

Suspension of treatments in intensive care units and its ethical foundations

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Abstract

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Despite the sophisticated and expensive resources available at intensive care units, decisions are occasionally made to suspend extraordinary treatments. This work arose from the need of knowing what are the ethical values that Portuguese nurses consider as basis for these decisions in an intensive care unit. A detailed bibliographic research was carried out, jointly with a number of guiding questions. A total of 9 intensive care units and a sample of 146 nurses were the field of study and the data obtained was statistically analyzed through the SPSS 11,0 program. The conclusion was that nurses considered that at the root of the decision of suspending extraordinary treatments, there is a concern with matters related to the patient care, which in fact translates into death at due time, without delay, anticipation, or suffering, based on the beneficence principles and not non-maleficence ones, with the individual good overcoming the common good.

Key words: Principle based ethics. Intensive care units. Withholding treatments. Nurses, male. Portugal.

Resumo

Apesar dos sofisticados e dispendiosos recursos disponíveis nas unidades de terapia intensiva, por vezes, em determinadas situações, é decidido suspender tratamentos extraordinários. Este trabalho surgiu da necessidade de saber quais são os fundamentos éticos que os enfermeiros portugueses consideram estar na base da decisão de suspender tratamentos extraordinários em unidades de terapia intensiva. Foi realizada intensa pesquisa bibliográfica e colocadas várias questões orientadoras, tendo por campo de estudo um total de nove unidades de terapia intensiva e uma amostra de 146 enfermeiros, e os dados obtidos foram estatisticamente tratados com base no programa SPSS 11,0. Concluiu-se que os enfermeiros consideram que na base da decisão de suspender tratamentos extraordinários se encontra uma preocupação com aspectos relativos ao cuidado, que se traduzem na morte no tempo certo, sem adiamento ou antecipação, sem sofrimento e com base nos princípios da beneficência e não maleficência, valorizando mais o bem individual do que o bem comum.

Palavras-chave: Ética baseada em princípios. Unidades de terapia intensiva. Suspensão de tratamento. Enfermeiros. Portugal.

Resumen

La suspensión de tratamientos en unidades de terapia intensiva y sus fundamentos éticos: una investigación sobre la realidad de Portugal

En las unidades de cuidados intensivos a pesar de los sofisticados y costosos recursos disponibles, en ciertas situaciones, se decide suspender tratamientos extraordinarios. Este trabajo, surgió ante la necesidad de saber cuáles son los fundamentos éticos que los/las enfermeros/as portugués consideran estar en la base de la decisión de suspender dichos tratamientos extraordinarios en la unidad de terapia intensiva. Se realizó una intensa búsqueda bibliográfica, se plantearon varias cuestiones orientativas, teniendo como campo de estudio un total de 9 unidades de terapia intensiva y una muestra de 146 enfermeros/as. Los datos obtenidos fueron analizados estadísticamente en base al programa SPSS 11,0. Concluimos que los/las enfermeros/as consideran que ante la decisión de suspender los tratamientos extraordinarios, es preciso tener en cuenta la preocupación de las cuestiones relacionadas con el cuidado, lo que se traduce en una muerte en el momento oportuno, sin prolongamiento ni anticipación de la misma, sin sufrimiento y en base a los principios de beneficencia y no maleficencia, valorizando así el bien de la persona sobre el bien común.

Palabras-clave: Ética basada en principios. Unidades de terapia intensiva. Privación de tratamientos. Enfermeras. Portugal.

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Men formed concepts such as ethics, in his evolutionary process and thanks to development of thought, in which the pillars for human action are found based in values and principles like respect, equality, tolerance, and doing the good.

In parallel, he developed capacities and has acquired knowledge that granted him powers that have not been curbed anymore – as exemplified by the discovery of the atom and genes. Technique has performed a core role in the relationship of Man with the environment, with other men and with himself, at the same time granting him powers that, allied to knowledge, mandatorily, make him responsible before all forms of life, including the ecosystems. In the realm of medical science and, specially, of the intensive care units (ICUs), scenario of high technician astonishment, much has been possible to do for patients in critical state throughout the past years, enabling recovery from situation that before were unthinkable. This fact has conditioned a change in face of death: it is possible to overcome it and not to give in or fail.

However, death exists because there is life, and they are the two faces of a same coin, it is the *continuum* between the old and the new, the past and the future. It is what leads to evolution. It is believed that in humans death is more encompassing than to other species because he dies not only biologically, he dies as a totality that goes beyond the physical dimension.

One may consider that death has two dimensions: an objective and another subjective. The objective death corresponds to the biological death, the death of the body, the physical death, scientifically noticeable. Subjective death corresponds to the human death, the ontological death, death of the entity or being that dwells the body, because the individual is a complex being comprising several dimensions that interconnect, correlate and grants him singularity. That is, the individual is a being of many *beings*: *natural being, social being, historical being, being of necessity, objective being, subjective being*¹.

Patrao Neves refers to the subjective dimension of death, in view of the objective focus of biological death by stating that *matters to underline is that death always appears to Man*

*under two distinct aspects: under an objective dimension, as a natural, biological phenomenon and, therefore, unavoidable and identical for all beings; under a subjective dimension, as an event happens with Man, which is of the existential or lived order and, thus, made human and experienced differently by each person*².

However, death does not exhaust in the objective and subjective dimension. As a result of the holistic vision of the human being, it can achieve other dimensions of our existence: (...) *there is also the professional death when one reaches the limit of age, the social death, when one loses friends and relations are shortened, family death when one is marked by the widow or orphanage, the political death, when one is placed in the reserve of the party in which he fought, and even death spiritual and supernatural, when feels the abandonment of God in whom one believed*³. One can also consider the death of reason, when intelligence is affected by loss of faculties or when life of relations ceases to exist by compromising the state of consciousness, as occurs in situations of deep coma.

Philosophers see the certainty of death in different ways: to Heidegger⁴, mortality is what provides meaning to life; to Sartre⁵, it takes all meaning from it, and to Hans Jonas⁶, in accordance with the circumstance in which it takes place, it has meaning or loses meaning.

However, the human being is mortal and, either by accident, disease or simply old age, the myth of immortality that insists in proving itself fades away: the body prepares us for death and, in face of this inevitability, both technique and man ally themselves, but often are able only to postpone the inevitable at very high cost. As referred by Elizari, *life is not an absolute value that one should protect and extend always and at any price. In a given moment, good sense shall recognize the limits of the organism and the limitations of science and technique*⁷.

This technical-scientific limit that one intends is assumed and internalized by health professionals takes us to the problem of therapeutic futility which leads to inevitable dysthanasia situations, frequent situation in the context of the ICU. The supply of aggressive care that only extends life at expense of

much suffering without real benefits for the patient sets up dysthanasia situation and the futility of a treatment should be evaluated based in three criteria: *effectiveness (linked to therapeutics), the benefit (in relation to the patient) and disproportionate burden (physical, emotional, social or economical that treatment entails), ultimately aiming at the "well of the sick"*⁸. As referred in Pessini, *clarifying the "what" and "which" are the objectives is one way to identify and to expose the roots of the conflict that characterizes discussions about what is a futile treatment*⁹.

An important issue must set in face with professional action: is it because we are invested in a strong technicist power and scientific knowledge, we must we do everything with no limits so life would prevail? Why stop? When stop? How to stop? The power/duty relationship has specific outlines and usually is understood as: the power exists to be served. In the area of health, however, the professional holds knowledge that grants him a power that in relation to the other, who is vulnerable, inverts this relationship and the power exists in order to serve. It is a power relationship due to the other, based on values and principles such as autonomy, beneficence, non-maleficence and equity.

When the moment comes, death appears, is the ultimate moment that is difficult to characterize: accepted by some with resignation, considered by others as an integral and complementary part of life or as a failure, in the face of technological ineptitude. The life that ended, lived in quality and/or in quantity, is the life of each one, unique.

When in the context of a disease, the decision to stop a treatment is made, one may question whether the decision was at the quantity, quality of life or both. At an ethical perspective, the two may interfere in the decision. The focus in quantity may suggest shorten life, leading us to face euthanasia. It may also imply in prolonging life, which becomes a situation of therapeutic persecution that is, of dysthanasia and therapeutic futility. The quality focus leads us to consider the when, how and why of this interference. *The when happens as soon as the available treatments show to be ineffective and superfluous;*

the *how*, providing the patient with an end of life without suffering, at the right moment, without delays or anticipations; the *why*, in order to safeguard the patient's best interest, his will and based on good. But in practice, what does effectively happen? What does condition this decision?

It is in this context that this study emerges, based on research- about the reality of Portugal, as a consequence of the multiple concerns experienced and shared with other professionals and long time the target of my reflection as a specialist nurse. Thus, I considered the *ethical basis underlying the decision on not starting or stop treatments in intensive care units as thematic area of this research*.

State of art

Several published studies approach the suspension or not starting treatments in intensive care units. The Ethicus study¹⁰ showed that the suspension or refusal of treatment is accepted by intensive staff and that factors such as age, diagnosis, religion and geographical location are at the base of the decision. And also considered that in future research must be addressed issues such as the family and nurses' perspective regarding the process of dying in the ICU, whereas different countries correspond different cultures and, therefore, different ways of understanding the problem.

As basis for the importance of the problem, other studies have shown that patients' death occurs some time after it has been decided to suspend or not start treatments^{11,12}. However, these studies show that the information in the clinical process is omitted regarding these decisions, which contradicts the expected, because from the legal and medical point of view its existence is essential^{11,13}; *guidelines* should be prepared to standardize decisions¹².

It is also important that the aspects of patient's prior will, expressed in document contemplated in law (vital testament), should be considered in these situations.

A study has shown that nurses were more aware than physicians in knowing the existence of this document and take note of its content; only half of the doctors of the sample read the vital testament, while the majority considered the wishes of sick when it is directed to the family; decisions on not resuscitating are discussed more openly when the prognosis is bad, while assuming that decision in writing is affected by the relationship with the family and by medico-legal aspects¹⁴.

A survey applied to Austrian doctors showed that they are motivated to integrate patient's preferences, stated in the vital testament, in the end of life decisions¹⁵. Another study, targeted to doctors in California, concluded that these have doubts about the assessment of therapeutic futility and that at the base of the conflict are religious aspects and the inaccuracies of the diagnosis¹⁶.

Study undertaken in France intended to know the existing discrepancies between the perceptions of doctors and nurses compared with end-of-life decisions in intensive care units. They concluded that the percentage of doctors satisfied with the decision process was greater than that of nurses. Although the majority of respondents consider that decisions should be collaborative, if half of the doctors and one fourth of the nurses believed that the nurses were involved.

Fear of litigation was the reason given by doctors to justify a change of information provided to competent patients, nurses and family. The perception of nurses about medical decisions can be an indicator of quality and serve as a tool to evaluate daily practices. Recommendations and legislation can help gather consensus and avoid conflicts between the elements of the health care team regarding end-of-life decisions¹⁷.

It was published recently a systematic review of the literature on nurses' role in end-of-life decisions, which concluded that their role in the process was scarce. Typically, they assume a link between the doctor and the family, facilitating communication concerning the decision to be made. They are an emotional support for the family and, often, they are

as *lawyers*, in such manner that both parties see the overall picture of the patient's situation, which can facilitate acceptance, by the family, on decision made¹⁸. It is crucial a rapprochement between doctors and nurses in the end-of-life decisions¹⁴.

The EfCCNa study undertaken with Europe's ICU nurses showed that many of them are involved in the discussion and in the end-of-life decisions. Religious and ethical aspects influence the opinions and they are similar among countries: they differ in relation to use of sedation and patient's nutrition¹⁹. Other studies have found that nurses have major contribution in end-of-life decisions and that the guidelines consider imperative that nurses provide the care after decisions to suspend or not start treatments²⁰. Sometimes, the difficulties experienced by nurses to implement caring for patients after end-of-life decisions are immense²¹.

From problem identification to empirical work

Resuming the vast subject considered for this research - *ethical foundations underlying the decision not to start or to stop treatments in intensive care units* - it becomes crucial to specify and delimit the study by identifying the problem.

According to the literature review performed, to some authors there are more ethical implications on treatment interruption than on not starting it, what in the perspective of Beauchamp and Childress²² is questionable since it is only a matter of circumstantial feature. Thus, based on the need to limit the study and taking into account the assumptions that ethically, according to some authors, a decision not to initiate and the decision to interrupt do not have the same weight, and that for the population under study the terms may have different ethical values, only the terminology of *suspension of treatments* was used.

Concerning treatments, they may be classified as *ordinary* or *extraordinary* - and configuring different situations also. According to Beauchamp e Childress²², one may define as ordinary treatment

all medical treatments and procedure offering a reasonable hope and benefit and that may be obtained and use, without high costs, suffering or other inconvenient. One may understand as extraordinary treatment all treatments and medical procedures that cannot be obtained without high costs, suffering or other inconvenience and that, do not offer a reasonable hope or benefit when used. This distinction of treatments converges, roughly speaking, to what is considered the patient's wellbeing and the cost-benefit arising out of that same treatment.

Currently, this terminology of ordinary and extraordinary treatments was replaced. Various intensive care societies from Europe, United Kingdom and United States are consensual in using *comfort care* terminology. In the resulting document from the 5th International Conference on Intensive Care held in 2004, one can read: *The majority of deaths in the ICU is, or should be, anticipated and properly managed. These deaths should be preceded by a decision to restrict or suspend aggressive treatments and focus on providing 'comfort care' (...)*²³. According to Pessini, it is crucial that professionals learn to distinguish between therapy and basic care, because this is the only way to avoid with ethical basis the practice of *dysthanasia*⁸.

This perspective confronts us with new way of dying in intensive care units: that which results from assuming that in certain situations the advanced life support therapies with the goal of a guided healing must be replaced by therapies that lead to guided comfort. It is the choice between curative therapy or the comfort therapy and one may say that it is another side of death, which currently one starts to glimpse, not a renegade and distant death but a closer and human death.

In practice, this therapy of comfort is the implementation of *orthotanasia*, which one intends that in front of the patient the professionals can just *humanize the process of dying, relieving his pain, not incurring in abusive prolonging of his existence through extraordinary or even disproportionate means*²⁴. It is this point of balance that allows for

death in the right time as the result of a decision that one advocates as weighed, based on what is Best for patient and taking into consideration the required legal and social support.

Marie de Henezel²⁵ points out that the optimized medicine at end of last century ended up forgetting the human being and the professionals have to know give permission for patients to die. This is nothing more than allow natural death to resume its rights. It is inviting it to come, letting nature to act, and, in this way, all those involved to continue present and loving. This viewpoint is the dignity of life through the dignity of death, which Pessini states as the *rescue of human dignity that integrates death into life. The denial of death opens the door to therapeutic obstinacy. There is a strong awareness of therapeutic investment limit. From this arises the wisdom and the need for discernment of what are the therapeutic investments that do not honor the dignity of the human being. The Christian stand supports life, and denies the therapeutic obstinacy*²⁶.

For this reason, we consider for this study only the *extraordinary treatment*, due to the greater impact that the terminology presents and due to the association that could be made to sophisticated, aggressive and expensive treatment techniques, not encompassing, thus, basic care such as feeding and hydration and those, as mentioned, according to the new terminology are called as *comfort care*.

Finally, another important aspect is related to the ethical assessment of the decision, which can be done by the doctor who decides on how, the nurse who performs it, as well as by the patient for whom it is addressed or by his family. For this study, the concern arose from a nurse and, as such, it will be targeted to nurses.

Thus, on the basis of these considerations, the following problem was formulated: "What is the perception of nurses, under the ethical point of view, on the suspension of extraordinary treatment in intensive care units?" One intends, with this, to achieve the following objectives:

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- to identify which factors related to the distribution of resources can be the basis of the decision to suspend extraordinary treatments in intensive care units;
 - to identify which ethical aspects inherent to principles could be at the basis of decision for extraordinary treatments suspension in intensive care units;
 - to identify if the decision on extraordinary treatment suspension in intensive care units results in any legal and deontological conflict for nurses.
- is it euthanasia to suspend treatments?
 - is it euthanasia not to suspend?
 - are the treatments suspended because they are futile?
 - will it be legitimate to resist death?
 - does the suspension of treatment kill or let die?
 - when one decides the suspension, will the patient' wellbeing underlined?
 - do nurses participate in this process?
 - is it hard for them to accept the decision?
 - will it be legitimate for them to claim conscientious objection?

Whereas this study intends to develop the theory because there are few scientific studies regarding the covered area, the following guidance issues were raised, which are based on the theoretical referential and the decision to suspend extraordinary treatment in intensive care units:

- for nurses, does sex, age, marital status, parenthood, and the number of children that constitute his/her household influence the perspective of the situation under study? Would the length of professional experience, the period of work in intensive care units, the religion and the particular experience of the situation under study with a loved one influence his/her positioning?
- would this a legitimate decision based on the principle of distributive justice?
- in order to decide is it important to meet the economic aspects, the need for vacancies, diagnosis and prognosis inherent to the situation under study?
- for the sick, are the quality of life, the age and the knowledge of his will liable to determine this decision?

The study is of the exploratory-descriptive type, and quantitative in relation to the methodological options taken, and considering the technical procedures adopted, the goals, the way to approach the problem and its nature. The survey was directed to nurses from nine multipurpose intensive care units, medical and surgical, from North to South of Continental Portugal. The population consists of 239 nurses, which correspond to all the nine units in study.

The sample is of the "non-probabilistic for convenience" type, consisting of 146 nurses with more than six months of experience in service and who answered correctly - which corresponds to 61% of obtained replies. Data were collected through a questionnaire of opinion based on a Likert scale. The statements were grouped considering three main dimensions: "resource allocation", "ethical principles" and "legal and ethical-deontological aspects". In all possible statements, we considered the bivalence between "power" and the "duty", based on the question "what can be done, should be done".

The statistical processing of data was done through the program SPSS 11.0. In the processing and analysis of obtained data, descriptive statistics, the factor analysis and non-parametric techniques were used.

Empirical work

For analysis of data obtained in the sample characterization, which constitute the demographic variables of this study, the absolute and relative frequencies were considered = variables have been recoded in some situations in order to facilitate statistical analysis

For the analysis of data obtained from the questionnaire, factor analysis was used for extraction of factors (i.e. latent variables) and the Mann-Whitney and Wilcoxon non-parametric tests and the Spearman correlation coefficient for variables crosschecking. In some situations there was the need to recode variables.

Sample characterization

Concerning sample characterization, it was obtained:

- majority female;
- over 50% of nurses in the sample present age range between 22 and 32 years old, reflecting the existence of young teams;
- the majority of nurses is married, without children, and catholic;
- with regard to professional practice, the median is between 5 and 10 years and for the working period in intensive care, the median is between 3 and 6 years;
- most nurses (89%) are level I (with competence to provide general nursing care and have not yet applied for a specialization).

A closed question was also considered in the questionnaire with dichotomic response in which one intended to know if the respondent had already experienced the suspension of treatments with some loved one; and if so, how long ago this event occurred. It was verified that most nurses did not have experienced such a situation and that this fact has shown to have influence on study.

However, concerning the time elapsed after this event, the results did not show influence in the study.

Considering the statements (or items) that constitute the questionnaire were in large number and represented expressed opinions, factor analysis was used to determine the latent variables (or factors) underlining each dimension. Thus, in 1st dimension known as "resource allocation" (which meets aspects related to costs with patient, need of vacancies, the patient's diagnosis, prognosis and quality of life after internment), the 10 items considered were reduced to three factors: "equity", "patient's survival" and "quality of life".

The term *equity* is because vacancies and economic factors are liable to interfere in the decision to suspend extraordinary treatments, and they may be seen as fair resource distribution. The term *patient survival* emerged because the diagnosis and prognosis have underlying, the notion of possibility of predicting patient's survival. The term *quality of life* comes from the fact that the two items relating to quality of life have been grouped.

In the second dimension, named "ethical principles" (in which aspects such as the patient's age, prior will, euthanasia, dysthanasia, orthotanasia, therapeutic futility, postponement of death, dignifying death, the family's involvement in the decision-making process, the beneficence and non-maleficence, and medical paternalism were considered), the 18 items have been reduced to five factors: "ways of dying", "intentionality-effectiveness", "the patient's age", "resist death" and "patient-family decision".

The choice of term *modes of dying* results from the fact that, underpinning the grouping of items, concepts like dysthanasia, orthotanasia, futility and dying with dignity are found, which we consider to configure different ways of dying. The term intentionality-effectiveness comes from the fact that the principle of non maleficence and beneficence, which were inherent in items, and have been grouped, by itself, constitute a deliberate and effective good, respectively.

The terminology *patient's age* results from the fact that three items relating to patient's age have been grouped. The terminology *resist death* is a consequence of the fact that two items relating to this concept were grouped. The terminology *decision of patient/family* arose because the items relating to the patient's desire and knowledge of the patient's family are associated, in view of the decision concerning suspension of treatments. The item referring to euthanasia did not have statistical weight.

In the third dimension, called "legal and ethical-deontological aspects" (in which aspects such as assuming in writing the decision to suspend treatments, the participation of nurses in decision-making, the acceptance of the decision by the nurses, the recourse to conscientious objection in view of the decision were addressed), the 11 items have been reduced to three factors: "non-acceptance by the nurse", "nurses' participation" and "medical prescription".

The term *non-acceptance by nurse* is because three items related to the level of difficulty that the nurse felt with relevance to the decision concerning the suspension of treatments, and how this reverberated in his ethical awareness have been associated. The designation of *participation of the of nurse* resulted from the association of two items that referred precisely on the participation of nurses in the decision-making process on the suspension of treatments. The term *medical prescription* results from the association of two items concerning the formalization in writing of the decision of suspension of treatments. Items related to *conscientious objection* did not have statistical weight.

Demographic variables that did not demonstrate influence on the study were: age of nurses, parenthood, number of children, religion and professional category; and those that have shown influence were: sex, marital state, academic accreditations, working time in ICU, time in professional exercise.

Considering the relationship between *power* and *duty* in nurses' stand, it was found that there is no significant difference between the items "quality of life", "patient's will" and "resisting death", reason which the two first aspects may and must be considered in the suspension of treatments, and the

third cannot or should not be considered.

With regard to the item "knowledge of the patient's family", there has been negligible difference, reason which this aspect can and must be addressed in the decision to suspend treatments. It was verified, moreover, significant difference with regard to the following items:

- the *economic factors* cannot or should not interfere in the decision, while *not ought to* more marked than *not able*;
- *prognosis, diagnosis and patient's age* can and should be considered in the decision to suspend treatments, but the been able is marked more that ought to;
- regarding *participation of nurses*, they believe that it can and should be considered for the decision, but that should more than could;
- *conscientious objection* can be alleged by nurses in view of the decision to suspend treatments, but should not be implemented, not ought to more marked that can do.

Discussion of results

From the point of view of several authors consulted, equity is based on rationalisation of resources with a view to a fair distribution, with the different theories diverging on the concept of justice. For some, justice shall take into consideration the common good; for others, the individual wellbeing; for some, it must be based on quality that is effectively demonstrated and still for the others, it must provide equal opportunities. As we can see, the concept of justice is not consensus-what hinders its operation in practice.

When nurses disagree that vacancies and the economic factors are, per se, a fair distribution of resources in the context of the ICU, they are somehow refuting that resources have to be distributed on the basis of the common good, in the quality perhaps demonstrated, in the achieved or achieving goal, and because they do not probably foresee in this procedure an equal opportunities

way, they might just consider patient's individual wellbeing.

Undoubtedly, under the economic, political and social point of view, these two aspects as criteria for suspension of treatments could be advantageous, but we must not forget that it is *the singular person or individual who embodies the ethical sense of his existence (...)the purposes of the political community and of the State are other than those of the singular and personal ethics*⁸. Therefore, in the event of a conflict between the political aims and the personal ethics goal, this latter should prevail, since it is not people serving politics, but politics serving people. Michel Renaud²⁷ refers to this situation by specifying that it does not mean that the State cannot require sacrifices from people viewing the common good understood as individual good, but in practice, it will represent a consented sacrifice by the citizens themselves, for the benefit of others and the based on a political decision.

The patient's age was considered in the guiding questions and it can be seen that nurses agree that it interferes with the decision to suspend treatments. This perspective is in accordance with Jonas, who argues that the old must give way to the new, because if we were to remove death we would suppress also procreation: *In this start over and over again, that can only be obtained in exchange for time and time to end again, could very well be rooted the hope of humanity, its defense mechanism to not fall into boredom and routine, its opportunity to preserve the spontaneity of life*²⁸.

According to this author, the existence of a world of elders, without youth, it would only lead to accrual of experience, would not allow the privilege of seeing the world for the first time, dazzling in face of the unknown, to have the curiosity proper to children and, thus, enabling knowledge to advance, in a permanent search, a constant thirst, want to know more, as if we had never exceeded the phase of "why?".

Callahan²⁹ considers also that the age is an individual factor that must weigh under the social point of view.

Decrease the death in young ages and not to prolong the life of the old, but to alleviate the suffering, are concepts that meet the common good, taking into account the individual wellbeing. In this case, the household support and the possibility of resorting to continued care units are means to ensure an individual and common good, in as much as it ensures the really needed individual care and, at the same time, prevents resorting to scarce and expensive resources for the individual to benefit from some care in his end-of-life even if it is not the most indicated under the ethical, social and economic standpoint.

Diagnosis and prognosis are partially indicators of patient's survival, and they were considered by nurses as important aspects to meet in the decision to suspend treatments. These two aspects will, indirectly, relate to other equally essential and widespread, that is the quality of life, toward which nurses take stand with little agreement, perhaps because of the subjectivity and relativity in which this concept is based.

The subjectivity attributed to quality of life always raises the question of which referential to follow for this opinion, because sometimes the professional incurs in the temptation to follow the referential itself instead of those of the patient. Severity indices are instruments enabling to evaluate the severity of the illness and the prognosis, allowing to predict any result to be discharged and, consequently, to assess the cost-benefits of interventions. These indices can, at certain times, help you decide on the suspension of extraordinary treatments in ICU.

The *ways of dying* factor encompassed several guiding questions related to orthotanasia, dysthanasia, futility and dignification of death, which intended that nurses expressed their opinion if the suspension of treatments were, in practice, good or bad professionals' attitudes under the legal, ethics, and deontological points of view. Thus, the questions that addressed the suspension of treatments, such as *letting die*, disguised the concept of orthotanasia,

which allows the patient to die in his due time, not postponing the inevitable or anticipate or precipitating the events. Nurses assumed, in face of this question, a not much accentuated disagreement stand, almost consensual.

It is possible that this is due to a difficulty of interpretation, which is why rather than a death in peace, without suffering, in a timely manner and accompanied, they have interpreted it as death in abandonment. With relevance to issues that they considered that the suspension of treatments avoided situations like futility, dysthanasia, postponing the moment of death and allowing the dignification of death, nurses, in their majority, agreed that this happened. This position is supported by the consulted theoretical referential, which advocates that the principles of beneficence and non-maleficence must form the basis of that decision.

The question that considered the suspension of treatments as a way of *killing* the patient and that underlying had the concept of euthanasia did not have statistical weight, but, according to the responses, nurses sharply disagreed that such fact took place. This is consistent with other opinions related to the other ways of dying, in which they look to a death in a timely manner and with guarantees of aspects relating to care. This sharp disagreement, which may be interpreted as a certainty that this is not the reason underlined or intended when it is decided to suspend extraordinary treatments, it is not theoretically confirmed, because the border where the intention to terminate the patient's life ends and begins the intention of wanting death to happen is not so clear. However, nurses seem to assume that the decision to suspend treatments does not carry the intention of wanting to kill the patient.

This factor related to ways of dying was based also on other aspects considered in the guiding questions, such as paternalism, the principles of beneficence and non-maleficence. Indeed, the decision to suspend the treatments must be based on some foundations, which can be: medical opinion that decides what is best for the patient (paternalism); the intention of doing what one considers as best for the patient (the principle of

non-maleficence) or achieve a purpose believed as good and, as such, would result in an effective wellbeing (principle of beneficence).

All these aspects are in part related and, undoubtedly, they aim at the same thing: the patient's wellbeing. The majority of nurses agreed that, in face of them, the suspension of treatments aimed at this wellbeing. Although some theorists criticize paternalism, in the ICU context it is practiced because, even though the patient holds the right to autonomy, most often he is incapable of exercising it due to changes in their state of consciousness, which may derive from his condition or from the clinical use of medication. For this reason, the decision is often of medical staff, associated with the fact that, in most cases, the patient's opinion is not known.

The patient's opinion related to the exercise of autonomy, as an acquired and recognized right, raises no doubts. The problem arises when, as mentioned, there is an inability to its exercise either temporarily or permanently. However, some other issues should be clarified: will it be that, even when responding to the reality that he is living, he is able to exercise its autonomy? And, if he ever thought about this subject? Would this be the indicated moment? Can it be in these circumstances considered free to decide? In parallel, if there is knowledge of the patient's will and he cannot confirm or infirm it, would this desire still prevail now? And what if the patient changed his opinion? How does one know it? If there is someone legitimized to represent him, must he indicate what is the patient's desire (if known)? And, what if the patient wants to continue to invest in his "salvation", even if medically impossible?

The patient's autonomy comes into conflict with the principles of beneficence and non-maleficence and, at the same time, the common good is compromised. What to do? It is not easy to answer these questions and there are many who advocate all situations described herein, which is why, in practice, if such situations occur hopefully they will be analyzed on a case basis, and not in a standard way, because each patient is unique and, therefore, each *case is a case*, but

applying a treatment that is contrary to the *leges artis* configures II-practice situation.

Still related to the patient's decision, there is another element considered in the guiding questions: of the study: his family. The participation of patient's family in the decision to suspend treatments was nurses' majority stand. In face of this point of view one might ask if this participation is passive or active? It would be passive when only it refers to communication on the decision to discontinue treatment, which is corroborated by consulted theorists, since in accordance with Portuguese legislation, the patient's family does not have power over him because it's not his legal representative, unless if he is an incapable or minor, and also because it must not carry the burden of making such a decision.

If it is interpreted as active, it means that the family had to participate in the decision with binding opinion, which for the reasons afore mentioned is contrary to theoretical concepts. It is legitimate, however, that the family is consulted to inform medical staff if it has knowledge of what would be the patient's opinion about the suspension of treatments or if this topic was never directly addressed, in an attempt to get clues that indirectly might indicate the patient's opinion on the subject. The figure of the vital testament would be a document that could assist in the decision, but it is not foreseen yet in the Portuguese legislation and its operationalization does not seem to be easy.

It was considered also a further element inherent in the aspect of decision to suspend treatments: the nursing team. In this regard, its members were asked about whether they could or should participate in decision-making and the majority agreed that more than could, they should participate - it should be highlighted that this was the only answer that when set against the *could* with the *ought to*, this latter had greater weight than the first one.

In some countries, nurses are not heard on these issues, while in others they are queried for expressing their opinion, even if the medical team has the final word. Whereas the decision to suspend treatments configures a medical act of prescription, there is no doubt that it is out of the scope of nurses' competence, but if

they hold information needed to learn more about the patient and what are his desires, it is probably desirable that they should be consulted on the subject.

Such a statement can be configured in a even more convincingly if it is the nurse who has competence to comply with the prescription. In those circumstances, he must be involved in some way in the decision, so that he does not have consciousness problems at the time of complying with the prescribed. Probably, nurses feel that more than been able, they should participate in decision-making because, during 24 hours daily, they are with patient in such intimate and close way, what can lead them to feel, although legally they cannot prescribe, ethically they must be heard.

As mentioned, the decision to suspend extraordinary treatments does not cause problems of conscience to them, because if such would have occurred, this decision, somehow, would be against what they consider to be good for the patient. In view of the data, it was thought that it was based on these assumptions that most nurses answer agreeing that can claim conscientious objection, but disagree on what they should do. Probably, they consider a possibility always open that, in order to be implemented, would need to be taken to the extreme, a fact not yet verified in their experiences. To date, they did not feel that something has been decided that would lead them into practicing an act contrary to their conscience.

The issue of the acceptance, by the nurse, the decision to suspend extraordinary treatments as to cause problems of conscience and that could result in a situation of conscientious objection, relates to another element, which is the medical prescription. Indeed, nurses, in their majority, have decided not to have doubts when this order was written, understood as required, i.e. the formalization of the decision in the patient's medical record (process in Portugal). One can understand this situation as a reinforcement and a stand on the decision, which in turn will facilitate for nurses the acceptance of the situation and perhaps even undo some doubts that might exist.

In spite of the theoretical referential reveal nothing, with the undertaken statistical processing some aspects related with the look of the decision to suspend treatments were found: -

the gender of the nurse, marital status, academic qualifications, the work time in ICU, professional exercise period and the particular experience of the suspension of treatments with a friend or family member.

In this analysis, it is assumed that the influence of sex arises from biological and generic differences inherent in men and women and other extrinsic factors, such as education, training and social role, which could lead to a different way of seeing the same problem either by man or woman. The influence of marital status in positioning in face of the decision to suspend treatments may be related to two heads thinking or just one, depending on the closeness relationship that one has with someone in the area of affections, and the difference may be located here.

The influence of other aspects may be related to something common to all: knowledge and experience. Perhaps for this reason, the age of nurses did not have any influence on the statistically, but, on the other hand, aspects connected with training, contact with reality and life experiences had, which may be conditioners of the view that each may present in this situation.

Religion and parenting did not show to have influence in this topic. With respect to religion, it is theoretically defensible that it influences the decision, but spirituality is present in all human beings and can exist independently of religion. Parenting was intended to have a higher sensitivity to this theme underlined, but, in practice, it did not influence, from which one may consider it probable that this increased sensitivity would be felt if the study was on children and not adults, as it is the case, since, in parallel, the fact that personally they have had the experience in this study was influencing placements.

The number of children also did not demonstrate to have meaning, which inserts in the cited.

Final considerations

The undertaking of this study emerged from practice and self questioning who wanted to know how nurses perceived ethically suspension of

extraordinary treatments in context of intensive - care units for adults. We start from three main areas aiming at answering the initial question, whereas for this purpose: resources distribution, the ethical aspects related to the principles and the legal and deontological features.

Once completed end of the study, we found that, usually, nurses do not consider the decision to suspend treatments can or should be based on a fair distribution of resources perspective based on the common good - once the patient is admitted, this decision does not have to meet vacancy needs or economic aspects of inpatient care. More important are the aspects related to quality of life, where this very concept is inserted, diagnosis and prognosis related to clinical situation experienced by the patient. Also, they do not consider that suspension of treatments abbreviate the patient's life in order to decrease suffering or social cost.

When it is decided to suspend the treatments, nurses consider that ethical aspects are more directed to the present quality of life than to the amount of life. With regard to quality of life, the concern that they consider to be indicated by who prescribes it, is an end-of-life without suffering and in due time, not incurring in unnecessary and traumatic treatments, highlighting the aspects of care that possibly can be provided in a hospital.

With relevance to amount of life, nurses consider age important as a means to the decision, but not as an end. To decide only on the basis of the prolonging life, even if it is of a young adult, and not consider other aspects, sets up a dysthanasia situation, or once again the quality of life, patient's autonomy, the principle of beneficence and non-maleficence have to substantiate the decision.

The prescription in writing of the decision, as legal aspect, consolidates the acceptance and compliance with it by nurses. From the deontological point of view of ethics, the majority of them does not consider having consciousness problems when complying with this and, consequently, should not consider claiming conscientious objection.

Nurses' age and the professed religion did not demonstrate to interfere with the way they saw the suspension of treatments, but life experiences with similar situations, yes: which confirms the influence of experience on our understanding of the world. The considered thematic area is vast and it is important that new work may arise, allowing constant questioning in search of more knowledge and an increasingly ethics acting, which is the same as saying more human.

This study presents some limitations in terms of external and internal validity, because it is not an experimental study. Thus, the internal validity when referring to the cause-effect relation and the

possibility that extraneous variables can influence the dependent and independent variables have not been verified in this study since it is not possible to state on causality, but on relationships; extraneous variables cannot be controlled to the extent that the addressed subject is influenced by subjective aspects such as culture, education, feelings, emotions, beliefs and values - which influence nurses standing positions. External validity is also conditioned, because it not possible to generalize locations or samples that are not studied, allowing only the transfer of findings to similar realities.

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