the elderly participants of the study demonstrated to be resigned about their decision making and free will when it comes to health. The reports demonstrate the delicate handling of situations

of relative autonomy mediated by institutional strength.

Autonomy depends on the type of problem you have, often we do not have any clarification, we know nothing and cannot say anything. It is not easy to practice that autonomy in an unknown environment. There are laws, rules to follow and a behavior, for each type of problem one follows the paths already defined. I think the autonomy of those who are ill is very little, or maybe none (P8).

In the speech above, one highlights the relativity of autonomy of being, when they are in a state of ignorance of the facts, away from their *status quo*. About the perception on their own autonomy, there is the following statement: *I think I can make decisions within the hospital, but it is difficult to know how, we have no chance (P10).*

In this speech, the patient believes he can make decisions, but does not consider it viable because opportunities do not appear. Besides the relativization of autonomy, professional paternalism and power of hospital infrastructure as barriers in this exercise come again.

In contrast, preserving their autonomy entails respect to their will, as well as respect for their beliefs and their moral values. The following speech reinforces the interference of professional paternalism in the patient's autonomy: *Autonomy we have when we are informed that somebody will come and say: 'Look, you have this, you will be treated for that and we'll have to take care of you this way, administer these drugs.' It was not like that, it was never anything detailed, they were groping and groping and never told me anything (P1).*

In this sense, in another speech a senior says that, in the hospital environment, there is a "depersonalization", placing himself at the disposal of others for decision making: *There, in that environment, my personal characteristics died, they do not exist. It was useless the will to decide. The one who knows does it, the one who doesn't stays available for the other (P3).*

The condition of vulnerability due to frailty and disability is a limiting factor of autonomy in hospitalization of the elderly. Thus, this condition shows a relative lack of protection of the elderly, because it

lives temporarily "outside" the process of hospital care and before potential damages, injuries and health hazards.

This is the demonstration that in terms of awareness of the vulnerability of the elderly as a reflective action about themselves, their illness and their actions, suffer significant changes during hospitalization. Consciousness as an identity of every human being is constantly changing and adapting, and it judges existing values and encourages the construction and reconstruction of a new way of living in these conditions of instability in the health of elderly human beings.

DISCUSSION

Hospitalization for the elderly becomes part of a specific, strict, limited scenario, making them more vulnerable, dependent and frail to the situation experienced. The standardization of care and institutional routines and the difficulties that arise in hospitals cause limitations that reduce the autonomy of the patient.

The vulnerability is externalized when the patient experiences the hospitalization, because during the period of hospitalization humans are vulnerable, living a unique experience, which can lead to a rupture in the relationship between human beings and the world. In this sense, the caregiver must exercise its functions to reduce this situation and maintain the autonomy and dignity of the human condition in hospitalized patients⁽⁹⁾.

This condition should be understood as a contingent of the fact of being alive. Thus, it goes beyond a specific condition or situation to get closer to cases sometimes milder, sometimes more intense or abrupt present in human living. Develop themselves in a *continuum* traversed by biological, affective, emotional, genetic, political, subjective aspects, in a multitude of

dimensions that cannot be separated or fragmented into categories. Therefore, the vulnerability is relevant to the process of human life at all times, including during hospitalization⁽¹⁰⁾.

In this line of thought, vulnerability causes the loss of power and consequent reduction in control of situations. It means that the person becomes controlled by, rather than controls, triggering feelings and sense of helplessness, incompetence and fear. When they fell ill, people are not just vulnerable, but susceptible to a possible worsening. Thus, physical, mental or intellectual disability is an aspect of vulnerability, which characterize the situation of dependence. Thus, vulnerability, dignity and integrity are descriptive characteristics of human beings and, although not normative themselves, are fundamental to inspire ethical requirements. The vulnerability is therefore an important benchmark in bioethics and it is independent of autonomy, justice and other references, although they are inextricably intertwined⁽¹¹⁻¹²⁾.

The vulnerability of sick human beings fosters the dependence of patients that need care in the hospital context⁽¹³⁾. In this sense, it is worth stressing that autonomy involves freedom of action, speech and thought of the individual, with the possibility of broad range of political, legal, civil and human rights constituting the philosophical basis of the human being, it can resist the coercive interference of external powers in their lives. This concept of autonomy includes independence, self-determination, the ability to make free decisions, and competence to make the assessment of what constitutes the best interest and will of the individual⁽¹⁴⁾. It can also be understood as the state of being able to establish and follow rules⁽¹⁵⁾.

In this way of thinking, the findings of this study that indicate the close and sensitive relationship

between elderly humans in conditions of vulnerability and dependency during hospitalization will meet earlier work on the subject^(14, 16-17).

The understanding about the experience of hospitalization of elderly patients, allowing both the apprehension and interpretation of things and the world around them, as the entry in their world, knowing them and guiding them through the process of care that enables the other (patient) to realize the true presence of the professional⁽¹⁶⁾. Thus, the understanding starts to guide this process allowing the unveiling of feelings and needs of the person receiving care.

In the multidimensionality of care, it is important to value the human being as a whole, because people want to receive care and to be treated with dignity, and not only to have identified diseases or diseased body parts. It is necessary to rescue the humanistic values in health care. Thus, it is necessary to listen to people who experience the process of care in the hospital setting⁽¹⁸⁾.

In the organizational hospital system, nursing professionals develop their actions based on rules and routines, which can hinder the possibility of space for the exercise of the citizen's autonomy, human being hospitalized, and often ends up limiting their decision-making, inducing their passivity in regard to their health⁽¹⁷⁾. When there is disagreement of thoughts and desires, the patient's validity of decision is usually placed in doubt. In practice, there are few alternatives offered, except the ones that are standard. Again, there is the notion that the hospital environment constrains the possibility of decision. Without options, the alternative is to follow the standards, rules, or a "discipline" seen as necessary for the proper conduct of care.

Thus, one points up the need for health professionals, besides understanding aging, also to recognize that their attitudes can aid in maximizing the

autonomy and independence of the elderly. For doing so, ethical values and communication in the care of hospitalized patients are fundamental, and they involve consideration of actions that respect the dignity and privacy of the elderly, which grants them freedom of choice and decision, the use with quality and attention of time in the interaction, gestures of motivation, which are strategies that contribute to the organization's environment so that the elderly feel inserted in the context, participate in activities and, therefore, are active⁽¹⁹⁾.

This does not mean to take autonomy to its extreme and convert it into an absolute principle without exceptions, which may lead to aberrations not smaller than beneficent paternalism. The common well requires, therefore, free decisions of individuals. From this perspective, only with the principle of autonomy, one cannot build coherent and responsible ethics. The reason sometimes is supporting beneficence and not supporting autonomy. And many other times it lies between these two principles, between pure beneficence and pure autonomy. Hence the need for a third principle that makes mediation between them: it is the principle of justice to people⁽²⁰⁾, which represents a possibility to be considered and valued by health professionals.

CONCLUSION

The study made it possible to reach the proposed objective to understand the experiences of the elderly in relation to their autonomy during hospitalization. The close and sensitive relationship between elderly human beings hospitalized in conditions of vulnerability and dependence was revealed, as factors limiting the exercise of their autonomy. The results highlighted the experiences and meanings of hospitalization, and the categories built were: experiencing vulnerability, living

with professional paternalism and becoming aware of the relative autonomy.

This theme is set in a complex way, immersed in a subjective and dynamic scenario, which requires further research and knowledge production towards care and well-being. The care to the vulnerable patient permeates the technical sphere and must necessarily rescue the dignity of the elderly patient in a way to grant security essential for the disruption of stigmas that give full powers to the caregiver.

The use of the phenomenological method in the study allowed us to understand the sense of vulnerability and dependence imbued in the hospitalization process. Understanding this situation can redirect congruent actions between professionals and patients, permeated by reciprocity and balance between bilateral rights and obligations.

A longing of human beings is to be recognized and feel valued. During hospitalization, this longing is even higher, because usually comes together with ignorance, doubts, fears and uncertainties. Faced with this situation, health professionals who work in the hospital context face several challenges in their daily life, among which one highlights the need to rethink and enhance the principle of people's autonomy.

The understanding of the phenomenon of vulnerability and the dependence of professional paternalism as limiting of the exercise of autonomy in hospitalization, stimulated reflection, almost constant, over the structuring of the care system and their meanings for these humans/patients. This experience includes the demonstration that there are other forms/ways to care in the hospital environment.

Thus, it is believed that this study, although restricted to the perspective of a limited group patients, contributes to nursing research to point out that there is

a long way to go to reframe the process of care, relationships, feelings and respect for human dignity in the hospital setting. Therefore, it is necessary to change the attitude of responsible, sensitive and ethical care, for the purpose of valuing life, of the human being who is receiving care.

The practices surrounding the context of care and the condition of vulnerability and dependency of the elderly during hospitalization need to be continually rethought. Thus, it is expected that the results emerged from this study are configured into possibilities of reflection and action in the sphere of care in order to enhance the autonomy of elderly patients during their hospitalization. Therefore, it is suggested the conduction of further studies to broaden the perspectives presented herein, including the look of other seniors and also health professionals in the hospital setting.

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