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CLINICAL CHARACTERISTICS OF MEN MET IN EMERGENCY CARE UNIT

CARACTERÍSTICAS CLÍNICAS DE HOMENS ATENDIDOS EM UNIDADE DE PRONTO ATENDIMENTO

CARACTERÍSTICAS CLÍNICAS DE LOS HOMBRES ATENDIDOS EN LA UNIDAD DE CUIDADOS DE EMERGENCIA

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Objective: to describe the clinical profile of men met in an emergency care unit, of the public health sector, in a city in Northeastern Brazil. Method: descriptive study, conducted through analysis of 500 records of men met in the emergency unit, in the period from January to December 2015. Results: the main complaint was pain (35.2%), stable clinical situation (90.4%), non-urgent risk classification (47.9%), without pre-existing injuries (80.2%), medical diagnosis of pain in general (22.6%), the therapy used was medication (87.4%), the case evolution was recovery-related discharge (91.6%), there was no need for referral (88.0%) and there were no records of nursing diagnoses (96.8%). Conclusion: the clinical profile of men met in a health care unit in Northeastern Brazil presents as characteristics situations of low complexity without changes in the level of hemodynamic stability and the need for other diagnostic and therapeutic resources.

Descriptors: Men's Health. Health Profile. Urgency Medical Services. Ambulatory Care.

Objetivo: descrever o perfil clínico de homens atendidos em uma unidade de pronto atendimento, do setor público de saúde, em uma cidade do Nordeste brasileiro. Método: estudo descritivo, realizado mediante consulta a 500 prontuários de atendimento de homens em unidade de emergência, no período de janeiro a dezembro de 2015. Resultados: a queixa principal foi dor (35,2%), situação clínica estável (90,4%), classificação de risco não urgente (47,9%), sem apresentação de agravos pré-existentes (80,2%), diagnóstico médico dor em geral (22,6%), terapêutica instituída foi a medicamentosa (87,4%), evolução do caso foi alta por melhora (91,6%), não houve necessidade de encaminhamento (88,0%) e não houve registros de diagnósticos de enfermagem (96,8%). Conclusão: o perfil clínico de homens atendidos em uma unidade de pronto atendimento no Nordeste brasileiro apresenta como características

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situações de baixa complexidade sem alterações do nível de estabilidade hemodinâmica e necessidade de outros recursos diagnósticos e terapêuticos.

Descritores: Saúde do Homem. Perfil da Saúde. Serviços Médicos de Urgência. Assistência Ambulatorial.

Objetivo: describir el perfil clínico de hombres atendidos en una unidad de cuidados de emergencia, del sector público de salud, en una ciudad en el noreste de Brasil. Método: estudio descriptivo, consultando 500 registros de atendimiento de los hombres en la unidad de emergencia, en el período de enero a diciembre de 2015. Resultados: la queja principal fue el dolor (35,2%), situación clínica estable (90,4%), clasificación de riesgo no urgente (47,9%), sin lesiones preexistentes (80,2%), diagnóstico médico dolor en general (22,6%), el tratamiento fue medicamentoso (87,4%), la evolución del caso fue alta por mejora (91,6%), no hubo necesidad de encaminamiento (88,0%) y no hubo registros de diagnósticos de enfermería (96,8%). Conclusión: el perfil clínico de hombres atendidos en una unidad de cuidados de salud en el nordeste brasileño presenta como características situaciones de baja complejidad sin cambios en el nivel de estabilidad hemodinámica y la necesidad de otros recursos diagnósticos y terapéuticos.

Descriptores: Salud del Hombre. Perfil de Salud. Servicios Médicos de Emergencia. Atención Ambulatoria.

Introduction

The strategies and actions for men's health is a priority that has emerged in Brazilian public health policies from the year 2009, after the implementation of the National Policy of Integral Care for Men's Health (PNAISH)[1]. The current Brazilian epidemiological panorama has shown a health clinical profile that points to the high morbidity and mortality in men[2-3]. Such scenario reveals that men's deaths have been early, and relate to the maintenance and practice of risk behaviors, expressed by the abusive consumption of alcohol and other drugs, violence, accidents at work and mental disorders[4-5], as well as the adoption of unhealthy habits that resonate in high growth of chronic comorbidities.

In addition to this risk behavior, other aspects are notorious in the relationship between men and health care. In this context, with great potential for influence, the social constructions of hegemonic masculinities prevail. These favors the perception of invulnerability, strength, virility and honor, which distance men from the logic of the establishment of a careful behavior, affecting the search for and the belonging in relation to health services, in particular those of Primary Care[6-7].

Seeking solutions to issues related to the health clinical demands, men jump over the care model, mostly attending urgency and emergency units, such as 24-hour Emergency Units (UPA)[8]. Some factors may be related to men's high demand for health emergency services, including: mischaracterization of Basic Care, absence of men's awareness and acquisition strategies, difficult access to medical appointments and other therapeutic resources in primary care, incompatibility of schedules between the work and the operating hours of primary health care services, culture of prolongation of symptoms, as well as the social imaginary that urgency and emergency units are faster and problem-solving[9-10].

As 24-hour services, the UPA comprise the Emergency Care Network in Brazil and are responsible for meeting a large part of health demands of users in the territories. These demands include from those that are the responsibility and scope of these units until those that go beyond the levels of resources and attention to be offered or even those whose characteristics do not correspond to the occurrences of urgency and emergency, but are present and in an expressive numeric volume[11].

An example of the result of men's search for demands of lesser clinical complexity is the presentation of minimal changes of vital signs, with preservation of the level of consciousness and in the presence of hemodynamic stability, which could be solved in Family Health Units (FHU) and Basic Health Units (BHU). Consequently, there are scenarios of overcrowding of urgency and emergency services, impacts on health work process, overload of professionals and

workers, difficulty to organize services and to provide human and material resources, structural inadequacy in comparison to the characteristic of the demand presented, disarticulation with the Primary Care network and impaired quality of care and patient safety[11-12]. This problem requires the integration between UPA and a policy of health care networks to ensure resolvability through the expansion of their services[13].

A study conducted in major Belgian cities on the profile of care outside operating hours, performed by patients met in the emergency room and by general clinicians on duty, pointed to high demand, with associated determining factors. These factors are related to being a man, excessive use of emergency services over the past 12 months, African nationality and no health insurance or provider. The study also suggests that the high demand, and sometimes considered inappropriate, for emergency services constitutes a worrying problem, jeopardizing the use of personnel, infrastructure and financial resources of the services, requiring redirection of patients, through expanded knowledge about their experiences, attitudes and behavior[14].

Although provided for in the National Policy for Reduction of Morbidity and Mortality from Accidents and Violence deployed in Brazil in 2001, the systematization of epidemiological information on the profile of calls in Emergency Units and Rooms is deficient, hindering the understanding of indicators and sensitive conditions for the development of actions geared to the care management and health care in the urgency network[15]. In contrast, the National Health Survey showed, regarding the access and utilization of health services in Brazil, that BHU was the establishment most sought by the population, when requiring health care. However, when including Emergency Care units or emergencies of public and private hospitals, as well as public hospitals or outpatient clinics, the polyclinics and the Medical Care Posts, the number of searches becomes significant[16].

The survey showed that men seek health care mostly by the presence of disease, followed by continued treatment and implementation of additional and diagnostic tests. The continuity of treatment occurred, in greater number, among people aged between 40 and 59 years. When observed the demand for health care due to accidents or injuries, men occupied a higher position, when compared to women[16].

Concerning the demands presented by users in emergency units, analyzed on the Reception System with Risk Classification, the profile is characterized by demands for a lower level of urgency, thus signaling a lesser degree of care prioritization[8]. Among the reasons that lead men to emergency services, a prospective study conducted in Australia on gender differences between women and men who have accessed an emergency room unit revealed higher prevalence in men of cardiovascular injuries, with higher odds of having to undergo a coronary angiography and myocardial revascularization than women[17].

A study conducted in a hospital emergency in Belo Horizonte, Minas Gerais, Brazil, when observing the survey of Nursing Diagnoses presented by patients in the emergency unit, higher prevalence of unbalanced nutrition – below bodily needs –, identified risk of impaired skin integrity, risk for infection, ineffective respiratory pattern and impaired spontaneous ventilation[18]. Given this scenario, rearranging the demand for care, as well as redirecting the search for health services by men, has set up a relevant contemporary challenge to be overcome, by both promulgators of public policies as health professionals and workers[11-13].

The knowledge of health demands of the male population may subsidize the planning of specific actions geared to their needs, expanding the potential of action of health services. Furthermore, it will provide information to substantiate the sensitization of men to seek health services of the Unified Health System (UHS) that are ideal to solve their problems, according to the degree of complexity of attention.

Therefore, with the intention of surveying the scientific evidence that assists the health professional practice focused on the male attention, this study sought to investigate: How is the clinical profile of men met in a health care unit?

The objective of this study was to describe the clinical profile of men met in a health care unit of the public health sector in a city in Northeastern Brazil.

Method

Descriptive, documentary study, conducted in a 24-hour Health Care Unit in the municipality of Feira de Santana (BA), on men's clinical profile of call in the year 2015.

The inclusion criteria were: elderly and adult men, aged over 20 years, as established by PNAISH, with call from January to December 2015 and availability of call records at the unit. There was exclusion of men who had no medical evaluation and/or those with more than one missing variable evaluated.

The sample size was calculated considering the population of 34,669 men met (according to the health care unit record where the study was performed), prevalence of 59.3% for the care with men in this kind of service[19], accuracy of error of 5%, confidence level of 95%, power of 80% and additional loss of 20%. The minimum sample size was set at 442, having been analyzed 500 records. These were selected by systematic random sampling, considering the sampling interval equal to 79. The records were organized by sequential numbering of admission. There was replacement of records excluded by the one directly subsequent to the sampling interval. When this was not included, the previous interval was considered.

Data collection was carried out during the months of October and November 2016. A structured form was used as the data collection instrument, consisting of variables related to sociodemographic (age range, race/ethnicity, marital status) and clinical characteristics (main complaint, clinical situation, risk classification, preexisting diseases, medical diagnosis, therapy, case evolution, type of referral and nursing evolution).

The software Statistical Package for the Social Sciences (SPSS), version 23.0, was used for the processing and treatment of data previously organized on Microsoft Excel 2010 spreadsheet. There was descriptive data analysis, estimating absolute and relative frequencies, with presentation in tables.

Complying with Resolution n. 466 of 12 December 2012, of the National Health Council, the study was approved by the Research Ethics Committee of the Anísio Teixeira College, Opinion n. 1.748.594.

Results

Of the 500 men met in the emergency room, there was higher frequency of the age range from 30 to 39 years, with ignored identification of race/color, marital status, education, employment and income.

The clinical characteristics that predominated were: pain as main complaint, non-urgent clinical conditions, stable clinical situation, non-urgent risk classification, without preexisting diseases. Among the preexisting diseases, circulatory system diseases, medical diagnosis of pain in general, drug therapy, case evolution of recovery-related discharge, no referral of the case and no record of Nursing Diagnoses, were the most frequent (Table 1).

Table 1 – Clinical care characteristics of men in an urgency/emergency unit. Feira de Santana, Bahia, Brazil – 2015 (N=500) (continued)

Variables	n	%
Main complaint/call reason (n=500)		
Pain	179	35.8
Dyspnea	24	4.8
Motorcycle accident	27	5.4
Psychiatric patient	6	1.2
Tonsillitis	16	3.2
Fall	14	2.8

Table 1 – Clinical care characteristics of men in an urgency/emergency unit. Feira de Santana, Bahia, Brazil – 2015 (N=500) (continued)

Variables	n	%
Main complaint/call reason (n=500)		
Precordial pain	17	3.4
Excessive consumption of alcoholic beverages	6	1.2
Malaise	14	2.8
Diabetes	11	2.2
Dizziness and nausea	9	1.8
White weapon accident	8	1.6
Fever	28	5.6
Epigastric pain	26	5.2
SAH	21	4.2
Non-urgent clinical conditions	94	18.8
Clinical situation (n=500)		
Stable	452	90.4
Unstable	48	9.6
Risk classification (n=499)		
Emergency	36	7.2
Urgency	224	44.9
Non-Urgency	239	47.9
Preexisting diseases (n=499)		
Diseases of the circulatory system	62	12.4
Metabolic diseases	10	2.0
Sexually transmitted diseases	2	0.4
Infectious diseases	7	1.4
Diseases of the digestive system	1	0.2
Respiratory discomfort	2	0.4
Associated Chronic Diseases (Systemic Arterial Hypertension+Diabetes *Mellitus*)	10	2.0
Others[1]	5	1.0
None	400	80.2
Medical diagnosis (n=473)		
Pain in general	107	22.6
Diseases of the circulatory system	60	12.7
Ill-defined symptoms, signs and conditions	51	10.8
Injuries, poisonings and external causes	47	9.9
Musculoskeletal and connective tissue diseases	43	9.1
Respiratory system diseases	41	8.7
Nervous system diseases	38	8.0
Infectious and parasitic diseases	35	7.4
Diseases of the digestive system	10	2.1
Metabolic diseases	8	1.7
Mental illnesses	7	1.5
Eyes and adnexa, ears and mastoid process	7	1.5
Urinary tract diseases	5	1.1
Diseases of the blood and hematopoietic organs and some immune disorders	1	0.2
Others[2]	13	2.7
Therapy (n=500)		
Medications	437	87.4
Surgery	3	0.6
X-Ray	1	0.2
Immobilization	6	1.2

Table 1 – Clinical care characteristics of men in an urgency/emergency unit. Feira de Santana, Bahia, Brazil – 2015 (N=500)

(conclusion)

Variables	n	%
Therapy (n=500)		
Suture	14	2.9
Vital Signs Control (SSVV)	2	0.4
Bladder Tube Exchange	1	0.2
Debridement	1	0.2
Abscess	1	0.2
No interventions	34	6.7
Case evolution (n=488)		
Recovery-related discharge	447	91.6
Transfer due to worsening	25	5.1
Referral to Primary Health Care	15	3.1
Death	1	0.2
Type of referral (n=500)		
Reference hospital	25	5.0
Family Health Program	9	1.8
Psychosocial Care Center	6	1.2
Cardiologist	4	0.8
Orthopedist	8	1.6
Others[3]	8	1.6
Not referred	440	88.0
Nursing Diagnoses (n=500)		
Found	16	3.2
Not found	484	96.8
Total	500	100%

Source: Created by the authors.

[1] Renal cyst, femur fracture, seizure, necrotic tissue and itch.
[2] Herniated disc, bladder tube obstruction, chronic alcoholism, jaundice, virus.
[3] Municipal Specialized Health Center, angiologist, otorhinolaryngologist, skull X-ray, dentist and urologist.

Discussion

The description of the clinical profile of care directed to men in emergency units should consider factors such as age, schooling, clinical situation, call reason, medical diagnosis and risk classification, which are inter-related and influence the use of health services by this population group. This influence is also permeated by issues such as the need and availability of health services, population's propensity to use them and easy access[20]. Therefore, when analyzing the call profiles, it is essential to consider the multiple elements present, to provide subsidies that allow monitoring the implementation of public health policies.

Young adult men, attending the urgency services, require directed health actions, as an alternative to reduce morbidity and mortality by external causes and serious health conditions. In addition, they need the strengthening of the implementation of PNAISH, for the effective reduction of costs in the health sector, due to severe complications, as well as the reduction of the economically active population[21].

The use of medium complexity health services by the male population is motivated by the presence of signs and symptoms of diseases already installed, as indicated by a national study[22]. Most of the male public met reported having no preexisting diseases. Those who reported them had cardiovascular diseases. The adult men themselves have commonly reported using with greater frequency the health services available in the urgency and emergency network to solve their health problems. This demand has

been justified by the speed, agility in the access and service to the demands[22].

In these scenarios, the male public met in the urgency services presents painful sensation mostly classified from moderate to severe, in particular in cases of orthopedic injuries[23]. Despite the intense pain, clinical conditions commonly presented by them in these services are not urgent, and their health conditions are stable, implying in less complex therapy. Thus, the fulfilment of the drug prescription and the adoption of medical behaviors disjointed from the health care network are expressed in the absence of referrals to other health services. In this way, these demands, which could have been resolved in Basic Health Care, overcrowd the services.

Among the main therapeutic measures imposed in UPA, men were submitted to drug administration, followed by sutures and immobilizations. Such therapies are related to the presented complaints and medical diagnoses raised to ensure response to pain, as well as the presence of injuries due to external causes. Nevertheless, there was a small number of evaluations mediated by diagnostic imaging, such as electrocardiographic evaluation, even considering the presence of cardiovascular diseases in that population.

Additionally, the data showed the presence of men admitted at the unit that were not submitted to medical and Nursing therapies, which suggests that the demands had been solved during the consultation or were related to factors, such as low complexity of the cases presented and/or issuing of medical certificates. An important alternative to be rethought is the need for implementing the reception of the spontaneous demand to be held in the BHU of municipalities, as a way to solve clinical situations of urgency.

Another relevant aspect evidenced in this study is the non-identification of pre-existing diseases among the clinical conditions presented by men. In this way, it is possible to infer possible weaknesses during the call and clinical screening, which can express in the unsatisfactory process of anamnesis and clinical history, in the performance of professional abilities and skills to identify these diseases, in addition to the problems existing in the work processes of the multiprofessional team, due to the elevation of service flows, overcrowding and non-manifestation of behaviors, habits and health practices by men.

As a reflection of the data presented on the main medical diagnoses raised during the visits, in addition to the pain, men presented clinical manifestations related to diseases of the circulatory system, as well as signs, symptoms and ill-defined affections added to injuries, poisoning and other external causes and musculoskeletal and connective tissue diseases, which indicate the occurrence of avoidable demands. These conditions are in line with the national panorama on morbidity and mortality in men, expressing as a reflection of this scenario in the everyday life of the services, as identified by an ecological study conducted in Cuiabá, Mato Grosso, Brazil, which analyzed 6,050 death records of men[21].

In this sense, preventive actions should be strengthened, in addition to investment in the care in these units, which include the training of human resources, for a high quality and problem-solving service, based on the structuring of specific care lines. In this context, a reflective study conducted by researchers from the Department of Studies on Violence and Health, of Fiocruz, Rio de Janeiro, draws attention to the need to institutionalize the theme of violence within the UHS. It stresses the need to overcome the challenges that exist in the implementation of the National Policy for Reduction of Morbidity and Mortality from Accidents and Violence promulgated by the Brazilian Ministry of Health[15].

In addition to the medical diagnoses, this study sought to investigate the existence of Nursing Diagnoses, expressed in a unique and essential way in the process of clinical reasoning, critical thinking and diagnostic reasoning for the care decision making. Nonetheless, there was high absence of description of those diagnoses by the nurses who work in the UPA. A Brazilian study, conducted in a university hospital in São Paulo, which sought to investigate the Nursing

Diagnoses most commonly used in emergency service, recommends the survey of diagnoses to facilitate the Nursing assistance at this health care level and subsidize the construction of individualized plans for specific care with patients in critical health contexts[22-23]. However, the findings of this study pointed to the fragility of the survey and documentation of Nursing Diagnoses along with the records of Nurses' professional practice[24].

When analyzing the outcomes presented in the evolution of the cases, the men were discharged after recovery, with a reduced number of transfers resulting from worsening, as well as referral to basic health care and only one death in the investigated period. In conjunction with the case evolution, the study allowed identifying that men met in the UPA were not referred to other existing services within the health care network. When this occurred, the majority was referred to reference hospital units, Family Health Units and, in smaller numbers, to areas of medical specialties, such as cardiology.

These findings require reflections on how health care conducted by the UPA has been practiced. Importantly, the states planned the existence of UPA, but the municipalities are the ones responsible for managing them and contribute to the significant number of open units, although not always fully operating. Moreover, there is the problem of tension in relation to the hospitals, considering the lack of beds in the country, which is allied to the location of these services far from the capitals of the states, the underfunding and the difficulty recruiting medical professionals. These factors, together, contribute to the operation of UPA also as places of hospitalization[25].

Even considering the essentiality of UPA to solve the demands of urgency and emergency presented in the territories, there are distinct problems in the municipalities. Among these, there stood out the full participation of the UPA along the Health Care Network, as well as care flows, obstacles in the follow-up of protocols, deficit of trained professionals, structural difficulties of referral and counter-referral of patients in health macro-region and participation in the state sphere. The studies also indicate the need for strengthening the development of computerized systems and standardization of evaluation structures, to reduce the demand, facilitate care flows and organizational planning, to guarantee the right of access to health[13-25].

Also worrying, there stands out the absence, in the researched records, of sociodemographic characteristics (race/color, schooling, marital status, economic situation) of the met public. This fact reveals the unimportance and unawareness of these variables, which help in the formulation of health indicators that subsidize the elaboration and implementation of public health policies. Furthermore, the lack of such information directly affects the internal planning of operational actions of the services. Therefore, it should be recorded and analyzed in the everyday practices of health care.

By recognizing that nurses and the nursing team constitute the essentiality in the production of care and assistive technologies in men's health in the urgency and emergency services, and that they are directly involved in the actions of planning, supervision, care, coordination, monitoring, management, surveillance, research, evaluation and training, this study is relevant to the advancement of knowledge production, when proposing to raise evidence that those professionals are able to qualify and guarantee safety in the assistance provided to this population.

A limitation of this study is its restriction to the analysis of the clinical profile of men in the emergency unit, not allowing establishing correlations that explain the factors that are associated with the search for such services. Moreover, the sociodemographic data are incipient due to under-record, which restricts the analysis of information related to the users' profile. However, knowing this characterization allows delineating care and health care lines specific to chronic diseases, as well as assisting in the development of the care production practices directed to men's health.

Conclusion

The clinical profile of men who attended the 24-hour Emergency Care Unit was characterized by the main complaint of pain, with stable clinical situation, non-urgent risk classification, without preexisting diseases. The most prevalent medical diagnosis was pain, requiring the implementation of drug therapy, with reduced presentation of survey of Nursing Diagnoses.

In relation to eh outcome, the cases progressed to recovery-related discharge, without referrals to other services of the health care network. Nevertheless, the findings do not allow evidencing if there is a lack of articulation or lack of a health care network available for the health of men in urgency and emergency situation. Therefore, there emerges the need to continue the investigations on the problem.

There was no description of Nursing Diagnoses in the records of care provided by nurses, which highlights the non-compliance with the Nursing Process. In this way, one highlights the importance of this record in the emergency Nursing care context to ensure the application of the Nursing work method in the care provided to persons, their families and communities. Thus, pointing out these findings is essential for the management of care practices, in order to assist in the organization of urgency and emergency services through the restructuring of healthcare flows, protocols and effective clinical practice guidelines, whether medical or Nursing.

A descrição rigorosa dos dados de atendimento possibilita a estruturação de indicadores de qualidade da assistência prestada, assim como possibilita a instrumentalização de ações nos serviços de saúde e a implementação de políticas públicas, a exemplo da Política Nacional de Atenção às Urgências e Emergências e da Política Nacional de Atenção Integral à Saúde do Homem. Nesse sentido, conhecer as características clínicas desse público, permitirá delinear linhas de atenção focalizadas na rede, além de propiciar o avanço das práticas para a garantia da segurança.

The precise description of care data enables the structuring of care quality indicators, as well as allows the instrumentalization of actions in health services and the implementation of public policies, such as the National Policy of Attention to Urgencies and Emergencies and the National Policy of Integral Care for Men's Health. In this sense, knowing the clinical characteristics of this population will delineate care lines focused on the network, in addition to providing the advancement of practices to guarantee safety.

Collaborations:

1 – conception, design, analysis and interpretation of data: Jéssica Cerqueira Silva, Silvia de Sousa Nassif and Anderson Reis de Sousa;

2 – writing of the article and relevant critical review of the intellectual content: Selton Diniz dos Santos and Tilson Nunes Mota;

3 – final approval of the version to be published: Anderson Reis de Sousa and Álvaro Pereira.

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