Family Attitude of Critically Ill Patients Regarding the Risk of Death in an Intensive Care Unit of a Highly Specialized Medical Center

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ABSTRACT

Introduction: Death has always been, and continues to be, a subject of profound reflection and contemplation for humankind—from philosophical and religious perspectives to, more recently, scientific ones. However, in advanced industrial societies, it is increasingly difficult to live with or accept even the idea of death.

Objective: To determine the attitude of family members of critically ill patients toward the risk of death in the intensive care unit of a high-specialty medical facility.

Materials and Methods: A descriptive cross-sectional study was conducted in the Intensive Care Unit, including, by convenience sampling, family members of critically ill patients who agreed to participate. A structured Likert-type questionnaire was administered, assessing attitudes toward death, and sociodemographic data were collected. The results were analyzed using frequencies, proportions, measures of central tendency, and dispersion.

Results: A total of 44 family members of critically ill patients participated; 15,9% were men and 84,1% women, with a mean age of 42,7 ± 15,9 years. Approach acceptance was rated as completely favorable; death avoidance, escape acceptance, and neutral acceptance were all favorable; and fear of death was completely favorable. Overall, the attitude was classified as completely favorable.

Conclusions: The attitude of family members of critically ill patients toward the risk of death is favorable. The most strongly endorsed dimensions were approach acceptance, fear of death, and neutral acceptance.

Keywords: Patients, Critical care, Death, Thanatology, Family

INTRODUCTION

Intensive Care Units (ICUs) are a substantive service dedicated to the care of critically ill patients, including conditions such as polytrauma, post-surgical cases, respiratory, coronary, or bleeding pathologies. They collaborate with other hospital services (Perdomo Cruz, 1992). These are settings that provide high-complexity care with strict and intensive monitoring (Cáceres, Torres, Cristancho & López, 2020).

A critically ill patient is one who presents with physiopathological alterations that have reached a level of severity, posing a real or potential threat to their life, but who is also susceptible to recovery. Four characteristics define them: severe illness, potential for reversing the illness, need for continuous nursing assistance and care, and the requirement of a specialized area (Aguilar & Martínez, 2017). Critical care includes automated multiparameter monitoring for the management of patients with multiorgan deterioration, complementary examinations, use of devices for basic and advanced support at the patient's bedside, as well as the participation of a multidisciplinary clinical team (Ochoa Parra, 2017).

Intensive nursing care is defined as “exhausting all therapeutic and care possibilities for the temporary

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substitution of altered vital functions without abandoning the underlying diagnosis that led the patient to a critical health state" (Ramírez, Perdomo & Perdomo, 2013). The nursing professional with a specialty in caring for critically ill patients becomes an essential resource in the management of cardiovascular processes, trauma, and urgent care (Narváez & Moreno, 2024). In intensive care units, this specialist promotes the relationship between the patient's therapy and the family; therefore, to meet these practical needs, they care for both the patient and their family (Pardavila & Vivar, 2012). Thus, care involves dimensions such as psycho-emotional needs, interpersonal and interprofessional relationships, affection, listening, institutional philosophical policies, community, and family (Barbosa & Azevedo, 2006).

During their stay in the intensive care unit, critically ill patients experience situations that cause anxiety, discomfort, disorientation, agitation, pain, fatigue, confusion, stress, tachycardia, increased myocardial oxygen consumption, hypercoagulability, immunosuppression, and an increase in metabolic rate (Olmos, Varela & Klein, 2019). Adding to the severity of the critically ill patient is the complexity of care, with highly advanced technologies, communication barriers, a high number of activities per patient per day, the practice of diagnostic procedures and invasive treatments, and the amount and complexity of information received. This makes intensive care units considered areas of risk (González & López, 2017).

Thus, the care of the critically ill patient reaches its highest expression, since the most probable final prognosis is death, which is characterized by loss of independence and decision-making capacity, despite technological and scientific advances and the efforts of the staff (Ospina, Henao & Rivera, 2019). Therefore, the care of the critically ill patient and the dying process in intensive care units undergo substantial changes due to technological advances, advanced age, chronic illnesses, and their participation in decision-making, leading to ethical dilemmas (González, Díaz & Martínez, 2019).

Death, seen as an external event, distant from reality and modern daily life, is projected as a trivial event that people avoid talking about. This requires the development of conceptions and ideas that allow for the creation of strategies to face it (Freitas et al., 2016). It also represents a conflict in decision-making at the end of life for the family members of the patient who passes away (Monzón Marín et al., 2008).

Family members of patients admitted to the intensive care unit face an unknown, unexpected, and difficult situation that disrupts their environment and forces them to adapt to a new reality (Alonso Ovies et al., 2014). Both the family and the sick person find themselves in crisis due to the care provided, exhibiting conflicts or behaviors such as denial, rationalization, guilt, anger, hopelessness, among others (Uribe, Muñoz & Restrepo, 2004). However, the lack of desire and time to think about death, the dependence and submission of the dying person to medical prescriptions, and rigid social censorship (Hernández, González, Fernández & Infante, 2002) have limited and interrupted the assessment of attitudes toward the risk of death. Nevertheless, many components—social, cultural, religious, and economic—affect each person's ability to face the death process, making it difficult to develop a proper attitude (Morales Ramón et al., 2021).

Some authors have measured the stress experienced by family members of patients in an intensive care unit, which plays an important role due to its complexity and severity. A favorable perception was reported in 80% of cases (Bautista, Arias & Carreño, 2016).

Objective

To determine the attitude of the family of critically ill patients towards the risk of death in an intensive care unit of a High Specialty Medical Unit.

METHODOLOGY

An observational, prospective, cross-sectional, descriptive, and homodemic study was conducted, with a cross-sectional descriptive design in the Intensive Care Unit of the High Specialty Medical Unit at the Hospital de Especialidades of the Mexican Social Security Institute in Ciudad Obregón, Sonora.

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Participants

Systematic probabilistic sampling was used to include the family members of critically ill patients hospitalized in the service, of both sexes, adults, and those who provided written consent. Family members of patients with brain death were excluded, as well as family members of patients who died during the course of the study. To determine the sample size, the formula for a proportion in infinite populations was used, considering a confidence level of 90%, a precision of 10%, and an expected proportion of 80%.

Data Collection

Selected family members were administered a structured survey, validated by two nursing graduates with a diploma in thanatology. After being tested on a pilot group, the survey achieved a reliability based on Cronbach's alpha of 0,8. The survey consisted of two questions about patient data, six questions about the sociodemographic data of the family member, four questions exploring their knowledge about death, and 32 items to assess the family member's attitude toward the risk of death of the critically ill patient. These were divided into five dimensions: acceptance of approach with 10 items, avoidance of death, acceptance of escape with five items each, fear of death with seven items, and neutral acceptance with five items. Responses used a Likert scale, ranging from 1 (completely disagree) to 7 (completely agree), where:

1 = Totally disagree

2 = Quite disagree

3 = Somewhat disagree

4 = Indecisive

5 = Somewhat agree

6 = Quite agree

7 = Totally agree

Scores were weighted as follows:

≤ 32 points = Totally unfavorable

33 to 64 = Quite unfavorable

65 to 96 = Somewhat unfavorable

97 to 128 = Neither favorable nor unfavorable

129 to 160 = Somewhat favorable

161 to 192 = Quite favorable

193 to 224 = Totally favorable

The variables analyzed included: patient diagnosis, days of hospital stay, the family member's relationship to the patient, age, sex, religion, education level, occupation, and attitude toward death.

Data Analysis

The data were collected using an Excel file and, after coding, subjected to statistical treatment. For the analysis of qualitative variables, frequencies and percentages were used; for quantitative variables, the mean and standard deviation were applied.

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Ethical Considerations

The development of the work was carried out in accordance with the provisions of the Regulations of the General Health Law on Health Research in Mexico, as well as the principles contained in the Declaration of Helsinki, its Tokyo amendment, the Nuremberg Code, and the Belmont Report.

RESULTS

A total of 44 family members of critically ill patients in the intensive care unit were included. Of these, 7 (15,9%) were male and 37 (84,1%) were female. The mean age was 42,7 ± 15,9 years.

The relationship to the patient was mother in 5 cases (11,4%), spouse in 14 cases (31,8%), child in 17 cases (38,6%), and sibling in 8 cases (18,2%). Most had completed high school education, as shown in Figure 1. Half were employed, as illustrated in Figure 2, and their religion was predominantly Catholic, as presented in Figure 3.

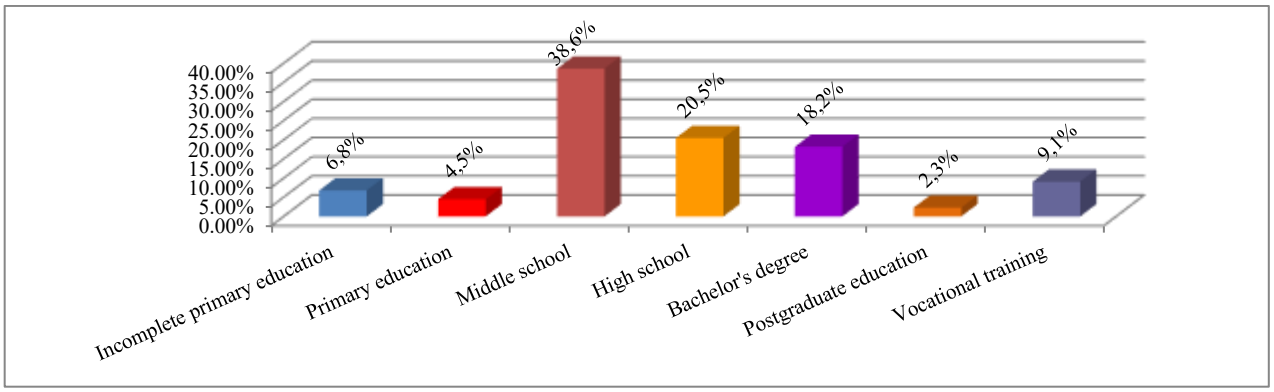

Figure 1. Educational level of the participating family members.

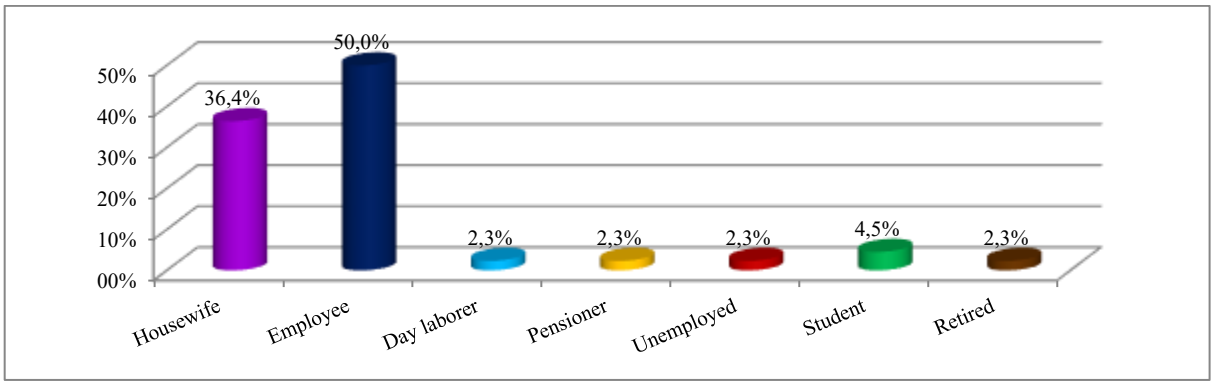

Figure 2. Occupation of the study population.

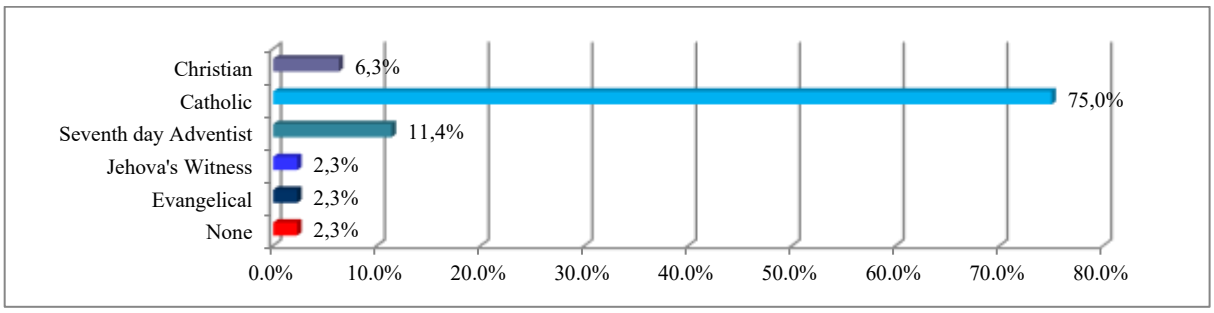

Figure 3. Religion of the interviewed family members.

When asked whether they had been spoken to about how to prepare for death, 18 (40,9%) of the family members stated they had received information, while 25 (56,8%) had not, and 1 (2,3%) did not respond. Among those

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who reported having received information about death, 1 (2,3%) received it at the hospital, 2 (4,5%) at school, 13 (29,5%) at home, and 3 (6,8%) elsewhere. Regarding the source of this information, 1 (2,3%) reported receiving it from a physician, 2 (4,5%) from a teacher, 9 (20,5%) from a parent, 1 (2,3%) from another relative, and 6 (13,6%) from a pastor.

Additionally, when asked whether they would like to be prepared for death at the hospital, 43 (97,7%) agreed, while 1 (2,3%) did not.

The results of the survey assessing the attitude of family members of critically ill patients toward the risk of death showed a reliability, according to Cronbach's alpha, of 0,731, and 0,814 when the items were standardized. The average score was 185,9 ± 26,7, which was statistically significant (p = 0,000) according to Friedman's test with ANOVA.

Regarding the dimensions of family members' attitudes toward the risk of death in critically ill patients, the acceptance and approach dimension had a mean of 57,8 and a standard deviation (SD) of 6,2; death avoidance had a mean of 24,2 and SD of 8,3; escape acceptance was 28,7 ± 6,1; fear of death was 33,9 ± 11,4; and neutral acceptance was 34,4 ± 10,2. The means and standard deviations are presented in Table I.

Table I Significance level of the attitude dimensions of family members of critically ill patients toward the risk of death.

	Root Mean Square	**F**	**p**
Approach acceptance was the most favorable dimension	1,825	2,04	0,068
Death avoidance	4,588	2,83	0,037
Escape acceptance	4,028	3,92	0,009
Fear of death	4,894	3,88	0,004
Neutral acceptance	23,939	4,6	0,004

Thus, the attitude of the family members of critically ill patients toward the risk of death was found to be entirely favorable, as shown in Figure 4.

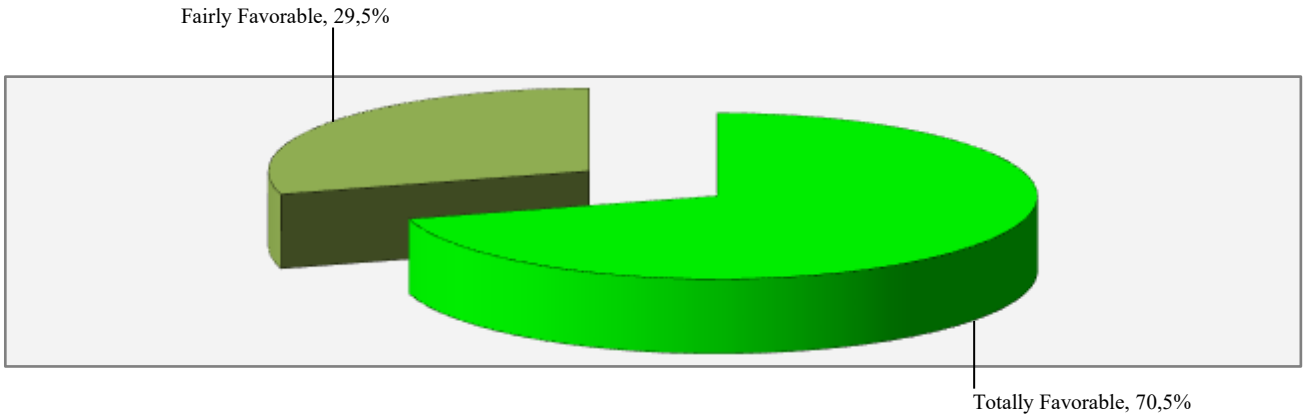

Figure 4. Attitude of the family members of critically ill patients toward the risk of death.

DISCUSSION AND CONCLUSION

Sudden death may occur in a patient who appears to be medically stable and compensated, without the family expecting such an outcome (Falconi Chalco, 2013). When faced with this possibility, the family of a critically ill patient often experiences fear, and following the patient's death, they require supervision and support to cope

with grief—a situation for which, in most cases, healthcare professionals are not adequately prepared to intervene. This contributes to the medicalization of the grieving process (Muñoz, Espinosa, Portillo & Benítez, 2002). Therefore, families should be aware that the patient's wishes regarding their desire to know or not know about their illness must be respected. In addition, families should be involved in the care process, be informed about the activities they can engage in with the patient, and understand the importance of avoiding negative judgments and guilt, in order to not complicate the grieving process when the time comes (Landa, García, Moyano & Molina, 2017).

According to the results obtained from the surveys administered to family members of critically ill patients in the hospital's intensive care units, the overall attitude ranged from considerably to completely favorable. Regarding the *acceptance and approach* dimension—closely associated with religious beliefs—the response was entirely positive. In the *death avoidance* dimension, participants tended to agree with rejecting the idea of death. Respondents also showed a significant level of agreement with *escape acceptance*, referring to those who prefer not to confront death directly. Similarly, they expressed agreement with the *fear of death* dimension. Finally, *neutral acceptance*, which reflects a normal or balanced fear of death, was met with complete agreement.

In other studies, the results have shown ambiguity and only some positive attitudes of acceptance, although those studies were conducted among physicians (Grau Abalo et al., 2008). Likewise, the family members of this type of patient in our study expressed agreement with the idea of being prepared for such a moment. Balcázar, Gurrola, Urcid, and Colín (2011), during the 12th Virtual Congress of Psychiatry, noted a range of acceptance toward death in a study conducted with elderly individuals. However, to date, there are no studies specifically addressing this issue from the perspective of the patient's family members.

In a study conducted with physicians, it was found that they tend to avoid naming death, refrain from facing the patient directly in critical cases, and often rely on technology in ways that may dehumanize care—demonstrating an overall unfavorable attitude (Gala León et al., 2002).

Meanwhile, according to the report by Uribe Rodríguez et al. (2008), older adults demonstrated a much more realistic attitude toward death, preparing for the resolution of personal, social, and religious matters as it approached. However, in recent decades, death has come to be perceived as something threatening and unfamiliar. According to their findings, younger adults tend to exhibit escape acceptance, approach acceptance, neutral acceptance, and death avoidance more frequently in comparison to older adults.

In a study conducted with the general population by Uribe, Valderrama and López (2007), the mean square values were considerably lower. However, the dimensions of approach acceptance, neutral acceptance, and escape acceptance still reflected favorable attitudes. In our case, escape acceptance was lower, although overall attitudes remained positive. Furthermore, in the same report by Uribe, Valderrama, and López, unfavorable results were observed regarding death avoidance and fear of death. In contrast, in our study, both were perceived as normal responses—particularly fear of death.

In conclusion, based on the results obtained, the attitude of family members of critically ill patients toward the risk of death is entirely favorable in 7 out of 10 cases, and the measurement instrument demonstrated reliability. The most favorable dimensions were approach acceptance, fear of death, and neutral acceptance. Furthermore, attitudes were more favorable among Seventh-day Adventists, homemakers, and individuals with an educational level of upper secondary or higher.

Therefore, based on these results, it is recommended to have personnel trained in thanatology to prepare not only the patient but also their family members for end-of-life processes. This could contribute to shorter hospital stays, more satisfactory care for patients, families, and healthcare providers, improved communication by reducing misinterpretations, and a decrease in complaints or even legal actions. Additionally, it may promote organ donation in applicable cases.

Conflict of Interest

The authors declare that they have no conflicts of interest regarding the publication of this work.

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