

The limitation of life support in intensive care: the medical perception

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Abstract

The present study sought to analyze the process of medical decision-making when limiting the life support of critical patients. A descriptive-exploratory, qualitative study was performed with 14 doctors from a public hospital in the southwest of the state of Bahia, Brazil, using semi-structured interviews. The Discourse of the Collective Subject technique was used to identify six central ideas: limitation means not employing useless treatment on terminal patients; the patient has the right to a dignified death and palliative care; it is important to be aware of the family and the professional role in including them when limiting life support; deciding on limitation is a rational and medical question; the family is only informed about the decision; I am not God, I have uncertainties and fear when diagnosing terminality; medicine has many biases, how will I create a protocol for the limitation of care? There was also one anchoring factor: we have no difficulty in limiting support when faced with terminality in cancer cases. It was concluded that there is a need to improve medical training when dealing with death and its challenges.

Keywords: Terminally ill. Death. Intensive care units. Decision making.

Resumo

Limitação do suporte de vida na terapia intensiva: percepção médica

Analisou-se o processo de tomada de decisão médica para limitar o suporte de vida de pacientes críticos. Trata-se de pesquisa exploratório-descritiva e qualitativa, realizada por entrevista semiestruturada com 14 médicos em hospital público no sudoeste baiano. Utilizou-se a técnica do discurso do sujeito coletivo, identificando seis ideias centrais: limitar não é prescrever terapia inútil a paciente terminal; o paciente tem direito à morte digna e a cuidados paliativos; é preciso perceber a família e o papel do profissional em incluí-la na limitação do suporte de vida; decidir pela limitação é questão racional e médica; a família é apenas comunicada; não sou Deus, tenho incertezas e medo de diagnosticar a terminalidade; a medicina tem muitos vieses, como vou protocolar a limitação? E uma ancoragem: se tem câncer, não temos dificuldade para limitar o suporte diante da terminalidade. Concluiu-se que há necessidade de aprimorar a formação médica em relação à morte e seus desafios.

Palavras-chave: Doente terminal. Morte. Unidades de terapia intensiva. Tomada de decisões.

Resumen

Limitación del soporte de vida en la Terapia Intensiva: percepción médica

Se analizó el proceso de toma de decisiones médicas para limitar el soporte de vida de pacientes críticos. Se trata de estudio descriptivo-exploratorio y cualitativo, realizado por medio de entrevistas semi-estructuradas con 14 médicos de un hospital público en el suroeste de Bahía, Brasil. Se utilizó la técnica del discurso del sujeto colectivo, identificando seis ideas centrales: limitar es no prescribir una terapia fútil a un paciente terminal; el paciente tiene derecho a una muerte digna y a cuidados paliativos; es necesario contemplar a la familia y atender al papel profesional de incluirla en el proceso de limitación del soporte de vida; decidirse por la limitación es una cuestión racional y médica, la familia sólo es informada; no soy Dios, tengo incertidumbre y miedo de diagnosticar la terminalidad; la Medicina tiene muchos sesgos, ¿cómo voy a protocolar la limitación? Y un anclaje: si tiene cáncer, no tenemos dificultad para limitar el soporte frente a la terminalidad. Se concluye que existe una necesidad de mejorar la formación médica en relación a la muerte y sus desafíos.

Palabras clave: Enfermo terminal. Muerte. Unidades de cuidados intensivos. Toma de decisiones.

Aprovado CEP-UFBA 12798813.2.0000.5556

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Declararam não haver conflito de interesse.

Life support limitation (LSL), also called therapeutic effort limitation, is defined as the decision not to institute medical therapy or to interrupt advanced life support already instituted in terminally ill patients with no possibility of recovery¹.

LSL is a legal practice in Brazil, guaranteed by the publication of Resolution 1,805/2006 of the Federal Council of Medicine (Conselho Federal de Medicina - CFM), and gives support to the physician to limit or suspend procedures that prolong the life of the patient in terminal phase, respected the will of the person or your legal representative. The physician should clarify the appropriate therapeutic modalities for each situation, record the decision in medical records, assure the patient and his/her family the right to a second medical opinion and continue providing comprehensive care to the patient for the relief of suffering².

However, despite the fact that LSL is a growing practice in the world^{3,4}, it is still surrounded by conflicts, because even with legal protection there are persistent insecurities and difficulties regarding the decision-making process for its adoption⁵⁻⁷.

The scenario of intensive care units (ICUs) is where the need for LSL is more likely to arise. Critical patients, often with compromised decision-making, have their therapy handled by the medical team and family. In this context, it is very important to consider family participation and their opinion about LSL, being evidenced in studies the willingness of family members to participate in this process. Thus, not only the legal obligation of family participation in these decisions, but the importance of inserting it as a participant in this process⁹.

Considering the complexity of the subject, we sought to know its state of the art, where there was a shortage of studies that address the subject in the country, especially in adult ICUs⁵⁻⁷. This review evidenced the importance of deepening the discussion, justifying the relevance of this study involving professionals who deal with this situation in their daily work.

Thus, it was constituted as a central problem: "how is the process of medical decision-making for LSL of critical patients established?". A question that pointed to the general objective: to analyze the medical decision-making process for limiting the life support of terminal patients hospitalized in Intensive Care Units.

Methods

This is a descriptive-exploratory study with a qualitative approach, of which the research scenario

involved two adult ICUs from the General Hospital of Vitória da Conquista (Hospital Geral de Vitória da Conquista - HGVC), a state institution located in the southwest region of Bahia. The study had the participation of 14 physicians on duty at these units, selected by non-probabilistic method and with at least one year of ICU work. The inclusion criterion was established to guarantee greater medical experience with situations that involve decision making regarding LSL.

The professionals were submitted to a semi-structured interview with the following questions: "What do you understand by limiting the life support of a terminal patient?"; "What kind of measure is most used to limit the life support of a terminal patient?"; "What are the main criteria that govern a medical decision, in your case, in deciding to no longer invest in a patient?"; "Is there any protocol here in the service that guides this?"; "What is the main difficulty for you in this process?"; "And you, as a physician, what is your view of the family in this process? What is their role?"

After assent by means of the free informed consent form (FICF), the interviews were recorded and later transcribed. They were performed in a private place of the ICU, over two months, with an average duration of thirty minutes. Fieldwork was approved by the Ethics and Research Committee of the Federal University of Bahia, Anísio Teixeira campus, in compliance with Resolution CNS 466/2012¹⁰.

The technique used to analyze the data was the Discourse of the Collective Subject (DCS), which is based on the theory of social representations, and which, in this study, served as a methodological reference for analysis. The DCS technique consists of organizing and tabulating qualitative verbal data, obtained through interviews.

The collective subject is expressed through a syntactically structured discourse in the first person singular, which refers to a single "I" that synthesizes the collective statement. This statement identified as an individual subject, however, expresses collective reference, since it speaks "on behalf of an interviewed group".

The obtained verbal material was obtained by extracting, from each statement, the central ideas (CI), anchors (AC) and their key expressions (KE). The latter are verbatim excerpts and transcriptions that reveal the essence of the discursive content, being the raw material for defining DCS. CIs are linguistic expressions that reliably describe the meaning of each discourse analyzed and each set of homogeneous key expressions. The CI is not an

interpretation of the discourse, but a description of its meaning. The AC is a linguistic manifestation of ideology or belief revealed by the author of the discourse and is only considered in the DCS method when it is explicitly present, which, unlike the CI, does not always happen.

After extracting the methodological figures from the discourse and from the junction of similar KEs, the DCS were elaborated in the first person singular¹¹.

Results

The analysis pointed to six central ideas and one anchor.

ICs included: 1) Limiting is not instituting useless therapy to terminal patient; 2) The patient has the right to a dignified death and palliative care; 3) It is necessary to understand the family and my role in including it in the LSL; 4) Deciding for LSL is a rational and medical issue; the family is only communicated; 5) I am not God, I have uncertainties and fear of diagnosing terminality; 6) Medicine has many biases, how will I protocol the LSL? The AC included: If the patient has cancer, we do not have difficulty for LSL in the face of terminality.

CI 1: Limiting is not instituting useless therapy to a terminal patient

"Limiting is to stop offering something that will not bring about any change in the patient's prognosis; it is about not applying a therapy that is considered futile because it will not achieve its goal, which is to improve the quality and not just the quantity of life, only prolonging the suffering. When the patient is terminal, what happens most is the non-installation of hemodialysis, the non-cardiopulmonary resuscitation and the non-increase of the flow of vasoactive drugs. In cases of terminality we establish that, even in hemodynamic instability, increasing vasoactive drug flow to have an increase in blood pressure does not change the prognosis. We do not increase, but we do not withdraw. Now, if the patient stops, no one comes to reanimate the patient, he/she just stops." (DCS 1)

CI 2: The patient has the right to a dignified death and palliative care

"When we realize that the efforts being made are not succeeding, that everything has been done and the patient has not responded to anything, we enter palliative care. Therefore, we never suspend analgesia, and if it has no side effects and

contraindication, we maintain the diet, the caloric intake. And even if the goal of the therapy is not palliative, if it is already instituted, it is maintained, if the patient has a serious infectious condition, he will continue receiving antibiotics that will cover that type of infection" (DCS 2)

CI 3: It is necessary to understand the family and my role in including it in the LSL

"What binds us to our families is not only the bonds of blood, but especially the love and affection we have for each other, and it is precisely this affection that is most difficult when we speak of limitation of effort. If there is no relationship of trust with the family, it will be the biggest obstacle in this process. I've seen family denials, but the moment you have an open relationship with the family, coming in, talking and explaining, that family ties in with you and very often agrees with us when we say that there is no longer a perspective of treatment for that patient. The family has to understand what is happening; when they realize that everything is already done, they are the first, in our practice, to agree" (DCS 3)

CI 4: Deciding for LSL is a rational and medical issue; the family is only communicated

"The decision for therapeutic limitation is merely technical and restricted to the physician, and the family's opinion can not prevail because it has an emotional involvement with the situation, losing some rationality. What we see is an absurd family attachment and much contestation. In fact they want you to stay alive for them and not for the person himself. But we, in the area of health, have a certain rationality, we can not allow absurdities because this is a decision based on science! So when we start limiting things to the patient, we decide it among us, and the family is only communicated" (DCS 4)

CI 5: I am not God, I have uncertainties and fear of diagnosing terminality

"I am not God! I find it difficult to determine who is terminal. Stopping some therapy is very complicated. I think all doctors have that doubt, and if this, and if that, you know? So, if I'm not sure, I make the patient a defendant in my judgment, as if you were playing a little God! Statistically, medicine is not absolutely certain because the human being is full of variables, the risk of death can be very high, but we are talking about risk, and how will I know? To be absolutely

sure that the investment for that individual is futile? We do not own the truth, we may be wrong.” (DCS 5)

CI 6: Medicine has many biases, how will I make a protocol for LSL?

“Here in the hospital there is no written protocol that deals with this, even because the construction and application of a protocol for these situations is very complicated, since each patient has his/her peculiarities and responds clinically in a particular way. We study each case as unique; how are we going to frame everyone into a protocol? Medicine has many biases, many considerations to be made, what there must be is common sense” (DCS 6)

AC 1: If the patient has cancer, we do not have difficulty for LSL in the face of terminality

“The terminal patient is one with some irreversible disease, for example, a cancer with metastases, that the patient has already undergone N treatments and has relapses. They should not even enter the ICU. It has no prognosis, so we have a greater facility in establishing a limit of life support in these cases” (DCS 7)

Discussion

CI 1: Limiting is not instituting useless therapy to a terminal patient

As for the meaning of limiting, discussed in DCS 1, the interviewees only exemplified therapies that should not be established, and which, if already started, should be maintained, a fact that contradicts the literature. Most of the studies on this subject state that life support is not just about the non-establishment of therapy, but also refers to the removal of advanced life support already instituted in the case of patients in end-of-life care¹.

The first article of Resolution CFM 1,805 / 2006 allows the physician not only to limit but also to suspend procedures and treatments that prolong the life of the patient in a terminal situation². Although the norm authorizes the suspension, in the second speech, only non-instituted therapies are mentioned: no hemodialysis institution; no increase in the flow of vasoactive drugs; and no cardiopulmonary resuscitation. Another study has already observed the same therapies cited by the interviewees as less established⁸.

Not to institute or suspend are moral and legally equivalent issues. However, the subjects in

this study were resistant to suspending something already instituted, even if they knew when the treatment is useless. This interpretation has to do with a certain ethical conflict also discussed in a study on end-of-life integrated palliative care in an ICU patient. This study confirms the emphasis on the non-establishment of advanced life support treatments, such as orotracheal intubation, hemodialysis, the use of vasoactive drugs and the order not to resuscitate¹².

Non-institution, therefore, is more frequently perceived in the ICU and reinforced by respect for the practice of orthothanasia, that is, the non-prolongation of life by artificial means when terminality is diagnosed. In this sense, the contribution of integrated palliative care is reinforced, so that the decisions on LSL are taken as soon as possible in the direction of the patients' orthothanasia¹².

It is worth emphasizing that palliative care goes beyond the concept of orthothanasia, given its greater principle of relieving suffering - to always intervene, provided that in the perspective of alleviating suffering and promoting the quality of life of the terminally ill person and the family.

DCS 1 also shows that all the physicians interviewed were in favor of LSL, with the same justifications pointed out by other studies, among them: to avoid procedures that do not result in a better quality of life and to reduce suffering, seeking to conduct the most sensible treatment, since some treatments do not present justifiable benefits, causing low quality of life, with no prospect of cure of the underlying disease⁵.

One last important aspect that this discourse revealed was the expression “if the patient stops, he/she just stops”, which refers to a certain anchor within IC 1. The expression is reflected in words frequently used in ICUs or other sectors of hospitalization in relation to the medical orientation of not to revive. The increasing use of this orientation raises the question of the adequacy of jargon and the possible consequences or generalizations that may arise in the contemporary hospital context.

Most of the physicians participating in another study knew the order of not resuscitating and agreed to prescribe it. However, it was pointed out the need to regulate the decision. Even in the case of progressive disease in terminal stage, it is important not to reanimate only upon request or family consent, although they agree that the physician should take part in the decision¹³.

CI 2: The patient has the right to a dignified death and palliative care

DCS 2 indicated therapies characterized by the participants as palliative care, generally those not suspended by physicians, to ensure comfort, well-being and a dignified death to the patient, as well as care for the family. In fact, it is important to consider that actions aimed at the comfort and well-being of the patient will never be considered useless; on the contrary, controlling pain, feeding and hydration, for example, are actions of care that can not be questioned when there is indication of relief from suffering, both for the patient and the family.

However, the significance of palliative care referred to in DCS 2 should be better discussed as those provided when the patient is dying. This understanding is reflected in a certain social anchor still impregnated in the discourse of some physicians, the association of palliative care with terminality.

According to the World Health Organization (WHO), palliative care can improve the quality of life of patients and their families, when they encounter problems related to life-threatening illnesses, the relief of early identified suffering, impeccable assessment and pain management, and other physical, psychosocial and spiritual problems¹⁴.

Thus, the concept of palliative care is currently directed to any individual with an incurable disease, that is, chronic and progressive, even if it does not threaten life in the short term, or is amenable to control but not cure. Instead of being exclusively associated with patients near death, such care must now be provided from the first stage of any incurable, progressive, and life-threatening illness. In this sense, its purpose is to achieve not only the body, but the psychological state of the patient and family, taking into account the sublimity and circumstance of being¹⁵.

In the context of terminality, the palliative care that should have been previously implemented should be continuous and not be limited to pain control and feeding, but to the attendance of the diverse needs of the patient and his family, as stated in CFM Resolution 1805/2006 by specifying that the patient should receive all the necessary care to alleviate the symptoms that cause suffering, making sure they have full assistance as well as physical, psychic, social and spiritual comfort².

In this perspective, care for the end of life emerges, which is an important part of palliative care, but differ from it because care for the end of life refers to the specific care that the person

must receive during the last stage of life. Such care is timely from the moment the individual is in progressive and inexorable decline, and extends to the support to mourning relatives¹⁶.

CI 3: It is necessary to understand the family and my role in including it in the LSL

In DCS 3 the understanding and respect for the feelings of relatives from the possibility of constant, honest and effective communication are observed, referred by the participants as fundamental to create bonds that favor the trust in the doctor and in his decisions, including in LSL.

Regarding the inferences of the participants of this study about the patient's relatives, the inclusion of contradictory ideas that can be better observed in concomitant analysis of this and the next CI. In this sense, it should be noted that the duality was generated by the following questions: "In your opinion, what is the main difficulty in this process (LSL)?" And "What is the role of the patient's family in the LSL process?".

It is important to clarify that the majority of the physicians interviewed pointed out dealing with the patient's family as the greatest difficulty of the LSL process, reporting in interviews the strategies developed by them to better work in this context of family ties and feelings. Such inferences have resulted in this CI.

Thus, empathic communication was central in dealing with the family, in the understanding that each one has a particular way of reacting to the terminality. This aspect is related to the history of life, culture, ideology, myths, among others. It is extremely important to know these factors, which should help understand what families think about LSL⁸.

In this context, it is pertinent that the health professional empathize with those involved in the situation, that is, understand the unique experiences that patient and family are going through, without judgments or prejudice, with the true intention of caring¹⁷.

It should be emphasized that the decision on the therapeutic limitation should not be taken in isolation by the physician, who should value the dialogue with the relatives of the terminally ill patient. This conduct is one of the ethical pillars in this decision-making process, since the indiscriminate use of advanced technology is no longer acceptable for all patients. It is necessary to refine the medical practice for an adequate

therapeutic limitation of terminal patients, including the team and the institution in the process¹⁸.

CI 4: Deciding for LSL is a rational and medical issue; the family is only communicated

DCS 4 demonstrates the supremacy of the medical decision, although respondents recognize the importance of the family in care and end-of-life decisions. According to about 78% of the study participants, family opinion should not be considered when it comes to LSL, a finding that contradicts the previous CI.

The importance of the family in this discussion is due to the fact that the majority of the patients hospitalized in the studied ICUs are incapable of making decisions, and in these cases the task should be left to the physician and family members. But as is evident in this discourse and in other studies on the subject, the physician has assumed the role of sole responsible for the decision to limit efforts⁵⁻⁷.

The professional even recognizes the importance of the family and their values, but, in case of discordant opinions, the physician's decision prevails. For the physician, the family hardly ever agrees with the patient's diagnosis of terminality because of emotional involvement. In fact, the family tends to decide what would be best for themselves and not their loved one.

This process of denial is understandable, because the family institution is extremely shaken when it perceives the proximity of the death of one of its members, establishing an imbalance among them⁹. In order for there to be a good relationship with family members, professionals need understand and respect the moment they are going through.

Studies have shown that often family members deny their loved one's terminal condition so as not to discourage any investment of care dispensed¹⁹, hoping for a cure or a miracle, even though the diagnosis reveals that there is no cure. The stage of trust in healing may be the most difficult for physicians, due to family attachment, the expectation that the patient will heal over. However, it must be understood that this is a natural and cultural reaction that demands skill from the professionals.

Regardless of the behavior of the family, it is their right to have a voice in the decisions regarding their relative, being recognized as their responsibility. Despite this, the terminal patient's family is often neglected. Therefore, reflecting on their insertion in matters related to terminality is essential to guarantee the dignity and fulfillment of

the wishes manifested by the patient, in addition to providing comfort to family members in this stressful situation. Health professionals should pay attention to caring for the family, avoiding inflexible behaviors and, as much as possible, encouraging heartfelt conversations in the context of end-of-life²⁰.

In this sense, early directives of will are regulated as an instrument that allows the person to register their will about future treatments and the assistance they want to receive if the disease worsens and they can no longer respond for themselves. This device is recognized by the Brazilian Federal Council of Medicine (CFM Resolution 1995/2012²¹) and represents ethical and legal support to ensure that health professionals respect the wishes of the person who appoints a representative to make decisions, usually a family member.

The directives can only be verbalized and registered by the doctor in medical records or registered with a notary, in order to elect as legal representative a person of the patient's confidence to make decisions²².

CI 5: I am not God, I have uncertainties and fear of diagnosing terminality

It is observed from DCS 5 that doctors understand that it is a very great responsibility to diagnose the terminal patient and affirm that nothing else can benefit him, an idea expressed by doubt, uncertainty and fear of occupying the "place of God" by signing the judgment that a patient has no more salvation, "sentencing" him/her to death.

This position is probably due to the lack of knowledge of health professionals about palliative care. Regarding the affirmation that "nothing else will benefit the patient," they forget that much can be done to minimize suffering in the course of the death process and its proximity, which requires professionals with specific skills to alleviate human suffering.

In this sense, it is observed in the literature that physicians recognize fear, relativity and subjectivity in the diagnosis of terminality. The fact that the situation does not depend only on technical know-how makes diagnosis even more difficult²³. It is understood, therefore, that even when centered on rationality medicine can not answer all questions objectively.

As the first speech of the axis points out, the physician feels much safer in switching off devices from a patient whose brain death protocol is already characterized by clinical and complementary examinations during variable intervals, specific to certain age groups²⁴ to have to limit some therapy

for the patient with a reserved prognosis, precisely because of the subjectivity and perception of each one in the decision-making process.

This greater ease in disconnecting devices from patients with brain death was also observed by the participants' insistence on associating LSL to patients with brain death. To solve this confusion, all respondents were made aware that the person needed to be alive rather than dead so that the life support would be limited. For as the term itself reveals, LSL is an alternative to be considered for patients who are alive, but in the terminal stage, and not for those who are already diagnosed with established death⁶.

This often results from the fact that health professionals do not feel prepared to communicate bad news, experiencing some suffering in doing so. It can be considered that this impasse begins in medical training, which, even in evolution, is still anchored in dictates of positivist science, leaving subjectivity in second place.

Therefore, training that creates barriers to feelings and emotions in clinical practice prevails. The relationship between physicians, patients and family members must develop from a medical behavior that is compatible with the situation of uncertainty. In this context, the greatest problem arises when the other's fragility reveals to the physician their own fragility and finitude, which can trigger defense mechanisms in the physicians, often not allowing them to deal adequately with emotional issues²⁵.

CI 6: Medicine has many biases, how will I protocol the LSL?

The DCS 6 shows that not all questions in medicine, despite its status as science, have exact and irrefutable answers. This lack of objectivity and linearity in the clinical picture of each patient makes the diagnosis of the terminality, as well as the establishment of protocols on the subject difficult.

In view of the above, it is possible to see the process involving end-of-life decisions permeated not only by objectivity but also by subjectivity, requiring that the decision-making process on therapeutic limitation go through a wide discussion.

Not only objective criteria of the disease should be taken into account, but also those that influence the patient's homeostasis according to the moment, disease and family and social context. In this sense, other members of the multi-professional team can

contribute with their knowledge to conduct the situation in a more balanced and secure way.

Results from another study corroborate the need for more subsidies and regulations to guide physicians more widely in the face of this difficult decision-making. In addition, it concludes that the moment is opportune to elaborate ethical guidance on the order not to reanimate in Brazil, which fills the current regulatory gap¹³.

Yet another study confirms this understanding with reports concerning the need to improve communication among ICU team professionals, standardizing procedures for patient care. It also indicates the urgency of training, so that the multiprofessional team can provide the necessary support to the family and the patient in the final stage of life²⁶.

AC 1: If the patient has cancer, we do not have difficulty for LSL in the face of terminality.

In DCS 7, which represents AC 1, the conventionalism with which the cancer patient is seen is clear. The idea that the diagnosis of cancer, accompanied by treatment-resistant metastases, implies terminality, explains the classification of this axis as an anchorage, that is, a central idea impregnated by socially constructed stigma.

This discussion refers to the transition of the leading causes of death in the world today. Epidemics have decimated lives in the past, but due to the rapid progress of preventive medicine, with actions such as vaccination and antibiotic therapy, among other health aspects, these causes have been giving way to chronic diseases such as cancer²⁷.

Neoplasias are growing all over the world and are already the second leading cause of death in most countries, expected to become the first in the next few years. Thus, cancer is considered one of the chronic diseases with higher mortality, a reason that explains the prejudice that the disease does not have a good prognosis²⁸.

However, orders not to reanimate are a sensitive expression of the ethical evolution in medicine, and are no longer regarded as bad practice. In other words, "not to reanimate" in the context of terminality is nowadays a standard of good medical practice and is established as a procedure in cases of end-stage metastatic neoplasia not only in Brazil but also in Europe²⁹.

This way, not to reanimate individuals in the terminal stage of a progressive disease is pointed out in the study as a human act that meets the

bioethical principle of non-maleficence, since it aims to minimize suffering and avoid dysthanasia¹³.

Final Considerations

The study showed that the medical decision-making process to limit therapies to terminal patients is influenced not only by objective and concrete criteria, but also by the nuances of subjectivity. This makes it more complex, revealing medical insecurity in determining terminality, complex behavior in the face of social interpretations involving human life and death.

In addition to this internal conflict, the challenge of the relationship with the family in the LSL context was also relevant. In this sense, empathy on the part of the medical team is imperative, since the sensitivity to conduct this relationship through honest and effective communication is a very important factor in empowering and developing family resilience.

In view of this, we suggest further research in the area, aiming to sensitize and mobilize these professionals about the need to transform their praxis in order to meet the subjective needs of patients and families, especially in the intensive care context. A curricular reform of undergraduate medical courses to discuss further death and dying and their psychosocial demands is also proposed.

The limitations of the present study are due to the fact that the perceptions represent the ICU professionals of a single hospital in the Northeast region of the country. Other scenarios could represent new diversities, demonstrating a variation of comfort and experience with the theme.

Lastly, it is proposed that the conversation between family members and multiprofessional team be established, enabling a better understanding by the latter of the LSL process and dilution of the disciplinary borders of the professions. Structuring teams that contemplate these differences in the intensive care setting would allow the critical patient and family members to enjoy assistance with more bonds and be enriched by the know-how of all professionals.

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Participation of the authors

Emanuelle Caires Dias Araújo Nunes participated in the conception and planning of the project; analysis and interpretation of results; preparation of the first version/draft of the manuscript; critical review of the content of the manuscript and final version of the manuscript. Jéssica de Oliveira Sousa contributed to the design and planning of the project; obtaining data; analysis and interpretation of the results, in addition to also elaborating the first version/draft of the manuscript.

