

# Nursing faculty and terminality with dignity

Júlio César Batista Santana <sup>1</sup>, Andréa Vaz dos Santos <sup>2</sup>, Bruna Reis da Silva <sup>3</sup>, Denísia Cristiane dos Anjos Oliveira <sup>4</sup>, Eberth Mesquita Caminha <sup>5</sup>, Flávia Soares Peres <sup>6</sup>, Cynthia Carolina Duarte Andrade <sup>7</sup>, Maria Bernadete de Oliveira Viana <sup>8</sup>

## Resumo

Este estudo teve como objetivo compreender o significado atribuído por um grupo de docentes enfermeiros sobre o fenômeno da ortotanásia. Trata-se de pesquisa qualitativa, com inspiração fenomenológica. Do estudo participaram cinco enfermeiros de uma universidade privada do Estado de Minas Gerais e emergiram quatro categorias: despreparo da equipe em situações que remetem à finitude humana; enfrentamento dos familiares no processo da finitude; prolongamento do sofrimento humano nas unidades de tratamento intensivo; perspectiva dos cuidados paliativos nas unidades de tratamento intensivo. Conclui que a reflexão acerca da terminalidade vem aumentando, mas ainda é insuficiente no tocante à prática dos profissionais da enfermagem. Percebe-se que a dificuldade em lidar com a morte é um problema comum aos profissionais de saúde. Novas pesquisas são necessárias à exploração das dificuldades e do conhecimento dos enfermeiros, englobando a ortotanásia e a assistência humanizada na terminalidade.

**Palavras-chave:** Doente terminal. Cuidados paliativos. Direito a morrer. Cuidados de enfermagem. Pesquisa.

## Resumem

### Docentes de enfermería y terminalidad en condiciones dignas

Este estudio tuvo como objetivo comprender el significado asignado por un grupo de profesores enfermeros sobre el fenómeno de la ortotanasia. Se trata de un estudio cualitativo con la inspiración fenomenológica. Asistieron a este estudio cinco enfermeros de una universidad privada en el Estado de Minas Gerais. Emergieron cuatro categorías: falta de preparación del equipo en situaciones que hacen referencia a la finitud humana; enfrentamiento de la familia en el proceso de la finitud; prolongación del sufrimiento humano en las unidades de cuidados intensivos; perspectiva de los cuidados paliativos en las unidades de cuidados intensivos. Se llega a la conclusión de que la reflexión acerca de la terminalidad es creciente, pero siguen siendo insuficientes en lo que considera la práctica de los profesionales de enfermería. Se observa que la dificultad de tratar con la muerte es un problema común para los profesionales de la salud. Se necesitan más investigaciones para explorar las dificultades y los conocimientos de los enfermeros, que abarca la ortotanasia y la atención humanizada en la fase terminal.

**Palabras-clave:** Enfermo terminal. Cuidados paliativos. Derecho a morir. Atención de enfermería. Investigación.

## Abstract

### Nursing professors and the terminality in conditions of dignity

This study aimed to understand the meaning assigned by a group of nursing professors on orthotanasia. This is a qualitative study with a phenomenological perspective. The study included five nurses from a private university of Minas Gerais State. Four categories emerged: Unpreparedness team in situations that refer to human finitude; Confronting the family in the process of finitude; Extension of human suffering in intensive care units; the perspective of palliative care in intensive care units. It may be concluded that reflections on the finality has been increasing but are still insufficient in contemplating the practice of professional nursing. It is observed that the difficulty in dealing with death is a common problem for health professionals. Further research is necessary to explore the difficulties and knowledge of nurses, encompassing orthotanasia and humanized in terminality.

**Key words:** Terminally ill. Palliative care. Right to die. Nursing care. Research. Approval CAAE n.º 0201.0.213.000-11

**1. Doctoral candidate** julio.santana@terra.com.br – Centro Universitário São Camilo, São Paulo **2. Graduate** avsbh1@hotmail.com **3. Graduate** reis.brunas@yahoo.com.br **4. Graduate** denisia\_cristiane@hotmail.com **5. Graduate** eberthcaminha@gmail.com **6. Graduate** flaviasoaresperes@gmail.com **7. Expert** cynthiaenf@yahoo.com.br **8. Master** mariabernadete@yahoo.com.br – Pontifícia Universidade

Católica de Minas Gerais, Belo Horizonte/MG, Brasil.

## Mailing address

Escola de Enfermagem – Av. Dom José Gaspar, 500, Prédio 25 Coração Eucarístico CEP 30535-610. Belo Horizonte/MG, Brasil.

All declare no conflict of interest.

In ancient times, death was treated as a natural process: the end of life occurred at home, assisted by family members, and there was no intervention in the process – as there is today, worldwide <sup>1</sup>. Nowadays, this picture has changed radically, and the uneventful scenery of death is the hospital, where one dies away from family, in a room full of wires, machinery, equipment and strangers <sup>2</sup>. So, the scientific-technologic advancement has propitiated an increase in the survival of terminal patients, but this fact is not always associated to quality of life <sup>1</sup>.

Under these circumstances, it is primordial to provide the patient and family with means to express their psychosocial and spiritual needs, in view of the process of dying. In addition to full medical care (curative and preventive), it is relevant to have interventions that potentiate the process of dying, such as providing a quiet environment, away from the noise and alarms of the invasive equipment and machinery <sup>2</sup>.

Studies show that the situation is delicate even for the professionals. They often feel frustrated over the patient's death, because their training is focused on saving lives at any cost. When that is not possible, i.e., when the patient progresses to death, professionals feel unprepared to deal with the situation, experiencing a turmoil of feelings that may lead to an association between the patient's death and their own, or the death of a beloved one <sup>3</sup>. Ergo, the patient's death might remind them of the finitude of life, common to all.

Analyzing the situation under a completely professional perspective, the nurse, many times, faces the patient's death at the institution as a frustration in their care plan. However, the illness at the hospital should be seen as any other human experience, measured and evaluated with maturity. At this stage, professionals, patients and family should adapt their behavior and expectations in order to ease the pain and anguish in the process of finitude, reaching the so-called dignified death <sup>2</sup>.

But it is in the training of caregivers to deal with terminal patients that the impact of unpreparedness before this theme is plainly perceived. So, the need to promote changes and deconstruct the vicious circle that consolidates the taboo about the subject, is brought to life: for believing that there is no preparation to talk and reflect on death, the theme is neither discussed nor understood. Such change should happen by questioning the teaching/learning, reformulation of curricula and defragmentation of subjects, so as to help the faculty to review human existence in its singularity and plurality <sup>3</sup>.

## Orthothanasia and palliative care: definitions

Dignified death is a reflection strictly connected to bioethics; because it is a process that involves the rights and the respect to the patient, attacking their autonomy when possible, i.e., before the conscientious patient <sup>4</sup>.

Under the perspective of performing care and treatment to a terminal patient, it is necessary to define, in this study, the definition given to the terms 'euthanasia', 'dysthanasia' and 'orthothonasia'. Euthanasia is acknowledged as the action aiming to shorten the life of a human being <sup>5</sup>. Practicing the euthanasia is illegal in Brazil and prohibited by the Code of Ethics for Nurses, according to article 29: *promoting the euthanasia or participating in practice designed to anticipate the client's death* <sup>6</sup>. The term dysthanasia means painful, futile or fruitless treatment, bringing no benefit to a terminal patient. They are procedures that extend the process of dying, not life itself. Consequently, the patients go through a slow and prolonged death, often bringing along pain, suffering and anguish <sup>7</sup>. The term orthothanasia refers to the therapeutic search to promote greater comfort to patients with no perspective of cure, who needs to accept finitude without extraordinary resources <sup>4</sup>.

The ruling Code of Medical Ethics (CEM) highlights on Chapter I, item XXII of the Fundamental Principles, that *in irreversible and terminal clinical situations, the doctor shall avoid the execution of unnecessary diagnostic and therapeutic procedures, and shall propitiate to the patients under his/her responsibility all appropriate palliative care* <sup>8</sup>. Based on these ideas, it can be inferred that the orthothanasia is understood as the set of care procedures, grounded on bioethics, which stipulates limits for biomedical conducts regarding human finitude. Under this perspective, palliative care becomes the best option for the exercise of orthothanasia.

According to the World Health Organization (WHO), palliative care is *an approach that promotes quality of life to patients and family, who face illnesses which threaten the continuity of life, through the prevention and relief of pain. It requires premature identification, evaluation and treatment of pain and other problems of physical, psychosocial and spiritual nature* <sup>9</sup>. Palliative care enriches the optimal level of pain control and administration of symptoms; it affirms life and faces death as a normal process; it does not rush or postpone death; it integrates psychological and spiritual aspects to patient care; it offers a support system to help patients to live as

actively as possible, until the moment of death; it helps the family to deal with the patient's illness and with mourning; it demands a team approach; and seeks to improve quality of life <sup>10</sup>.

Bellato, Araújo, Ferreira and Rodrigues highlight that, during nursing training, there is great emphasis in the subjects that capacitate professionals in caring for health maintenance and cure of diseases, but little or none support is provided for the nurse to learn to attend a dying person <sup>11</sup>. Such contradiction in the process of nursing training, associated to the increase in chronic degenerative diseases, due to the increase in fostered human survival, among other aspects, because of the advent of increasingly advanced technologies in the field of health <sup>12</sup>, brings about the forceful questioning: what is the nurse faculty's contribution in the diffusion of knowledge to future professionals, when it comes to orthothanasia, in order to ensure dignity to a terminal patient?

This question guides the presented study, which is justified by the relevance of the theme finitude in nursing training, considering especially the unpreparedness and lack of knowledge on the subject, of professionals already in the labor market, but also seeking to extend the discussion to professional training. Thus, this research aims to understand the meaning attributed by a nursing faculty group to the phenomenon of orthothanasia, seeking to contribute to the practice of the orthothanasia and the palliative care to terminal patients.

## Method

It is a qualitative research performed with professors from the nursing undergraduate course of Pontifícia Universidade Católica de Minas Gerais (PUC/MG). The goal was to investigate the faculty's interpretations about dignified death in the intensive inpatient units of the institution. The technique applied was the phenomenological research, which, coming from subjectivity, leans toward the particular collection and interpretation of the phenomenon itself <sup>13</sup>. The phenomenological resource seeks to interpret the phenomenon from each person's subjectivity <sup>14</sup>.

To be successful, a phenomenological study demands three fundamental stages: phenomenological description, reduction and comprehension. Coltro <sup>13</sup> argues that during the process of *description*, the research subject elaborates their speech and reports on how he/she sees themselves facing such situation in the world. From this subjectivity, the researcher

intends to reach the descriptive objectivity <sup>13</sup>. It is worth noting that intersubjectivity can be found in the speeches, i.e., the intercession of experiences. The *reduction* is the stage in which the researcher seeks in the speeches of their interviewees to find the meaning to their guiding questions.

The subject's ideas shall sustain their speech, and oftentimes the reflection of the respondents reaches new possibilities, not thought of or studied at first. Lastly, the reduction aims to elucidate the phenomenon, but it does not deny or limit the world of experiences of the respondent. The *comprehension* approaches how to understand the manners of others, an aspect full of possibilities. It is about understanding others in order to interpret them. To reach comprehension, it is necessary to accept the reduction stage, looking for the soul of the respondent. So, the three stages interconnect and are reversible <sup>14</sup>.

It becomes clear to understand that the phenomenological inspiration will not result in concrete answers, but in the reflection on dignified death. The research was performed with five nursing faculty members from PUC/MG. The subjects were invited to participate in this study whose exclusion criteria was professors who did not provide nursing assistance to terminal patients, or refused to participate for private reasons.

The data collection was performed in the months of February and March of 2012, by recorded semi-structured interview, contemplating the following guiding questions:

- What is the meaning of the process of dignified death (orthothanasia) attributed to terminal patients?
- What are your thoughts on the health care provided to terminal patients nowadays?
- what changes in nursing training do you consider important concerning the implementation of humanized care for dying patients?

The term "free, prior and informed consent" was presented to the interviewees, in order to explain the ground of the research and its relevance in the context of care in life terminality situations. After the subjects' consent, the interviews were recorded in MP3 and transcript for the analysis of the speeches. The interviews will be stored in a secret spot for five years, for future evaluations, and destroyed afterwards. For the anonymity of the subjects, the speeches were identified by pseudonyms as a tribute to the caregivers: Florence Nightingale, Anna Nery, Callis-ta Roy, Wanda Horta and Saint Francis of Assisi.

The project was submitted and approved by the Ethics Committee of Pontifícia Universidade Católica de Minas Gerais concerning the guidelines and rules for research involving human beings. From the speeches, the following analytical categories were built: unpreparedness of the team in situations related to human finitude; extension of human suffering in intensive care units; perspective of the palliative care in the intensive treatment units.

## Results e discussion

### *Unpreparedness of the, team in situations related to human finitude*

During the training, the future nurse needs to find subsidies to face death, learning, for instance, to deal with terminal patients. As nurses, we are prepared to take care of every stage of life, and death is the last of them. The challenge in dealing with death and the need for discussions of the process of dying are perceived in undergraduate courses and in daily work, as observed in the following reports:

*"I didn't learn that in college. I learnt that in life, when I got to work." (Nurse Florence Nightingale);*

*"We don't discuss the fear of a professional. Professionals have to be prepared, too." (Nurse Florence Nightingale);*

*"Lack of a guideline, of adequate training. Training meaning, first of all, a discussion." (Nurse Wanda Horta).*

As can be seen, death is feared and little discussed by health professionals. Despite the curricular advances of the academies and the development of the continuing professional education service, the nurses' knowledge about palliative care to be adopted for each patient are yet insufficient. Nurses have a difficulty in managing not only signs and symptoms, but also suspending or retaining the care, according to the needs of patients facing the end of life <sup>15</sup>.

The training occurs under a curative health model, which makes it difficult to act before the process of dying. There is a struggle to prevent the suffering of others and minimize the frustration and the sense of failure from the non-healing:

*"So there is a taboo with the word death. We say it is certain as it is, but we generally avoid thinking about this certainty" (Nurse Callista Roy);*

*"It is somewhat complicated. So it depends on that, because I think we have to have a certain neutralism as professionals" (Nurse Saint Francis of Assisi).*

Medical and nursing students are trained for the technical treatment, not to deal with the paradox between life and death. Health professionals pursue the cure and grieve the death of patients under their care <sup>16</sup>.

Professional unpreparedness when facing death and training focused on saving lives are primarily responsible for the frustrations and suffering of nurses before the patient in the process of death <sup>3,17</sup>. In order to change this scenery, it is necessary for nursing professionals to start, since the beginning of their training, to gradually deconstruct the taboo around finitude. Frustration should give rise to a new way of thinking and acting, so that nurses can plan and provide the best possible humanized care to the patient. This attitude should bring great positive changes to the process, considering that nurses are the professionals who are able to prescribe care.

*"This conception of humanization, which goes from birth to one's process of finitude" (Nurse Callista Roy);*

*"It is taking care of them every minute, every day is their day. Death as a stage of life" (Nurse Wanda Horta);*

*"And I don't mean treated, ok? But I think this needs to be taken care of because the fact that they don't have a prognosis doesn't mean I'm not taking proper care of them" (Nurse Anna Nery);*

*"When we learn a patient is going to die, they're neglected. So we stop providing care to them. The one they deserved" (Nurse Florence Nightingale).*

Nurse Florence Nightingale's speech also, brings the perspective of humanized care to terminal patients: *"In some places, people have given a lot of thought to the human way to treat human beings, which is the great duality that we often discuss, right? Humanizing the human being, that's a redundancy"*. How to look at death is a relatively new pedagogical proposal, the nursing faculty members longer graduated little discussed the process of finitude during their academic education, experiencing, at some point in their professional practice, suffering and frustration. It is perceived in the speeches that

nurses suffer along with terminal patients and their families, and go through sadness, sense of failure and anguish facing the situation:

*"I suffered a lot... I get chills when I think of it (...) it's a very sad scene, watching someone die, not being able to 'do anything', and understanding their pain..." (Nurse Florence Nightingale);*

*"And I've had a few experiences when every time I stopped being this facilitator, I grieved much more than the family" (Nurse Wanda Horta).*

The speeches showed that in order to take care of caregivers it is essential to discuss the process of dying with health professionals. It is fundamental to ensure the existence of institutional spaces to expose fears, anxieties and frustrations of professionals facing the process of dying. It is required to have specialized environments in which professionals can elaborate their daily grieving and minimize the pain and loss, also considering psychological support inside health institutions. It must be considered, moreover, that the preparation and appreciation of these professionals results, still, in a decrease in cases of burnout syndrome, the final reaction of the individual against the stressful experiences accumulated through their career<sup>3</sup>.

Having humanized care to patients in process of finitude as a perspective, it becomes evident the importance of extending the discussion and reflection to academic dimensions, so that in the future, professionals can understand dying in its subjectivity, thus respecting the time of the patient and their family. If it is already possible to notice such change in professional education, which begins to contemplate the teaching of practices related to death and dying, the findings of the study allow us to state that such process should be built, amplified and extended to all universities, to contemplate care practice to terminal patients in consonance with the needs and principles of SUS:

*"We need to be prepared because it isn't easy dealing with the situation" (Nurse Florence Nightingale);*

*"I think it's touching the students, showing them the reality (...) inside the institutions and making them (...) feel, eh? The discomfort!" (Nurse Anna Nery);*

*"I hope that, sometime from now, the work of nurses will improve, we are in a process of change..." (Nurse Florence Nightingale).*

Lastly, it is worth noting that in order to promote a transformation in their perception, for their own benefit, around the phenomenon of death and dying itself, it is important for the nursing professional to aggregate knowledge to the essence of palliative care, whose goal is to eliminate the suffering caused by physical, psychic and spiritual pain. In addition, it is beneficial for the professional to overcome the limitations imposed by the hodiernal cultural patterns on human finitude in order to start facing death as a natural consequence in every person's life, without banalizing it.

### **Confronting the family in the process of finitude**

In the speeches of the faculty members, it is perceived that the pain of the family of an individual without any life perspective is often underestimated and forgotten by the multidisciplinary teams:

*"We often worry about the patient only, and neglect the family that grieves for a beloved one who's dying" (Nurse Florence Nightingale);*

*"They understand that there's no prognosis, no conditions to continue treatment, but still there's a human limitation, I guess, in accepting that, right?" (Nurse Anna Nery);*

*"They also confront this fear and look for someone or something in support, and it's often us, nurses. We're there, on the front line" (Nurse Callista Roy);*

*"Well, this is a very private situation, very particular of every person involved" (Nurse Saint Francis of Assisi).*

The reality found in the inpatient units with terminal patients modifies according to the families. Many accept the process of dying and some insist on demanding investment from the team, extending the patient's suffering. As nurses providing holistic care, the spiritual dimension of the patients and families should not be left aside, because it may help them at that moment. Spirituality is a complex concept, related to the supersensible sphere, which seeks the meaning of life by the transcendence in God or in a higher power. Pessini and Bertachini find it necessary when accepting the process of finitude<sup>19</sup>.

Another aspect to be considered is the professional-patient communication, which should reduce uncertainties and direct the patient to the situational reality in the process of terminality<sup>20</sup>. Based on clear

and relevant information, the communication should be extended also to reach the family's acceptance<sup>20</sup>.

*"They know it's best for the patient to go, but they don't want to lose them because the human being is selfish" (Nurse Florence Nightingale);*

*"You go through the entire situation with them and still they go: I want you to do everything in your reach to save my son" (Nurse Anna Nery).*

The family plays an essential role in the moment of the decision about ceasing futile investments and treatments for the execution of the orthothanasia and palliative care<sup>21</sup>. In order for there to be a conduct based on bioethical principles, respecting beneficence, not maleficence, autonomy and justice, it is indispensable to introduce the terminal patient's family to the process of care until the last moment of their life. On the other hand, to Garcia<sup>22</sup>, the principle of autonomy puts the patient as the only moral authority over their own body; so, at first, nobody has the right to decide for them or to limit their decision.

There is no specific regulation in Brazil regarding orthothanasia and therapeutic limitation in terminal patients, but the refuse to medical treatment is legally protected<sup>23</sup>.

The constitutional principle of human dignity and the Law 10.245/99 allow terminal patients to refuse medical therapy<sup>23,24</sup>. In addition, the Resolution 41/95 of the National Council for the Rights of Children and Adolescents (Conanda) ensures the young or infant patient the right to dignified death, close to family, when all possibilities of therapy run out<sup>23,25</sup>.

Despite little known in Brazil, the prior declaration of will of terminal patients is the document through which the patient informs the family and professionals what treatments they would or would not like to undergo, in case of terminality<sup>8,26</sup>. In 2012, the Resolution 1.995 of the Federal Board of medicine (CFM) considers the physician's duty to put in the records the patient's previous will – which, in turn, should prevail over any other non-medical opinion, including the desire of the family. This resolution also states that should be taken into account the information from legal representatives previously designated by the patient<sup>8,23</sup>.

According to the laws stated here, the Code of Ethics for Nurses highlights – on Chapter I, Section I, article 18 – that it is the professional's responsibility and duty to *respect, recognize and perform actions that ensure the right of the person or their legal*

*representative, to make decisions on his/her health, treatment, comfort and welfare*<sup>6</sup>.

### **Extension of human suffering in intensive care units**

Retrospectively in the history of health care, the reality is understood by technological and professional apparatuses, highly capable to deal with the health-illness process. However, the teachers interviewed affirm that there is a need for changes in the qualification of a professional able to deal with the acceptance of the non-continuity of investments in patients with guarded prognosis:

*"Sometimes, the pain isn't only physical, it's also psychical; sometimes for the lack of orthothanasia itself" (Nurse Callista Roy);*

*"Even when the team notices 'it's better if I just medicate them so they won't feel pain, and I know it's best for them'. But they thirst for life; you can see that in the patient. At that point, the duality is installed" (Nurse Florence Nightingale).*

It is worth noting that health professionals become vulnerable when taken by the anguish of loss and failure in the process of dying, when therapeutic interventions and responses from the technological apparatuses run out.<sup>27</sup> Associated to the difficulty to promote the orthothanasia, there is also the respect to the patient's decision, which interferes in the process of acceptance of the human finitude. So, it is necessary to be a facilitator of the acceptance of death as an end to the suffering of the patient and their family; knowing to respect their individuality, rights and feelings.

To Nurse Callista Roy, insisting on treating terminal patients is contradicting the principles of orthothanasia: *"we also have dysthanasia, right? The suffering before the process of death"*. At the same time, terminal patients cannot have an early end of life, under penalty of proceeding with the euthanasia. So, essential care must be provided to terminal patients, such as adequate nutrition and hydration, sedation for the pain and general hygiene care, in order to promote death in its natural course and with dignity.

Technological improvement, besides increasing life expectation, may extend the process of dying. Therefore, the conducts of therapeutic effort limitations (TEL) and their ethical-legal implications have been widely discussed<sup>28</sup>. The promotion of care to TEL patients depends, primarily, on accept-

ing human finitude and recognizing the inability of cure by professionals 29. To these patients, it is indispensable to adopt palliativist therapeutic plans which prioritize the control of pain and discomfort, and the promotion of welfare 29.

### **Perspective of palliative care in intensive treatment units**

The care provided adequately to terminal patients respects the subjectivity of the individual. At this point, palliative care brings the best way to assist terminal patients:

*"I understand that dignified death, for a terminal patient, is providing them with comfort" (Nurse Florence Nightingale);*

*"Dignified death is... I see it as taking good care of the patient at the end of their life" (Nurse Anna Nery).*

Knowing that the patient is at terminal stage does not mean overlooking them and denying care, according to Nurse Callista Roy: *"We can't differentiate the care provided to that patient, right? Listen to the patient, listen to the family, instruct the family, help the family".*

The way each patient lives their terminality is related to the circumstances of the care provided, the dynamics of the ethics in the relation created between the patient and the professionals assisting them<sup>17</sup>. So, the therapeutic focus is turned to quality of life, control of the symptoms and relief of the human suffering, based on trans, multi and interdisciplinary aspects of palliative care<sup>30</sup>. Palliative therapy aims to the symptomatic control and preservation of quality of life for the patient, with no curative function, of extension or shortening of survival<sup>30</sup>.

Professional work on patients in process of finitude demands special training, including continuous updates on the subject, because it is by dealing with this theme that professionals become more prepared and confident about the care provided to patients under their responsibility. This way, it is highly important to treat death as a continuous theme, including after academic education, considering that acquaintanceship, observation, interventions and constant updates make nurses become increasingly confident in their practice:

*"It's a friendly word, it's standing by the patient, it's listening to what they're feeling, it's providing the best nursing care I can" (Nurse Florence Nightingale);*

*"We know that a lot has been discussed about caregiving to terminal patients, but it still isn't, not in my past and present experience, it isn't the best possible" (Nurse Florence Nightingale).*

Furthermore, it is implied in the speeches that some institutions do not provide adequate conditions for the best treatment, often restricting materials that hinder the process of dying. As exemplified by Nurse Anna Nery: *"and then it's a bedridden patient, with a request for bandage covering blocked by the insurance company for lack of prognosis. That's how I see the private institutions, dehumanized! In SUS (unified health system), on the other hand, I see a certain flexibility. If it's prescribed, if it was evaluated by the nurse, or the doctor prescribed, this covering is authorized independently of the prognosis".*

From this illustrative speech, it is understood that the ideal of "justice as fairness" will always be debated in the conflict between the "universalization politics", responsible for the distribution of goods for all, and the "focus politics", responsible for the election of the people and goods to be distributed<sup>17</sup>.

Palliative care are a humanized complement of the practices of caring and treating others, besides providing more comfort to caregivers in the fulfillment of their tasks, avoiding frustrations, responding to the other's call without doing more than it's possible, respecting the right to die with dignity.

### **Final remarks**

Discussions about terminality have increased, but are still not enough in regard to the practice of nursing professionals. To reach progress in these discussions, it is necessary to transversely introduce the subject in every undergraduate discipline, making it more than just an isolated topic, distant from the actions in nursing.

It is noticeable that faculty nurses influence the academic point of view and are essential to spread the importance of dignified death in the hospital scenario. The justification is in the fact that nurses who experience death in their professional practice turn out to be mostly unprepared when neglecting palliative care, i.e., humanized and holistic care for terminal patients.

Regarding palliative care, the speeches of the interviewees acknowledge considering the existence of a niche for nursing performance that should not be despised or unknown by the responsible profession-

als. Considering that these professionals are primarily responsible by caregiving to patients, they are the ones who will put orthothanasia in practice: dignified, respectful and humanized death to terminal patients.

It is perceived that the orthothanasia is grounded on bioethical principles, neither to shorten nor to extend the lives of patients without therapeutic perspectives. On the other hand, it is also perceived that health professionals acknowledge the orthothanasia, but show difficulties in practicing it, whether by emotional unpreparedness or by not actually realizing the patient's needs. It is possible that professionals practice dysthanasia because they feel that they have to invest once more on a patient to whom they conferred so much care. This way, this research shows the need, from professional education, to review questions related to dignified death. The suggestion is to conduct questions referring to terminality in a more objective, less artificial way.

It is worth noting that researching, studying, discussing or reflecting on death is always very im-

portant, because it is a way of treating it as part of the reality of caregiving, as well as providing improvements in the quality of the process of dying of terminal patients. In view of this phenomenon, it is essential to increasingly spread the ethics of care in educational institutions, aiming to train professionals able to care for the lives of those who are dying, not only to extend the time of dying.

Promoting dignity in the process of finitude is an indispensable attitude nowadays. So, the impressions and considerations of professors about the orthothanasia and human finitude have to be investigated, both because of their professional experience and because they should play a reference role in the process of training of new professionals, who hopefully will guarantee humanized care to a dignified finitude. Lastly, it is considered that other studies are necessary to the exploitation of the difficulties concerning the heterogeneity of the nurses' actions and knowledge, comprising the orthothanasia and humanized assistance in terminality.

## References

1. Marquis AI. Sufrimiento y cuidados paliativos al final de la vida: hacia una muerte digna. *Rev Argent Cancerol*. 2007;35(2):87-9.
2. Gutierrez BAO. O processo de morrer no cotidiano dos trabalhos dos profissionais de enfermagem de unidades de terapia intensiva [tese]. São Paulo: USP; 2003.
3. Santos JL, Bueno SMV. A questão da morte e os profissionais de enfermagem. *Rev Enferm Uerj*. 2010;18(3):484-7.
4. Balla A, Haas RE. Percepção do enfermeiro em relação à ortotanásia. *Revista Bioethikos*. 2008;2(2):204-13.
5. Pessini L. Distanásia: até quando prolongar a vida? São Paulo: Centro Universitário São Camilo; 2005.
6. Conselho Federal de Enfermagem. Código de ética dos profissionais de enfermagem. [Internet]. 8 fev. 2007 [acesso 20 abr. 2011]. Disponível: <http://www.portalcofen.gov.br/sitenovo/node/4158>
7. Biondo CA, Silva MJP, Secco LMD. Distanásia, eutanásia e ortotanásia: percepções dos enfermeiros de unidades de terapia intensiva e implicações na assistência. *Rev Latinoam Enferm*. [Internet]. out. 2009 [acesso 6 set. 2012];17(5):613-9. Disponível: [http://www.scielo.br/pdf/rlae/v17n5/pt\\_03.pdf](http://www.scielo.br/pdf/rlae/v17n5/pt_03.pdf)
8. Conselho Federal de Medicina. Resolução CFM nº 1.931, de 24 de setembro de 2009. [Internet]. Aprova o Código de Ética Médica. 2010 [acesso 20 abr. 2011]. Disponível: <https://www.mar.mil.br/dsm/Download/CodigoEticaMedica.html>
9. Academia Nacional de Cuidados Paliativos. Manual de cuidados paliativos. Rio de Janeiro: Diagraphic; 2009.
10. Brasil. Ministério da Saúde. Portaria nº 2.439, de 8 de dezembro de 2005. [Internet]. Institui a Política Nacional de Atenção Oncológica, promoção, prevenção, diagnóstico, tratamento, reabilitação e cuidados paliativos, a ser implantada em todas as unidades federadas, respeitadas as competências das três esferas de gestão. [acesso 28 set. 2011]. Disponível: [http://bvsms.saude.gov.br/bvs/saudelegis/gm/2005/prt2439\\_08\\_12\\_2005.html](http://bvsms.saude.gov.br/bvs/saudelegis/gm/2005/prt2439_08_12_2005.html)
11. Bellato R, Araújo AP, Ferreira HF, Rodrigues PF. A abordagem do processo do morrer e da morte feita por docentes em um curso de graduação em enfermagem. *Acta Paul Enferm*. [Internet]. 2007 [acesso 8 set. 2012]; 20(3):255-63. Disponível: <http://www.scielo.br/pdf/ape/v20n3/a03v20n3.pdf>
12. Brasil. Ministério da Saúde. Diretrizes e recomendações para o cuidado integral de doenças crônicas não transmissíveis: promoção da saúde, vigilância, prevenção e assistência. Brasília: Ministério da Saúde; 2008.
13. Coltro A. A fenomenologia: um enfoque metodológico para além da modernidade. *Caderno de Pesquisa em Administração*. 2000;1(11):37-45.

14. Graças EM. Pesquisa qualitativa e a perspectiva fenomenológica: fundamentos que norteiam sua trajetória. *Reme Rev Min Enferm.* 2000;1(4):28-33.
15. Hansen BL, Goodell TT, DeHaven J, Smith M. Nurses' perceptions of end-of-life care after multiple interventions for improvement. *Am J Crit Care.* [Internet]. 2009 [acesso 2 maio 2013];18(3):263-71. Disponível: <http://www.aacn.org/WD/CETests/Media/A0918033.pdf>
16. Moritz RD. Os profissionais de saúde diante da morte e do morrer. *Bioética.* [Internet]. 2005 [acesso 2 maio 2013];13(2):51-63. Disponível: [http://revistabioetica.cfm.org.br/index.php/revista\\_bioetica/article/view/107/112](http://revistabioetica.cfm.org.br/index.php/revista_bioetica/article/view/107/112)
17. Py L. A não ressuscitação, do ponto de vista dos pacientes, em uma unidade de cuidados paliativos oncológicos. *Rev Bras Cancerol (Impr.).* 2007;53(2):237-40.
18. Oliveira JR, Amaral CFS, Ferreira AC, Grossi YS, Rezende NA. Percepção bioética sobre a dignidade no processo de morrer. *Rev. bioét. (Impr.).* 2009;17(1):77-94.
19. Pessini L, Bertachini L. O que entender por cuidados paliativos. 2ª ed. São Paulo: Paulus; 2006. (Coleção Questões Fundamentais da Saúde).
20. Burlá C, Py L. Peculiaridades da comunicação ao fim da vida de pacientes idosos. *Bioética.* [Internet]. 2005 [acesso 2 maio 2013];13(2):51-63. Disponível: [http://revistabioetica.cfm.org.br/index.php/revista\\_bioetica/article/view/111/115](http://revistabioetica.cfm.org.br/index.php/revista_bioetica/article/view/111/115)
21. Santana JCB, Dutra BS, Paula LB, Freitas RHF, Martins TCO, Moura IC. Ortotanásia: significado do morrer com dignidade na percepção dos enfermeiros do curso de especialização em unidade de terapia intensiva. *Revista Bioethikos.* 2010;4(3):324-31.
22. Gracia D. *Bioética clínica.* Santa Fé de Bogotá: El Buho; 1988.
23. Rocha AR, Buonicore JP, Silva AC, Pithan LH, Feijó AGS. Declaração prévia de vontade do paciente terminal: reflexão bioética. *Rev. bioét. (Impr.).* [Internet]. 2013 [acesso abr. 2013];21(1):84-95. Disponível: [http://revistabioetica.cfm.org.br/index.php/revista\\_bioetica/article/view/790/859](http://revistabioetica.cfm.org.br/index.php/revista_bioetica/article/view/790/859)
24. São Paulo (Estado). Lei nº 10.241, de 17 de março de 1999. Dispõe sobre os direitos dos usuários dos serviços e das ações de saúde no Estado e dá outras providências. *Diário Oficial do Estado de São Paulo.* 18 mar. 1999;Seção 1:1.
25. Brasil. Ministério da Justiça. Conselho Nacional dos Direitos da Criança e do Adolescente. Resolução nº 41, de 13 de outubro de 1995. Dispõe sobre os direitos da criança e do adolescente hospitalizados. *Diário Oficial da União.* 17 out. 1995;Seção 1:163-9.
26. Penalva LD. Declaração prévia de vontade do paciente terminal. *Rev. bioét. (Impr.).* [Internet]. 2009 [acesso 2 maio 2013];17(3):523-43. Disponível: [http://www.revistabioetica.cfm.org.br/index.php/revista\\_bioetica/article/viewFile/515/516](http://www.revistabioetica.cfm.org.br/index.php/revista_bioetica/article/viewFile/515/516)
27. Oliveira Júnior JO. Cuidando do cuidador. *Prática hospitalar.* 2009;11(65):117-9.
28. Moritz RD, Deicas A, Rossini JP, Silva NB, Lago PM, Machado FO. Percepção dos profissionais sobre o tratamento no fim da vida, nas unidades de terapia intensiva da Argentina, Brasil e Uruguai. *Rev Bras Ter Intensiva.* [Internet]. 2010 [acesso 2 jun. 2013]; 22(2):125-32. Disponível: <http://dx.doi.org/10.1590/S0103-507X2010000200005>
29. Moritz RD, Machado FO, Heerd M, Rosso B, Beduschi G. Avaliação das decisões médicas durante o processo do morrer. *Rev Bras Ter Intensiva.* [Internet]. 2009 [acesso 2 jun. 2013];21(2):141-47. Disponível: <http://dx.doi.org/10.1590/S0103-507X2009000200005>
30. Brasil. Ministério da Saúde. Instituto Nacional de Câncer. Cuidados paliativos oncológicos: controle de sintomas. Rio de Janeiro: Inca; 2001.

#### Authors' participation

Júlio César Batista Santana was responsible for structuring the project, analyzing the interviews and structuring the article. Bruna Reis da Silva, Denísia Cristiane dos Anjos Oliveira, Eberth Mesquita Caminha and Flávia Soares Peres were responsible for structuring the project, collecting data and structuring the article. Cynthia Carolina Duarte Andrade was responsible for the analysis of the results, and Maria Bernadete de Oliveira Viana, for structuring the project.

Received: 8. 9.2012

Reviewed: 8. 5.2013

Approved: 11. 6.2013