Ethical problems identified by nurses in relation to patients in critical condition

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Abstract

This article presents an identification and analysis of ethical issues identified by nurses in relation to patients in a critical condition, who are at imminent risk of death and whose survival depends on advanced means of surveillance, monitoring and therapy. The main ethical concerns are providing information to the client, end of life monitoring, professional liability in interdependent interventions; themes related to the decisions of the patient (consent to/refusal of therapeutic treatment), information dilemmas, action to be taken during the processes of dying and with regard to do not resuscitate orders, and respect for human rights in unfavorable situations. The present study considers the importance of a sense of responsibility and of protecting the individual at risk, the influence of moral conscience in decision-making, and professional experiences when overcoming challenges. Finally, mediating factors in the management of ethical difficulties are identified.

Keywords: Bioethics. Bioethical issues. Nursing care. Problem solving. Research.

Resumo

Problemas éticos identificados por enfermeiros na relação com usuários em situação crítica

O artigo apresenta os resultados da análise das questões éticas identificadas por enfermeiros perante usuários em situação crítica, de risco iminente de morte, e cuja sobrevivência depende de métodos avançados de vigilância, monitorização e terapêutica. As principais preocupações éticas dizem respeito à informação ao cliente, ao acompanhamento em fim de vida, à responsabilidade profissional em intervenções interdependentes; as temáticas reportam à decisão da pessoa (consentimento/recusa de proposta terapêutica), dilemas na informação, atuação nos processos de morrer e decisão de não tentar reanimar, respeito pelos direitos humanos em contextos desfavoráveis. Destacamos as dimensões do sentido de responsabilidade, da influência da consciência moral nas decisões, da deliberação de proteger o Outro em risco e da vivência de episódios profissionais de superação; finalmente, identificamos fatores mediadores na gestão das dificuldades éticas.

Palavras-chave: Bioética. Temas bioéticos. Assistência de enfermagem. Resolução de problemas. Pesquisa.

Resumen

Los problemas éticos identificados por enfermeros en relación a los pacientes en estado crítico

El artículo presenta los resultados de las cuestiones éticas identificadas por enfermeros ante usuarios en situación crítica, en una situación de riesgo inminente de muerte y cuya supervivencia depende de medios avanzados de vigilancia, monitoreo y tratamiento terapêutico. Las principales preocupaciones éticas se han expresado respecto a la información al cliente, el acompañamiento en el final de la vida, a la responsabilidad profesional en intervenciones interdependientes; las temáticas reportan la decisión de una persona (el consentimiento / rechazo de la propuesta terapéutica), dilemas en la información, actuación en los procesos de morir y de la decisión de no tratar de revivir, respeto de los derechos humanos en contextos desfavorables. Destacamos las dimensiones del sentido de la responsabilidad, la influencia de la conciencia moral en las decisiones, la deliberación para proteger el Otro en riesgo y la experiencia de episodios profesionales de superación. Por último, se identifican factores de mediación en la gestión de las dificultades éticas.

Palabras-clave: Bioética. Temas bioéticos. Atención de enfermería. Solución de problemas. Investigación.

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Declara não haver conflito de interesse.

Research article

The definition of *critical situation* may vary, since it represents health care facilities including urgency and emergency care, as well as people submitted to intensive care. In the literature, the common denominator is the idea of a situation of imminent risk of death, and theoretically, *critically ill patient* is defined as the one who*, because of a dysfunction or failure of one or more organs or systems, depends on advanced means monitoring and therapy to survive* [1]. The person in a *critical situation* is found in the center of attention of professional, who constantly demand the maintenance of life support in a context of uncertainty and complexity.

Thus, nursing care to the patient in a critical situation is highly qualified, *provided continuously to the patient with one or more vital functions in immediate risk, as a response to the affected requirements, and allowing to maintain basic functions of life, preventing complications and limiting disabilities, in view of their total recovery* [2]. Among the objectives of the health care to the patient, we highlight the continuous monitoring of his/her situation to be able to foresee and early detect any complications, enabling an accurate, effective and timely intervention.

Providing health care in critical situations requires a safe and immediate work, marked by the conscience of its impact in the survival, recovery and in the quality of life of the person. Apparently tangential aspects, such as the professional formation or the team work, have significant proportions in the care in severe, unstable and potentially harmful situations, which affect the survival. Taking into consideration that, several times, the professional concerns are therapeutic priorities, focused on the correction of homeostatic imbalances, in the hemodynamic stabilization and of ventilation conditions, in the restoration and conservation of volemia, as well as fixing the electrolyte imbalance, metabolic changes and control the pain. In summary, most of the attention is focused on the support of systems.

The issue which guided this study consists in identifying ethical problems that emerge from the clinical practice in critical and complex situations, from the perspective of nurses. As warned by Diego Gracia and Elma Zoboli, such problems *may be considered as any situation that at least one person consider as such* [3].

Method

Data collection was made in several phases by means of two collection techniques: application of questionnaire and focus group. The group was composed of professionals who were taking the postgraduate course in medical-surgical nursing and who developed their professional activity for at least two years. Postgraduate students took part in a module "Ethical issues emerging from complex health care", with the following objectives: (a) explore ethical issues arising from care providing in a complex environment; e (b) articulate ethics and deontology and promote reflection on the situation in focus.

The total of 220 students registered in six courses taught by the author of this research: two from the postgraduate, two from the post-licenciatura of specialization and two from master's degree, all of them in medical-surgical nursing. Most of them came from central hospitals from the region of Lisbon and also from Vale do Tejo, and 75% took part in the data collection. Therefore, it is a convenience sample – not probabilistic and accidental.

Data obtained required an individual response to an open question: "*Identify three ethical issues related to complex health care*". In the following phase, there was a three-step task, repeated with small groups of three to five nursing students: (a) identification of ethical issues related to complex health care, according to the theoretical, clinical (experiential) and conceptual perspective of the group; (b) listing of questions and choice of a case and; (c) preliminary exploration of the fundamentals for ethical analysis.

We must state that this open question is consistent with the purpose of the study, as well as identifying, choosing and exploring fundamentals of a case by a small focus working group improved substantially the methodological design.

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The first collections were carried out in July 2007 (31 respondents) and May 2009 (30 respondents), and their results were identified as Group A. Surveys regarding the reflection in group occurred in October 2011 (30 respondents, six groups), February (18 respondents, four groups), May 2012 (25 respondents, five groups), July 2013 (22 respondents, four groups) and May 2014 (10 respondents, two groups), with results identified as Group B.

Table 1. Synthesis of data collection, population, sample and techniques

Dates	Population	Sample	Technique and collection	
July 2007	39	31	Individual Questionnaire Identification of three ethical issues (176 statements of problem)	A
May 2009	40	30		
October 2011	32	30	Work in small groups Identification of ethical issues – choice of cases (21 cases/problem-situations)	B
February 2012	25	18		
May 2012	28	25		
July 2013	30	22		
May 2014	26	10		
Total	220	166		

Between the target population comprised in the beginning of the study and data related to effective participants of the study, about 25% were lost when compared to the total. This reduction occurred because of the long-term of the study: seven years. In spite of this reduction in the amount of participants, it is believed that there is no reason to argue about the length of the research; if it were another topic, this length might be questioned but as it refers to the identification of ethical issues of the professional practice of nurses who provide care to patients in a critical situation, the core of the discussion remains unchanged. In addition, this interval would be even more interesting, also by the comparison with the previous study, carried out in 2004 [4].

Results of the first phase

In the analysis of Group A, *a priori* the matrix from the previous study [4] was used with twelve categories: "information"; "end-of-life monitoring"; "decision of the health care recipient", "respect for the person"; "professional secrecy"; "professional liability in interdependent activities"; "institutional liability"; "distribution of resources"; "professional reflection"; "development of technologies"; "protection of health" and "beginning of life".

In this study, issues proposed by the presence of only seven of these categories were verified – which is understandable as for the specificity of the critical situation of patients as well as for the fact that nurses are in a medical-surgical context: information; end-of-life monitoring; recipient of information; respect for the person; professional secrecy; professional liability in interdependent activities; and distribution of resources.

Out of Group A (61 respondents), 183 statements on ethical issues might be expected; however, not all responded three questions (some responded to only two), leading to a total of 176 statements. Content analysis technique according to Bardin [5] was used as a data processing technique.

In the category "Information", most testimonials are related to dilemmas in communication with the patient – who should transmit the information, to whom, in which situation; about the information related to "bad news" and the fragmentation of the information as for the right to the truth. Difficulties in a situation of emergency and facing the need to transmit difficult diagnostic information are highlighted. Participating nurses consider this problem as a acute and frequent, particularly when there is news of death and fatal diagnosis.

Table 2. Description of the category "Information"

Category	Subcategories	Recording Units	Enumeration Units (EU)
Information	dilemmas in the information	Transmission of clinical information to patients and family (10)	27
		Transmission of diagnostic information to patients (9)	
		Patient with no diagnostic information asks questions to the nurse (4)	
		The family does not want the patient to be informed b his/her diagnosis (2)	
		The family wishes to hide diagnoses related to diseases which are not well accepted by the society (2)	
Information	dilemmas regarding the information	Decision of the medical team to inform the family, and not the patient about his/her clinical condition (2)	5
		Telephone information required by the patient's family (2)	
		Information being transmitted from the surgical team to the ICU. Who should transmit the information? Which information should be shared? (1)	
	bad news	Communication of bad news (9)	10
		Correct information transmitted to the patient about his/her clinical condition (organophosphorus poisoning, multiple organ failure) (1)	
	problem with the truth	Communicating the whole truth or part of it (5)	6
		People's right to the truth (1)	
	Total		**48**

In the category "end-of-life monitoring", classical dilemmas emerged surrounding death processes, and the resulting difficulties are also marked by questions on an eventual therapeutic obstination. Several recording units report issues related to the decision to resuscitate or not the patient, verbally indicated or by report, as well as the difficulty of consensus or to establish criteria to determine the beginning and the interruption of measures to support life. Particular cases indicated are of a terminally-ill patient and of a person who attempted suicide. The questioning as for dysthanasia or therapeutic obstination seems to be associated both with terminally ill patients and with patients in a critical situation with no prognosis of recovery.

Table 3. Description of the category "End-of-life monitoring"

Category	Subcategories	Recording Units	Enumeration Units (EU)
End-of-life monitoring	dilemmas surrounding death	Situation of the critical patient and verbal indication of no resuscitation (6)	28
		Resuscitation, no resuscitation – a difficult consensus (5)	
		Criteria to start and interrupt measures to support life (4)	
		Patients in the end of life, terminal disease – to what extent should invasive procedures go? (3)	
		Resuscitate and ventilate patients with several suicidal attempts (2)	
		Maintaining inotropic support in patient with a written indication of no resuscitation (2)	
		Prolonging the life *versus* quality of life, when death is inevitable (2)	
		In ICU, patient receiving invasive mechanical ventilation – chronic, without the possibility of ventilator weaning (2)	
		Call the family to be with the patient in his/her last minutes of life (1)	
		Decision of the medical team to provide "comfort care" (prescribed this way) concomitant with invasive therapeutics (1)	
	therapeutic obstination	Providing resuscitation in patients in the end of life in order to prolong their lives (4)	10
		Maintaining health care and therapeutics in patients with a bad prognosis; useless prolongation of life (4)	
		Patient with multiple organ failure, in an extreme situation, in which the treatment is prolonged continuously and with no possible solution(1)	
		Invasive intervention repeated in a critical patient – situation considered complicated (1)	
	Total		**38**

In the category "professional liability in interdependent (or collaborative) interventions", problems related to work and to communication within the team are highlighted. Issues related to physical restraint and immobilization seem to predominate, maybe because they are part of the discussions of the "*Circular Normativa da Direção Geral de Saúde*" [6]. Such issues give rise to disagreements as for prescriptions or modes of prescribing, particularly about therapeutic prescription performed by the phone, without the presence of the person.

In the category "decision of health care recipients" there are mainly issues on the consent and respect for the decision expressed by the user, when this will is known. It is important to point out the specificity of the consent, the extent given to the presumed consent, the scarcity of conditions to consent, as well as bureaucratization of the consent, related to the "signed paper". The emergency situation in which patients are might serve as a base to dispense consent, particularly when this survey had been carried out before the legislation of 2012 and the regulation of 2014, referring to "living will", although the subject had already been a matter of public discussion [7,8] and it had already been determined legally [9-11].

Table 4a. Description of the category "Professional liability in interdependent interventions"

Category	Subcategories	Recording units	Enumeration units (EU)
Professional liability in interdependent interventions	work in a multidisciplinary team	Immobilization of patients – in the emergency service, in intensive care (6)	12
		Agitated patient – clinical condition in which sedation is not indicated, high risk of fall and/or accident(2)	
		Physical restraint of patients who refuse to adhere to non-invasive ventilation therapy (1)	
		Patient submitted to abdominal surgery, disoriented, externalized catheters and tries to stand up. Can he/she have the upper limbs immobilized? (1)	
		Refusal of immobilization of patients in a situation of psychomotor agitation without a prescription of the GP(1)	
		Delay of the physician to accept speaking to the patient and difficulty to maintain assertivity and make a "connection" (1)	
	communication within the team	Telephone medical prescription (therapeutic prescriptions by the phone) (5)	10
		Disagreement between the internist and specialist physician. Contradictory prescriptions and medical indications (3)	
		Nurse refuses to obtain four venous accesses or other incorrect indications (according to guidelines) (1)	
		Follow or not a medical indication to treat injuries, when it is known that it is not the most appropriate option(1)	
	Total		**22**
Decision of the health care recipient	consent	In a critical situation, the clinical situation and the patient's will are not known (5)	10
		Informed consent to perform procedures (tracheostomy, amputations, etc.) in sedated patients in intensive care (1)	
		Multidisciplinary decision when, during a surgery, additional procedures than those previously agreed by the patient are required (1)	
		Informed consent, signed by the family, for a programmed tracheostomy	
		Sedated/ventilated patients, unable to manifest their will. Should the opinion/will expressed by the significant partner be respected? (1)	
		Informed consent – patients who are submitted to surgeries or exams without knowing what procedures will be performed, the risks and the consequences (1)	
	respect for the decision expressed	The patient asks not to speak about the disease – the family wants to know (3)	10
		Nasogastric intubation of a patient who refuses to eat, because of a severe nutritional impairment (2)	
		Why not respect the patient when he/she manifests his/her will to determine any type of proposed treatment? (1)	
		The situation of the patient who does not want to be resuscitated and the family who begs not to let him/her die (1)	
		Refusal of blood transfusion in hemodynamically unstable patients	
		Homosexual patient – the family does not want the partner to visit; but the patient does (1)	
		Fulfillment of medical prescriptions against the patients will (1)	
	Total		**20**

In the category "distribution of resources", there are subcategories such as allocation, particularly related to priorities and transport of the patients, as well as working conditions and, particularly, the work overload (by scarcity of human resources).

In the category "respect for the person", there are questions as for the conditions for the exercise of human rights and the humanization of health care, particularly when it refers to therapeutic communication. Physical spaces and the architecture of health care units appear as conditioning, as well as some established routines (for example, removing the patient's clothes and belongings when he/she is admitted to hospital).

In the category "professional secrecy", recording units were verified alluding to sharing difficult diagnostic information, as well as cases of violence. It is clearly difficult to protect personal information in contexts of working conditions. There is a higher frequency of recording units in emergency services, in which it is particularly difficult to protect the information and to guarantee confidentiality of the clinical information (mainly due to circumstances of space and to the lack of physical privacy). Concerns with dilemmas between maintaining secrecy and sharing the information reflecting situations which expose the idea of *imminent risk* (to others, such as in the case of HIV, and for himself/herself in cases of domestic violence).

Table 5. Description of categories "Distribution of resources", "Respect for the person" and "Professional Secrecy"

Category	Subcategories	Recording units	Enumeration units (UE)
Distribution of resources	allocation of resources	Transport of the critically ill patient only with a nurse (4) – conditions not to obey?	10
		Management of patient mobility (for exams or external transfers) (3)	
		Management of priorities – making nursing reports or providing care such as positioning in case of ulceration risk (1)	
		Fill vacancies of ICU with chronic patients when another type of patient also needs the vacancy (1)	
		Recommending contact isolation – permanence in a reduced physical space, with patients and personnel in circulation (1)	
	working conditions	Nurses overloaded work – emergency and ICU (7)	8
		To what extent should a nurse have the obligation to be informed and updated on new surgical and therapeutic techniques, when his/her practice requires him/her to be excessively productive in health care? (1)	
	Total		**18**
Respect for the person	respect for human rights	Management of the patient's privacy in an environment without conditions (5)	12
		Who should be considered as a reference person for the sedated/ unconscious patient? (3)	
		removal of clothes and personal objects as a routine service (2)	
		Recommending patient isolation – permanence in a reduced physical space, with patients and personnel in circulation (2)	
	humanization of health care	Difficulty to establish a verbal communication (and non-verbal) with patients subjected to ventilation/invasive ventilatory support; difficulty to establish a therapeutic relationship (5)	5
	Total		**17**

Research article

Category	Subcategories	Recording units	Enumeration units (UE)
Professional secrecy	dilemmas of the secrecy	After communicating the diagnosis of HIV, the person verbalizes that he/she will not share this information with his/her partner (3)	5
		An elderly is a victim of violence by the family– denunciate or not, even if the elderly hides it for fear of the family and denies being a victim (1)	
		In case of domestic violence against women, does the nurse have the duty to or have the right to, after trying to help the person, denunciate the situation to the competent authorities? (1)	
	contexts of practices	In a context of emergency care, the difficulty to protects information about people (6)	8
		Documents/process of the patient pass through several people – How is it possible to maintain secrecy? Are the nurse and the doctor the only people in charge?	
		Shift change in the hospital with the patient –with comments aside	
	Total		13

Following, we have a single table showing a global systematic, with all categories and subcategories identified. This comparison allows the identification of three categories which are more common than the others, with a total of 61.4% of statements of the participants.

Table 6. Categories e subcategories of problems identified

Category	UE	Fi (%)	Subcategories	UE
Information	48	27,27	Dilemas about the information	**32**
			Bad news	**10**
			The problem of truth	**6**
Follow-un in the end of life	38	21.59	Dilemmas facing death	**28**
			Therapeutic Obstination	**10**
Professional liability in interdependent interventions	22	12.5	Work in a multidisciplinary team	**12**
			Communication as a team	**10**
Decision of the health care recipient	20	1..36	Consentment	**10**
			Respect for the expressed decision	**10**
Distribution of resources	18	10.227	Allocation of resources	**10**
			Working conditions	**8**
Respect for the Person	17	9.66	Respect for human rights	**12**
			Humanization of care	**5**
Professional secrecy	13	7.39	Dilemmas to do secretly	**5**
			Contexts of practices	**8**

First conclusions

The most frequent categories of problems are thought to refer to as “information”, followed by “work-up in the end of life” and “liability in interdependent interventions”; subcategories with a higher frequency of units are “dilemmas in information”, “dilemmas when dying” and, *ex aequo*, “multidisciplinary field work” and “respect for human rights”.

As for the “information” category, most testimonials refer to dilemmas in communication – particularly those who should inform, who should be informed and in which situation – considering particularly that information related to “bad news” and the fragmentation of information facing the right to the truth. Regarding the patients, there are difficulties as for ethical emergency, in the urge of transmitting difficult diagnostic information (which influences the life cycle). From the human point of view, the management of something we do not know well how to describe is particularly complex for the nurse to make a decision.

The “follow-un in the end of life” category points out to problem aspects made evident in death processes and also for difficulties facing a possible therapeutic obstination. Data show that several recording units report the decision to resuscitate, verbally indicated or by medical chart, as

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well as the need to reach a consensus to establish criteria for the beginning and for the interruption of life support measurements. These problems exemplify cases of terminally-ill patients, as well as those who tried to commit suicide. The questioning as for dysthanasia or therapeutic obstination seems to be associated with both the terminally-ill patients and the critical situation with prognosis of recovery.

As for the "decision of the health care recipient" category, difficulties are visible when the user's will is not known, when it is in conflict with what professionals consider as what is the best for the person and, still, when the patient's will and his/her family differ. There is often the concern for not knowing the user's will, considering that anticipation may allow asking about his/her preference, which is not always possible due to the circumstances.

Evidences emerge from the confrontation of will – between the patient and his/her family, or between the professionals and the patients. The frequency of such conflicts are attributed to the fact that most respondents work in emergency services, intensive care units, and in the medical-surgical area, in which highlights the trend to exacerbate conflicts in face of the ever-present imminence of death.

In the "respect for the person" category, the issues on the conditions for the exercise of human rights and for the humanization of health care focus on physical spaces and on established routines, with the fundamental idea being the need to adequate to the management of space and application of the rules.

In the "professional secrecy" category, there are legal aspects and the choice between keeping a secret and sharing information. Here, the well-being of the patients is the main concern of professionals, increasing the meaning of care, which extends from the user to his/her significant ones.

In the "distribution of resources" category, the scarcity of personnel and the overload of the team stressed by constraints when providing care, with ethical problems.

Results of the second phase

As for Group B, participants identified ethical issues from principals and duties and in each small group, they selected a case or an issue to analyze more deeply.

The *design* of investigation is thought to be intrinsic to the methodology applied in case studies, from the focal group, may be conducted with very distinct paradigms, as a results, aiming at very different proposals [12]. In this study, the resource to the real nature of the case, as well as the experiences of nurses (several times difficult and unresolved), aims at responding to the pretension to understand and analyze a concrete situation and the develop a reflexive competence, improve the capacity of resolution in future cases. After defining the subject with the students, each group chose a representative case. Thus, the selection was made by considering the most significant case for the group, materializing the complexity of possibilities in the selection process.

The 21 cases chosen by the groups of nurses were mainly related to clinical experience (17) and report situations de end-of-life monitoring (5), consent and refusal of therapeutic proposals (3), decision of the health care recipient (3), diagnostic information (3), respect for the person (2) professional conditions (1). In some cases, choices were for what is thought as a problem situation that is, the decision for no resuscitation; information and consent; decision of the recipient and respect for the person; and end-of-life monitoring and palliative care. In these groups, participants did not narrate a case, but described a situation more generally.

When systemizing all data obtained, it was possible to see that the main ethical concerns expressed by nurses relate to the information to the person, to the end-of-life monitoring and the professional liability in interdependent interventions (here designated as "collaborative"). The most frequent issues are the person's decision (consent/refusal of the therapeutic proposal), dilemmas in the information, procedure facing death processes, decision of no resuscitation and respect for human rights in unfavorable contexts.

Some examples were chosen, distinguishing problem situations in general are as follows:

Case A

A 53-year-old man is admitted to the emergency service with nausea, vomiting and weight loss of 10 kilos in the past month. He has no relevant personal history. He is single, with no children, lives alone and is conscious. After taking the additional exams, he was diagnosed with a stomach cancer, he is transferred to surgery. In the ward, he is informed by the doctor that his tumor was inoperable, some therapeutics are suggested aiming to make him start eating again and thus, improve his quality of life. These are the suggestions: placement of an esophageal prosthesis or a nasojejunal feeding tube or jejunostomy,

both are refused by the patient. Because of the patient's decision, the doctor decides to discharge him.

Case B

A 50-year-old man is admitted to the emergency service, victim of a car accident. He is unconscious and has an open fracture of the left femur. He is hemodynamically unstable, with the need for a surgical intervention and probably a blood transfusion. His daughter, also a victim of the accident, is also admitted to the emergency service, but conscious and with no apparent injuries; and she says they are both Jehovah's Witnesses and, according to their religion, he cannot receive blood transfusion.

Case C

A 35-years-old man, with an ischemic stroke for 3 years, with several cognitive and motor deficits. Highly dependable on several activities, such as for feeding themselves, evacuating, mobility, among others. Due to his several deficits, he cannot express his will. He is used to being followed by his wife and children, who have not informed his will either. He turned to the emergency service due to a difficulty breathing and vomiting; he was then admitted to hospital due to aspiration pneumonia. There is no legal representative appointed by the court. During the night shift, he had a respiratory arrest and the team needed to decide whether they would start resuscitation.

Case D

Unconscious patient, in the terminal phase. Morphine infusion is prescribed. Nurses question each other about it, as the patient has always expressed refusal, during the disease, of the administration of opioids.

Situation A

Formulation of criteria to make a decision on no resuscitation.

Situation B

Therapeutic obstination. Problem situation: person under palliative care, in the terminal phase, with an acute disease associated.

Situation C

People in a state of emergency, with unknown cultural specificities of healthcare professionals, either in terms of food or in terms of health care.

Discussion and results

Decision making is complex, whether by the required analysis or because the decisions have to be made and carried out according to a sequence of priorities, generally quickly identified. We should recognize that, in several life-saving situations, there is no real sequence of phases in decision making, even if protocols and algorithms are established, for example.

We consider that an algorithm comprises a set of defined stages in order to get to a solution of a problem, aiming to formulate a certain number of alternatives according to the present data to make the best decision. Algorithms increase the brevity of the decision, if well built, reduce risks and increase possibilities of an adequate decision. Those algorithms built in agreement with experts, based on evidences and on the best results obtained, which have been tested and validated are considered well built.

The use of algorithm requires adopting a pre-determined decision scheme, the most adequate for each situation. These are good examples of algorithm Basic Life Support (BLS), Immediate Life Support (ILS), Advanced Life Support (ALS) and Advanced Trauma Life Support (ATLS). Analogously, and at the same time different, protocols, regulations or established routines, although they are intended to organize health care or service, they may oppose the best interest or will of the person concerned. Here, the appeal is to ponder what supports the resolution of doing or not, in a particular situation, what is recommended in general.

One of the relevant elements to consider is the time available; that is, the *length*, because it is not just the chronological time. There are several situations when you cannot take long to make a decision and this delay becomes irreversible as for the possibilities of decision making regarding taking action. Time in a critical or palliative situation is a determining factor, although it makes a big difference whether the team and the nurses discuss and analyze what happened, in order to have internal resources for the decision making in a similar case in the future.

It seems evident that ethical problem, regardless of differences in reporting units, focuses primarily on the *information* (most common category in the results of 2004 and in two groups of study presented here). This is a place of ethical issues in health care, related to decision making and to the user's self-determination – since the information

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is a resource for the deliberation and the decision making, which is closely related to consent. National and international studies [13] and reports [14] reaffirm these essential understanding and concern.

The issue of follow-up in in the end of life arises as a significant problem in the concerns raised as well as the decision about the recipient of care. Some recent studies, such as those of Sandra Pereira [15] and of Ana Paula Sapeta [16], focused on palliative care, being relevant those related to the formation of the bioethical consciousness associated with the care, as mentioned in the researches carried out by Ana Paula França [17] and by Susana Pacheco [18], bioethical reflection as an anthropological reference such as that of Ferreira da Silva [19], and the capabilities approach that allows us to know, regulate, achieve and manage emotional phenomena in order to build and maintain interpersonal relationships in an affective environment, as it is seen in the work of Sandra Xavier [20].

Aspects related to the distribution of human resources are thought to be more incisive in the last few years. This brings into focus issues of justice in health and in health care services and encourages the reflection and the discussion as for the distribution of resources in a perspective of social justice and equality. Several studies [21] support the theory that inequality is strongly related to mortality, mean life expectancy and variation of other indicators, whereas it is recognized that system organization and the distribution of resources significantly affect the access.

Furthermore, it is important to consider that some documents on bioethical perspective [22] focus on this problem, particularly on the access to health care and on dimensions associated (availability, proximity, costs, quality and acceptance). Among these aspects, availability is particularly highlighted, as it is considered as an adequate provision of services which enables the opportunity of using healthcare services. It seems evident that, for a strategy to reduce inequalities to be practicable, the affectation of human and financial resources needs to be applied according to the population's needs, with the rationalization of resources.

Some dimensions exceed in the discourses, in all debates and analyses carried out, and it is relevant to represent them systematically as follows:

a) The sense (expressed) of liability, accurate in critical, urgent, emergency situations and also those of intensive care, requiring (the nurse) to make decisions quickly and complex care, that lead him/her to take relational, cultural and human aspects *for granted*, prioritizing technical aspects aiming to reestablish and increase the quality of life of the sick person. The idea of taking something for granted represents the reestablishing of priorities, which gives priority to the preservation of life; therefore, ethical issues are not always highlighted, even when in some cases they are necessary for the decision making facing a real or imminent risk, particularly considering the expressed will of the user.

b) Moral consciousness is often verified as the one that influences decisively the decision making process, which arbitrates in dilemma contexts and moves the action, based on knowledge, skills and professional experience. It is noted in this finding that the expertise requires the knowledge and experience reflected and that, in the presence of ethical dilemmas, the nurse makes his/her choice based on professional deontology, identifying the arbitration of his/her own moral consciousness.

c) In addition, the constancy and the firmness of the resolution of helping and protecting the *person at risk of death*, which is so present that induces feelings, emotions and conflicts in a multidisciplinary team. Such conflicts materialize in the professional descriptions of compassion, gratitude, sadness, anxiety, joy, relief; it seems that, the more intense the perception of severity of the person's medical condition and the wiser is the resolution (that includes feeling that cared properly for the one who died), more congruent seems to be the professional *sense of self*.

The analysis of the questionings presented also show the rise of factors, considered *mediators,* which promote the decision making felt by the participants of the study as *fairer*, *more correct or more efficient*: (a) support of team leadership; (b) the dialog between different professionals of the team; (c) physical and technical suitability of health care centers; (d) knowing the person's history; and (e) professional self-confidence and self-esteem. From these mediators, the issue of knowing the person and the questions that may be asked about care provided to strangers, for example in an emergency situation, who had just arrived to be taken care by professionals should be highlighted.

Some situations, which have been systematized by the participants among episodes they have experienced in a large scale, are described as *events of overcoming obstacles* – such as cases of transport of critical patients, of evacuations, of savings in re-

suscitation rooms or in a pre-hospital situation. Such events are significant as they require technical and scientific expertise and also relational skills, ethical capacity and human sensitivity, gathering a list of attributes that tend to develop with time and as long as the good professional practice is performed.

In conclusion, depending on the complexities of the critical situation, the central focus of the nurse is believed to be the *other person at risk*, whether death risk, whether as for their choices and decisions, or for a way to die with dignity. The other occasionally attacks and insults and offends the nurses - and the professional judges the risk of decision making, which may, in extreme situations, lead to the refusal of care. Even in these cases, the primary concern is what is best for the person.

Final considerations

When the situation is considered as a *risk* situation it has significant contours in health care centers where complex care is provided to the person in *imminent risk of death* and whose survival depends on advanced surveillance, monitoring and therapeutic systems.

We have analyzed ethical issues identified by nurses taking a postgraduate course in medical surgical nursing and used a categorical theme analysis of statements and of cases. Categories identified were: information, support at the end of life, professional liability in interdependent interventions, decision making of the recipient of care, distribution of resources, respect for the person and professional secrecy.

We concluded that the main ethical worries expressed concern the information to the client, the supporting the end of life care and the professional liability in interdependent interventions. The most common issues are those related to the person's decision (agreement/refusal of the therapeutic approach), dilemmas regarding information, procedures regarding death processes and the decision to not resuscitate a person and respect for human rights in adverse contexts

The dimensions of the sense of liability, of the influence of moral conscience in decision making, of the determination of protecting the *others at risk* and experience with professional episodes of overcoming obstacles are highlighted. We have identified mediator factors in the management of ethical difficulties, such as the team leadership support, the dialog among different professionals in the team, physical and technical suitability of health care centers, knowing the person's history, professional self confidence and self-esteem.

Rom the obtained results, we may define to moments of action in the future: (a) in the short term, disseminate and discuss these results in the postgraduate courses and in the ethical-professional thinking promoting an ethical debate and involving professionals from the teams; (b) awareness of decision makers, sharing cases and events of overcoming obstacles may be strategies to be developed in moments of reflection on practices and development of the experiential knowledge. Studying the impact of these interventions will be very important, as well as studying the relationship among the self-consciousness, emotional capacities and ethical and ethical competence.

Referências

1. Sociedade Portuguesa de Cuidados Intensivos. Transporte de doentes críticos – recomendações. Lisboa: Comissão da Competência em Emergência Médica da Ordem dos Médicos; 2008. p. 9.
2. Ordem dos Enfermeiros (Portugal). Preâmbulo do Regulamento nº 124/2011. Regulamento das competências específicas do enfermeiro especialista em enfermagem em pessoa em situação crítica. Diário da República, 2ª Série, nº 35, 18 fev. 2011, p. 8.656-7.
3. Zoboli EP, Lima AC, Morales DA, Sartório NA. Problemas éticos na atenção básica: a visão de enfermeiros e médicos. Cogitare Enferm. abr./jun. 2009;14(2):294-303. p. 295
4. Nunes L. Justiça, poder e responsabilidade: articulação e mediações nos cuidados de enfermagem. Loures: Lusociência; 2005. p. 221-34.
5. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2007.
6. Direção Geral de Saúde (Portugal). Circular normativa: Medidas preventivas de comportamentos agressivos/violentos de doentes. [Internet]. 2007 [acesso 25 ago 2014]. Disponível: http://www.dgs.pt/?cr=11390
7. Conselho Nacional de Ética para as Ciências da Vida. (Portugal). Parecer 59/CNECV/2010. Parecer sobre os projectos de lei relativos às declarações antecipadas de vontade. Nunes L, Renaud M, Silva MO, Almeida R, relatores. [Internet]. Lisboa, dez 2010. [acesso 25 ago 2014]. Disponível: http://www.cnecv.pt/admin/files/data/docs/1273053812_P057_CNECV.pdf

8. Conselho Nacional de Ética para as Ciências da Vida (Portugal). Memorando sobre os projectos de lei relativos às declarações antecipadas de vontade. [Internet]. dez 2010. [acesso 25 ago 2014]. Disponível: http://www.cnecv.pt/admin/files/data/docs/1293115784_Memorando%20Parecer%2059%20CNECV_DAV.pdf
9. Conselho da Europa. Convenção para a protecção dos direitos do homem e da dignidade do ser humano face às aplicações da biologia e da medicina: convenção sobre os direitos do homem e a biomedicina, aberta à assinatura dos Estados-membros do Conselho da Europa em Oviedo, em 4 de abril de 1997. [Internet]. 2001. [acesso 8 mar 2015]. Disponível: http://www.gddc.pt/direitos-humanos/textos-internacionais-dh/tidhregionais/convbiologiaNOVO.html
10. Ordem dos Enfermeiros. (Portugal). Código Deontológico do Enfermeiro. [Internet]. 2009. [acesso 24 ago 2014]. Disponível: http://www.ordemenfermeiros.pt/legislacao/documents/legislacaooe/codigodeontologico.pdf
11. Ordem dos Médicos. (Portugal). Código Deontológico dos Médicos. [Internet]. 1994. [acesso 24 ago 2014]. Disponível: https://www.ordemdosmedicos.pt/send_file.php?tid=ZmljaGVpcm9z&did=c06d06da9666a219db15cf575aff2824
12. Willis JW. Foundations of qualitative research. Thousand Oaks: SAGE Publications; 2007.
13. Almeida OMO. O consentimento informado na prática do cuidar em enfermagem. Porto: Instituto Ciências Biomédicas Abel Salazar; 2007. (dissertação). [acesso 24 ago 2014]. Disponível: http://repositorio-aberto.up.pt/bitstream/10216/22448/4/O%20Consentimento%20Informado%20na%20Prtica%20do%20Cuidar%20em%20Enfermagem.pdf
14. Entidade Reguladora da Saúde. (Portugal). Consentimento informado – relatório final. Porto: Entidade Reguladora da Saúde: maio 2009. [acesso 25 ago 2014]. Disponível: https://www.ers.pt/uploads/writer_file/document/73/Estudo-CI.pdf
15. Pereira S. Cuidados paliativos: confrontar a morte. Lisboa: Universidade Católica Editora; 2011.
16. Sapeta AP. Cuidar em fim de vida. O processo de interacção enfermeiro-doente. Loures: Lusodidacta; 2012.
17. França AP. A consciência bioética e o cuidar. Coimbra: Formasau; 2012.
18. Pacheco S. Desenvolvimento da competência ética dos estudantes de enfermagem – uma teoria explicativa. Lisboa: Universidade Católica Editora; 2011. [acesso 25 ago 2014]. Disponível: http://repositorio.ucp.pt/handle/10400.14/7947
19. Ferreira da Silva JN. A morte e o morrer entre o deslugar e o lugar. Precedência da antropologia para uma ética da hospitalidade e cuidados paliativos. Porto: Afrontamento; 2012.
20. Xavier da Silva SM. Significar a competência emocional do enfermeiro na prestação de cuidados de conforto à pessoa em fim de vida. [Internet]. 2014. [acesso 24 ago 2014]. Disponível: http://hdl.handle.net/10451/10565
21. Furtado C, Pereira J. Equidade e acesso aos cuidados de saúde bem como o estudo do acesso aos cuidados primários do SNS. Relatório (com revisão sistemática). Lisboa: Entidade Reguladora da Saúde; 2009.
22. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Securing access to health care: a report on the ethical implications of differences in the availability of health services. Volume One: Report. [Internet]. mar 1983. [acesso 24 ago 2014]. Disponível: http://bioethics.georgetown.edu/pcbe/reports/past_commissions/securing_access.pdf

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