

Perception of intensive care nurses in regional hospital on dysthanasia, euthanasia and orthothanasia

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Abstract

The objective of this study was to analyze the perception of intensive care nurses on the concepts of dysthanasia, euthanasia and orthothanasia and the possible bioethical implications for care. An exploratory and descriptive study of a qualitative nature was carried out through questionnaires applied to eight nurses working in Intensive Care Units. The themes that emerged from the responses were identified and analyzed based on literature. The results showed that nurses understood the concepts of dysthanasia, euthanasia and orthothanasia correctly, but could not carry out practical care based on the principles of orthothanasia, and demonstrated difficulty in defining the four bioethical principles that should direct care. It was concluded that although nurses understood these three concepts relating to terminal illness and recognized their importance for the provision of care, from the responses analyzed it could not be inferred that the principles of orthothanasia were actually present in routine care, which can negatively influence the quality of such care.

Keywords: Palliative care. Nursing care. Bioethics. Intensive care units.

Resumo

Percepção de enfermeiras intensivistas de hospital regional sobre distanásia, eutanásia e ortotanásia

Este estudo analisa a percepção de enfermeiras intensivistas de hospital regional sobre os conceitos distanásia, eutanásia e ortotanásia e possíveis implicações bioéticas no cuidado do doente terminal. Realizou-se pesquisa exploratória e descritiva, de natureza qualitativa, aplicando questionários a oito enfermeiras que atuam em duas unidades de terapia intensiva. Identificaram-se os temas que emergiram das respostas, que foram então analisados com base na literatura. Os resultados evidenciaram que as enfermeiras sabiam conceituar distanásia, eutanásia e ortotanásia; contudo não conseguiam efetivar um cuidado direcionado pelos princípios da ortotanásia, além de demonstrarem dificuldade em definir os quatro princípios bioéticos que devem direcionar os cuidados. Conclui-se que, apesar das enfermeiras compreenderem os três conceitos de terminalidade e reconhecerem sua importância em relação ao cuidado, não foi possível depreender, das respostas analisadas, que na sua prática cotidiana os princípios da ortotanásia estejam efetivamente presentes, o que pode influenciar negativamente a qualidade da assistência.

Palavras-chave: Cuidados paliativos. Cuidados de enfermagem. Bioética. Unidades de terapia intensiva.

Resumen

Percepción de las enfermeras intensivistas de un hospital regional sobre distanasia, eutanasia y ortotanasia

El objetivo de este estudio es analizar la percepción de enfermeras intensivistas sobre los conceptos de la distanasia, eutanasia y ortotanasia, y las posibles implicaciones bioéticas en el cuidado de paciente terminal. Se llevó a cabo un estudio exploratorio y descriptivo de naturaleza cualitativa, a través del uso de cuestionarios con ocho enfermeras que trabajan en dos Unidades de Cuidados Intensivos. Se identificaron los temas que surgieron de las respuestas y los analizaron a partir de la literatura. Los resultados mostraron que las enfermeras sabían conceptualizar la distanasia, eutanasia y ortotanasia correctamente, pero no pueden llevar a la práctica un cuidado dirigido por los principios de la ortotanasia, además demostraron dificultad en definir los cuatro principios bioéticos que deben conducir los cuidados. Se concluye que, a pesar de que las enfermeras entienden los tres conceptos acerca de un paciente terminal y reconocen su importancia en el cuidado, no fue posible deducir de las respuestas analizadas que en su práctica diaria los principios de la ortotanasia estén realmente presentes, lo cual puede de cierta forma influir negativamente en la calidad de la atención.

Palabras clave: Cuidados paliativos. Atención de enfermería. Bioética. Unidades de cuidados intensivos.

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Declararam não haver conflito de interesse.

The technological advances achieved from the second half of the twentieth century, associated with the development of therapeutics, enabled many diseases hitherto considered lethal transform into chronic conditions, also opening the possibility of increasing longevity. However, despite accumulated knowledge and the efforts of researchers, death remains a certainty and threatens the ideal of healing and the preservation of life¹.

In view of this development and, consequently, the dilemmas imbricated in the relationship between technological advances and human life, the question arises, "what life is being discussed?" From this question comes the need to discuss the ethical and legal dilemmas in the process of caring for the terminally ill in the context of intensive care units (ICU), considering especially the care provided by nurses. These professionals spend the most time with patients in the ICU, providing care and/or supervising the indicated procedures. As many patients of these units are beyond the possibility of a cure, it appears that sometimes care practices end up directed at possible dysthanasia processes, guided by futile and often unnecessary treatment, and with little use of guided measures to limit the therapeutic effort, as well as to adjust measures for the relief of suffering, in order to provide a dignified death.

In this context, it is not only necessary but also imperative to discuss issues related to bioethics in relation to care practices, since this is a field of study that, steadily, addresses issues involving the boundaries between the beginning and the end of human life. Thus, it seeks to stimulate reflection regarding the meaning of biotechnological advances and the support health of team professionals in decision making².

It is possible to recognize that the actions of nurses as health team members line up with the four pillars of principlist bioethics: beneficence, non-maleficence, autonomy and justice, with the purpose of preserving the rights of the patient as a person in vulnerable conditions, providing the assurance of actions based on sensitive, decent and safe care³. Linked to discussions on technological advances and bioethical dilemmas of care for people with no chance of cure came new concepts that define these impasses in terms of how the process of dying is faced by health professionals. Among these concepts, euthanasia is the most often reported by the media and has sparked wider discussion in scientific publications.

The word "euthanasia" has its etymological origin from the Greek: *eu* (good) and *thanatos* (death), presented by Francis Bacon as a noble medical duty that consisted of alleviating suffering in the care of people in the terminal process^{4,5}. However, from the twentieth century, a markedly negative connotation of the term has crystallized, distorting its definition of "good death" and applying a new semantic definition, which refers to practices whose purpose is death caused by a health professional⁵. The change is so striking, that the Brazilian Code of Ethics of Nursing Professionals, in its article 29, says that it is forbidden for nursing professionals to promote euthanasia or to participate in practices designed to anticipate a patient's death⁶. In the field of bioethics, it is argued that it is possible to achieve the practice of "good death" through resources related to therapeutic adequacy, without shortening life.

Therefore, in opposition to the new definition of euthanasia, the concept of dysthanasia arose. It is still little known but widely used by health professionals. Contrary to what happens with its antonym, dysthanasia is defined as slow death accompanied by much suffering. It is a concept used as a synonym of futile treatment or therapeutic obstinacy, despite its practice being highly present in health institutions, especially in the ICU^{7,8}.

In order to propose an intermediate reflection, the concept of orthothanasia arose as a mediatorial way, considered by palliative care specialists as the more appropriate care option for patients with terminal illness, who present intense physical and mental suffering, in line with more humane care practices⁹. This practice is consistent with care that takes into account the natural course of life and death as part of life, seeking relief of suffering by adopting palliative care and avoiding unnecessary procedures that only prolong the suffering of the patient and the family, and constitutes the limit of therapeutic efforts⁹.

Coupled with the concept of orthothanasia, in favor of carefully directed and appropriate therapy in order to minimize the people's suffering during the process of dying, the drive for palliative care intensifies, with the development of proactive and holistic care for the person whose disease is unresponsive to curative treatment. This movement aims to provide the best possible quality of life for patients and families, by controlling pain, other symptoms and psychosocial and spiritual problems. Palliative care goes beyond the concept of orthothanasia and is

based on philosophical principles that are aimed at relieving symptoms and discomfort, preserving the quality of life to the end, so that death occurs naturally and is never deliberate, paying attention to the family as part of the care unit, and extending care after death during the grieving process¹.

The practice of palliative care advocates interdisciplinary team activities, and the participation of nurses in this process is essential. In this sense, it is necessary to think about the role of the nursing team from the interdisciplinary perspective, so that, guided by bioethical principles, the nurse can help patients in their process of dying, taking the preservation of dignity and the relief of suffering as the guiding care principle¹⁰.

Nurses can identify situations in which bioethical principles and the rights of patients are not respected, and are able to provide the necessary interventions to ensure humane and dignified care. Hence, it is important that these professionals have knowledge of the concepts of euthanasia, dysthanasia and orthothanasia, and of the principles of bioethics regarding the scope of proactive and holistic care, as recommended by the World Health Organization (WHO) with the philosophical principles of palliative care¹¹.

There are many publications on palliative care; however, with regard to bioethical issues, palliative care and nursing care, there is a relative scarcity. This justifies the development of this study, considering that all nursing professionals, as provided in their Code of Ethics⁶, are co-responsible for the search and the adoption of respectful, ethical and responsible measures for the dignified and humane care of terminal ill patients and their families.

Starting from the assumption that intensivist nurses deal, in their daily life, with critically ill patients that are potentially curable, but also with patients that present diagnosis of incurable diseases, and that these professionals are sometimes unaware that the care provided in many situations is a dysthanasic process - which has contributed to the practice of therapeutic obstinacy - the objective of this study was to analyze the perception of intensive care nurses regarding the concepts of dysthanasia, euthanasia and orthothanasia, and the possible bioethical implications for care. The aim is also to contribute to the evaluation of ongoing training processes offered to these professionals, particularly considering the practice of palliative care in ICUs.

Methodology

It is exploratory and descriptive research with a qualitative approach¹², in which eight nurses have participated - seven assisting and one resident nurse - who worked in two public hospital intensive care units in the São Francisco Valley region in Brazil. Those who were selected worked in the ICU for more than six months. During the period of data collection, the two units were comprised of fifteen nurses (twelve assisting, two coordinators and one resident) and a twenty-bed capacity. The profile of patients cared for included those suffering from chronic diseases, recovering from serious surgeries and/or with hemodynamic complications.

Data collection occurred from September 2014 to February 2015, with the application of questionnaires to the profiling of participants, addressing the following variables: age, gender, time elapsed since graduation and working in intensive care, possession of a specialization degree, and function in the ICU (clinical, coordinator or resident nurse). It also consisted of eight subjective questions about their knowledge regarding euthanasia concepts, dysthanasia and orthothanasia, of the four bioethical principles (of principlism) and its implications in the care (Appendix). It is worth mentioning that the questionnaire was validated and already applied in other research¹³, being made available by the authors for reuse in this scenario. Professionals completed the questionnaire while on duty and then returned it to the researcher, not being allowed to take it away to respond later.

All study participants, after the necessary clarifications regarding the objective of the research, agreed to voluntarily participate in the study and then signed the consent form.

The obtained data was analyzed qualitatively, using the questionnaires and the content analysis technique¹⁴. The topics that emerged from the responses were identified, and then received proper analysis, with the assistance of literature related to the research subject, in order to achieve the objective of the research. The sequence of questions was as follows: knowledge of dysthanasia, euthanasia and orthothanasia; frequency of such processes in the daily practice of nurses; applicability or not of the concepts in their daily practice; guiding actions in the face of dysthanasia situations; knowledge of bioethical principles and their relevance to health care.

To maintain the anonymity of the participants, a code was used for each participant, the letter "P" followed by a number (P1, P2, P3, etc.), according to

the sequence that completed questionnaires were returned. The Ethics and Research Committee considered and approved the project, and the study followed the precepts of Resolução 466/2012 [Resolution 466/2012] of the Brazilian National Health Council¹⁵.

Seeking the best strategy for presenting the responses regarding the concepts of euthanasia, orthothanasia and dysthanasia, a summary table was built in order to optimize the visual presentation of the answers. From this summary, information was generated and discussed according to the literature. Its use in this study is considered fundamental for the construction of the analysis, since, based on the responses collected, study participants were profiled and the findings were interpreted and analyzed.

Limitations of the study centered on the difficulty of professionals complying to respond to the questionnaire: they justified themselves saying that the questionnaire was extensive and,

therefore, requested to take it home, citing lack of time to answer it while on duty. With concerns that respondents might consult references on the subject, it was emphasized that the questions should be answered in due time and that the questionnaire could not be taken home. This eventually reduced the number of study participants.

Results

As for the profiling of the study participants, the average age was 27.5 years, with time since graduation ranging from one to seven years, and time working in ICUs was between six months and four years. Among the participants, six had a specialization degree, of which three were in intensive care and the rest in other areas, such as nephrology, surgery and public health. Two of them only had an undergraduate degree.

Table 1. Study participants' responses regarding the concepts of euthanasia, orthothanasia and dysthanasia.

	Euthanasia	Orthothanasia	Dysthanasia
P1	It is the interruption of the natural course of life.	In contrast, orthothanasia aims to promote a dignified death, without the imposition of futile measures, seeking comfort and quality of life.	It is the institution of futile measures with the consequent prolonging of the patient's suffering in palliative care.
P2	To abbreviate death or the dying process.	It is natural death.	It is the opposite of euthanasia, this means, the prolonging of life, even with a prognosis that is inconsistent with life.
P3	To forcefully anticipate death.	It is to let death follows its natural course, without artificially increasing the length of life.	Useless prolonging of the patient's life, since there is no possibility of reversing the pathological condition.
P4	The doctor leads the patient to death	Technique performed on terminally ill patients, made with the patient's and or the family's consent. The procedures and relief measures to keep the patient alive are suspended, but palliative care that will help control pain is provided.	Cases in which the prognosis is of incurable and irreversible diseases, and the patients' lives are prolonged.
P5	To end a patient's suffering. To disconnect the patient from intensive therapy.	To minimize suffering, to not perform futile therapy, to provide support for palliative or terminal care.	Prolonging suffering, therapy without relieving patient's pain.
P6	To eliminate pain and chronic illness, stopping suffering.	Providing palliative care to patients until the time of death.	Painful and useless life extension.
P7	Practice of giving comfort during the terminal phase of a patient whose disease knowingly has no cure. Corresponds to assisted death.	Middle ground between the two other definitions: it would be to let death happen without any kind of interference.	Act of prolonging life, even when it is known that the patient's death is inevitable.
P8	A mechanism by which death is induced by drugs or other means.	Continuous assistance that grants palliative care, even if it does not bring hope of cure and only eases the pain, allowing death to come naturally.	It is to delay death by all means, even without hope of cure.

All participants responded positively regarding having knowledge about the concepts of euthanasia, orthothanasia and dysthanasia as shown in the partial quotes transcribed in Table 1.

Regarding the question about the occurrence of these processes in their daily practice, the answers of the participants were unanimous in stating that euthanasia does not exist, as it is considered a criminal act in accordance with Brazilian law. However, there are care practices that tend either towards therapeutic futility or towards care based on measures that limit the therapeutic effort, with a view to alleviating suffering.

When questioned, all nurses agreed that they contribute to the provision of care aimed at a dignified death, and recognize the influence of the knowledge of the concepts of euthanasia, dysthanasia and orthothanasia, as well as the application of these to promote a death with dignity. Two participants pointed out that communication is a major element for the proper applicability of care; another three responded that a proper interrelationship of teamwork and multidisciplinary is a factor that favors the quality of care; the other three stated that care should be based on practices that avoid euthanasia and dysthanasia, in order to promote orthothanasia.

With regard to the question about what guides the nurse's actions when faced with dysthanasia practices, four respondents answered that their attitude against these practices was based on bioethical principles and religiosity; two said it was based on patients' desires and emotions; for the others, the basis of their convictions would be based on respect for human dignity.

On being asked about bioethical principles, all said they knew the four principles; however, only five listed them correctly. The other three nurses did not correctly answer the question, citing other principles such as equity, or gave incomplete responses.

In response to the question related to the relevance of nurses knowing these concepts, all agreed on the need to apply the four bioethical principles, in order to preserve the dignity of patients and their families. Three reinforced that this knowledge contributes to improving the practice of caring for terminally ill patients.

All agreed on the importance of the participation of patients, families and nurses in the decision-making process regarding treatment.

However, only three considered the bioethical principle of patient autonomy as essential to this process; the others said that the decision should be made by the multidisciplinary team.

The last question brought up the issue of what underlined respondents professional mode of action. All answered that, for the good development of their work, it is necessary to be aware of bioethical principles, in particular the respect for the patient's individuality, taking into account respect for autonomy as a guiding principle for their professional actions.

Discussion

As for the definition of euthanasia, there were responses that converged with the original concept of euthanasia meaning "good death", as in the responses of nurses P5, P6 and P7, described in Table 1. Meanwhile, the others expressed their perception that euthanasia is an illegal practice, which implies the inducement of an anticipated death.

Establishing a correlation between the variables of postgraduate training and the duration of experience in ICU, among the P5, P6 and P7 nurses, two have completed specialization courses in intensive care, while the other has more experience in ICU (more than three years). This association leads us to think that these are factors that provide greater reflection and analysis regarding the concept of euthanasia, in its etymological essence, demonstrating knowledge that goes beyond the current concept of euthanasia as induced death.

The definition of euthanasia by other participants corresponds to what is set by the national legal and ethical system, which supports the Brazilian Code of Ethics of Nursing Professionals⁶: that it is a prohibited act, related to promoting or participating in practices designed to anticipate the death of the patient⁷. Therefore, for these nurses euthanasia is illegal, and assumes the current definition of a criminal act, according to Brazilian law. It is noteworthy that one can correlate the early concept of euthanasia as "good death" to palliative care, which seeks to provide care guided by principles that integrate technique, technology and humaneness in order to promote quality of life for terminally ill patients, with the relief of pain and suffering, without shortening life, and avoiding therapeutic futility and obstinacy.

The participant P7 defined euthanasia as “assisted death”, which allows us to think that she associated this idea to the concept of assisted suicide. However, for some authors⁵, there are differences between these concepts, and euthanasia is seen as an act through which the professional puts an end to the life of a person affected by incurable disease, while assisted suicide occurs when someone asks for the help of another to, in fact, provoke his/her death, if he/she is not able to perform this action himself/herself.

The data observed in this study are consistent with the results of another study in which the findings highlight a concept of euthanasia similar to the meaning provided by the new definition, which is also conveyed via the media and is part of people’s general knowledge¹⁶.

The answers regarding the definition of dysthanasia are quite convergent and tend towards the correct definition, focusing on the promotion of therapeutic measures, considered futile and useless, given to terminally ill patients, resulting in slow and prolonged death, accompanied by suffering, pain and agony. Research on the concept reveal that, in fact, this practice has been questioned and discussed for years, regarding the lack of purpose in the treatment of unrecoverable patients, with the indiscriminate use of advanced therapeutic arsenals, promoting indefinite life support¹⁷. The observation of pain and suffering associated with this situation has generated discussions and implies a bioethical dilemma, which also interferes with the delivery of care undertaken by the nursing staff.

This dilemma covers the matter related to the time in which one can or should make a decision regarding the continuity of treatment without causing additional suffering to the patient^{17, 18}. In this study, the nurses see this issue as a generator of bioethical conflict, as they recognize the need for intense discussion between medical and nursing staff for decision making regarding the assistance plan to be proposed to patients in terminal situations.

This discussion should take advantage of the principle of autonomy, based on enlightening dialogue that allows the patient to refuse treatment with knowledge and freedom, understanding that it is possible to avoid moral conflict when the patient’s autonomy is respected, even if the patient is not communicative at the time of decision making. It is also important to consider the bioethical resources, like the advance directives, as a strategy to assist the

decision-making - by the professional staff, patients and their families - in order to serve the best interest of patients.

In a similar study¹³, carried out with 27 nurses, 15 of them (55.5%) understood the practice of dysthanasia as the artificial prolongation of life without benefits, and 3 participants (11.1%), as slow death accompanied by suffering. The others were unable to conceptualize dysthanasia. In this study, participants were unanimous in answering that dysthanasia is the artificial prolongation of life without benefits; and three highlighted that this extension is characterized by the adoption of measures that are futile and/or useless to the quality of life of the patient.

The participant P4 defined dysthanasia as a situation in which the prognosis is of incurable and irreversible disease, opting for the extension of this condition. This highlights a practice of excessive therapeutic measures that end up imposing suffering and pain on people with irreversible and terminal diseases, culminating in a scenario that generates ethical conflicts regarding the excessive use of technology as therapy in patients for whom death is inevitable¹⁷.

Finally, orthothanasia is the term used to describe and represent what is currently presented as dignified death, without adding measures to abbreviate life and without imposing measures that increase unnecessary suffering, but with the promotion of comforting measures to allow death to occur in its own time, as naturally as possible^{13,18,19}. This perspective is also evident in the responses of the nurses in this study. Most answers converged with the concept of orthothanasia as a synonym for natural death and as a process related to the final stage of the life cycle. However, the responses from nurses P4, P6 and P8, which translated the concept as synonymous with palliative care, drew attention. Participant P4, in turn, emphasized the need to respect the patients’ autonomy recognizing their right to accept death and to decide not to invest in disproportionate treatments. Meanwhile, nurse P7 brought a somewhat distorted definition, referring to an abandonment connotation, saying that orthothanasia is letting death happen without interference.

A research that aimed to understand the perception of nurses regarding the practice of orthothanasia in the hospital context¹⁹ found that this is considered as a new concept. According to nurses,

orthothanasia is a viable option for treating death as a constant and irretrievable process, in a way that counteracts the prolonging of human suffering. This interpretation corroborates the responses of the eight nurses who answered the questionnaire in this study.

This data reinforces that participants considered that the actions of nurses should be supported by the promotion of care, with a view to the principles of orthothanasia, which is seen as the art of dying with dignity and humanity, in order to integrate ethics, aesthetics, science and technical skills²⁰. However, although the nurses have described orthothanasia based on the theoretical concept, it is noticeable, on further analysis, that the concept, although consistent, is not used appropriately in their practice within the ICU. It is important to note that orthothanasia seeks to promote care that allows death with relief from pain²¹.

Although some nurses considered orthothanasia as a synonym for “palliative care”, the most appropriate concept is of natural and desirable death, without the artificial prolongation of life, which would cause suffering and alter the natural process of dying⁹. Therefore, palliative care extends this concept to the total care of those who are terminally ill and their families. However, what was not evident in the responses of the participants of this study, is the concern of involving the family in the decision-making process, and if there is, in fact, discussion in defense of the practice of palliative care.

There is a theoretical knowledge, but unfortunately it is not applied in practice. Other studies¹⁶, also showed that nurses, in their daily lives, acknowledge that their care practices in the ICU environment are guided by dysthanasia measures, reflecting the great appreciation of the therapeutic arsenal intended to artificially sustain life. The disproportionate expectations regarding the effectiveness of medical practices, as well as the fear of patients and their families in the face of terminal illness, require from professionals a better reasoning that considers ethics and humaneness, aiming at the best possible comfort for patients. Otherwise, there is the risk of incurring dysthanasia measures that promote suffering and divert patients from orthothanasia.

Finally, when asked about the adoption of these practices (euthanasia, orthothanasia and dysthanasia) in their daily lives, the participants were unanimous in answering that orthothanasia recurred in the context of the two ICUs studied. However,

six nurses pointed out that, although they practiced orthothanasia, it was very common to identify dysthanasia processes. All denied the existence of the practice of euthanasia.

Another study²² also points out that nurses identify dysthanasia, in their day-to-day, as death with suffering and great pain, introducing aggressive treatment that only prolongs the process of dying. However, it revealed that it is also nurses' practice to fight dysthanasia processes and provide orthothanasia, always giving priority to comfort and pain relief in favor of better quality of life in the remaining days of the patient. This condition allows us to infer that the same happens in the environment in which this research was developed.

Moving on to subsequent questions - the question regarding nurses' contribution in the care process for a dignified death, and if this contribution is influenced by their knowledge regarding euthanasia, orthothanasia and dysthanasia - it verified a consensus that participants seek to provide such care for patients' wellbeing, based on participants' previous knowledge. Such interference goes through actions based on an appropriate interrelationship amongst the multidisciplinary team, configured as a harmonic and dynamic communication process, aiming at avoiding euthanasia and dysthanasia processes, and promoting orthothanasia.

Communication, verbal or nonverbal, is essential for nursing professionals to interpret the information and signals transmitted by the patients, to pass it on to other caregivers, and to interact properly with patients and their families. However, given the sensitivity of the situation and the possibility of patients feeling and expressing contradictory emotions and desires, a large proportion of the participants felt unprepared to safely exercise their communication skills, making therapy difficult, regarding an aspect considered key for proper exercise of palliative care for patients, families and staff³. Although verbal and non-verbal communication is part of the arsenal of innate human capacities, it does not always prove to be an easy ability to exercise.

The full exercise of communicative skills demands the exchange of information between sender and receiver. It appears that the process is not easy in situations of difficult decisions for both professionals and patients, in circumstances which allow for more than one interpretation, because of the natural dichotomy between the desire to live and the fear of dying. That happens under

the responsibility assumed by professionals when trying to do their best for others, based on their moral consciousness and deontological standards that underlie the exercise of their work activities. Together, these circumstances may hinder the professional practice of palliative care nursing, thereby conveying a sense of helplessness and failure to professionals.

Given this subjective but powerful picture, intensive care professionals seek guidance to facilitate their daily work activity. As for what guides their practice, nurses responded that bioethical principles are benchmark instruments, in particular the principle of autonomy, that is, respecting the patients' wishes in order to provide humane care in seeking to promote orthothanasia. Although, it was noted that this contradicts previous answers, which can be attributed to the analysis presented above.

Literature suggests that it is the responsibility and duty of the nursing staff attending to patients' rights and bioethical principles, guaranteeing them assistance that meets all their needs and gives them comfort. Therefore, it is important that nurses have knowledge of dysthanasia practices, in order to avoid them, for the sake of proper care that does not violate the ethical principles of their profession. This way, providing care that prolongs suffering is avoided²³. This is a situation that is still difficult to manage, because the work guided by interdisciplinarity is very incipient, especially because decision-making by nurses is minimal, being restricted to doctors²². Therefore, it is important to emphasize that, in palliative care, the participation of the other members of the multidisciplinary team is recommended, fostering interdisciplinary care that does not only involve the participation of nurses and doctors.

It is known that principlism in bioethics defines as guiding elements the four principles (autonomy, justice, beneficence and non-maleficence) and directs its practical application to the care with dignity of both patients and their families. However, it was noted that three participants had difficulty recognizing and describing what those principles were: they were not able to quote or define the principles. This situation brings to mind the undervaluation of bioethics training and discussions regarding its role in professional health practice, which can influence the proper ethical and professional practice of teams. It is worth highlighting the fact that, although ethics is an intertwined topic in nurse training, there are still professionals who are confused or unaware

of the bioethical principles that guide their professional practice.

Bioethics has been incorporated into the historical and social construction of nursing, which ensures new foundations to face daily challenges in connecting ethical and technical care, integrating principles and competencies in the context of caring and accountability for the respect for the human being, in the promotion of health and the relief of suffering¹⁶. Therefore, it is necessary to value bioethics as an important field for reflecting about life and, to consider its inclusion in a professional context, ensuring that it is possible to use it as a tool capable of promoting dialogue and respect, making it pluralist and less complex², particularly when it comes to the principle of autonomy.

By analyzing the responses of participants, it is clear that there is a need for better use of bioethical principles to prevent dysthanasia processes and to achieve the practice of orthothanasia, respecting individuality in the planning of care, recognizing autonomy and human dignity. As evidenced in another study²⁴, nurses emphasized the importance of the use of palliative care in ICUs and discussed the need for the presence of family, comfort measures and respect for patients' autonomy to provide humane care. The data collected also made it possible to deduce the need for all professionals involved in clinical practice to include ethical evaluation in their work, to ensure a dignified death for the patient²⁵.

Regarding decision-making, nurses' responses allowed the inference that their participation, as well as that of patients and their families, are extremely important, through a process of effective communication, to ensure patients' autonomy. Therefore, from the perspective of interdisciplinarity, it is necessary to include nurses in the palliative care team's decision-making, since care is inherent in the profession, from its conception by Florence Nightingale. Thus, nurses use these guidelines to help terminally ill patients, and their families in the grieving process, using the care and preservation of dignity as guidelines¹⁰.

Final considerations

The study concluded that, although nurses understand the concepts of euthanasia, orthothanasia and dysthanasia, and recognize its importance for the care of both terminal patients and their families,

it was not possible to conclude from the responses analyzed if, in the everyday practice of professionals, the principles of orthothanasia are actually present. This may, to some extent, negatively influence the quality of care, particularly with regard to the applicability of bioethical principles and to the inclusion and participation of the family in the process.

It was evident that the concept of orthothanasia is understood as a synonym for “palliative care”. However, as shown in the discussions, palliative care goes beyond the simple acceptance of death at the right time, and requires care measures to alleviate

the suffering, and the inclusion of the family as a unit of care, so that it also receives attention from the interdisciplinary health care team.

It is still striking that health care presents evidence of therapeutic futility and obstinacy. However, it is expected that nurses begin to reflect on their situations in everyday practice, in order to avoid futile treatment and to provide care that promotes the dignity of the terminally ill, minimizing patients’ and their families’ suffering, for the sake of a more human grieving process.

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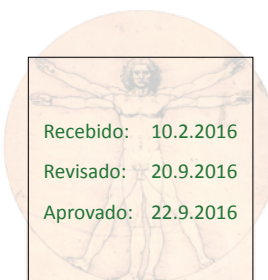
Participation of authors'

Rudval Souza da Silva is responsible for the conception, design, direction, drafting and revising of the study. Cassia Luiza de Souza Evangelista, Rodrigo Duarte dos Santos and Gilvânia Patrícia do Nascimento Paixão participated in the conception, data collection, drafting and revising of the project. Christielle Lidianne Alencar Marinho and Gerlene Grudka Lira participated in drafting and revising the article.

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Appendix

Data collection instrument

Initials: ____ Age: ____ Gender: F () M ()

Time elapsed since graduation: ____ Time working in ICU: ____

Do you have a specialization degree? Y () N ()

Which one(s)? _____

Function:

() Nurse Coordinator

() Healthcare Nurse

() Resident nurse

1. Do you know the concepts of dysthanasia, euthanasia and orthothanasia? Y () N ()

If so, define them:

2. Do these processes occur in your daily practice? Y () N ()

If so, which?

3. Do you believe that the nurse may contribute by knowing these concepts and their proper applicability?

Y () N ()

How?

4. What guides your actions as a nurse in the face of a dysthanasia situation?

5. What bioethical principles do you know?

6. What is the importance, in your daily care duties, of having knowledge of these concepts?

7. Do you believe that the nurse, the family and patients themselves should participate in decision-making processes with regard to their treatment? Y () N ()

If so, how?

8. What is the basis of your professional action mode?
