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ORIGINAL ARTICLE

THE EXPERIENCE OF ORTOTHANASIA BY HEALTH PROFESSIONALS OF AN INTENSIVE THERAPY UNIT

A EXPERIÊNCIA DA ORTOTANÁSIA POR PROFISSIONAIS DA SAÚDE DE UMA UNIDADE DE TERAPIA INTENSIVA

LA EXPERIENCIA DE ORTOTANÁSIA POR PROFESIONALES DE SALUD DE UNA UNIDAD DE TERAPIA INTENSIVOS

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ABSTRACT

Objective: to know the experiences of orthatanasia by health professionals of an Intensive Care Unit. ***Method:*** qualitative, exploratory study, with data collected by semi-structured interviews with 14 professionals working in the ICU of a University Hospital in the extreme south of Brazil. ***Results:*** clear information is the basis for safe conduct and decisions, but differences in individual thinking and performance prevail and generate conflicts; are recognized practices of therapeutic obstinacy and experiences of anguish and impotence in the face of unnecessary suffering. Empathy is an element of humanized care, and spirituality supports confronting terminality. ***Conclusion:*** training and professional practice do not favor the processes of moral deliberation and teamwork, aggravating the difficulties of approaching the dying process. ***Descriptors*:** Ethics; Intense Therapy; Death; Health Professional.

RESUMO

***Objetivo*:** conhecer as experiências de ortotanásia por profissionais da saúde de uma Unidade de Terapia Intensiva. ***Método*:** estudo qualitativo, de caráter exploratório, com dados coletados por entrevistas semiestruturadas com 14 profissionais atuantes na UTI de um Hospital Universitário do extremo sul do Brasil. ***Resultados*:** a clara informação é a base para condutas e decisões seguras, mas diferenças de pensamento e atuação individuais prevalecem e geram conflitos; são reconhecidas práticas de obstinação terapêutica e vivências de angústia e impotência frente ao sofrimento desnecessário. A empatia é elemento do cuidado humanizado e a espiritualidade apoia o enfrentamento da terminalidade. ***Conclusão*:** a formação e a prática profissional não favorecem os processos de deliberação moral e o trabalho em equipe, acirrando as dificuldades de abordagem do processo de morrer. ***Descritores*:** Ética; Terapia Intensiva; Óbito; Profissional da Saúde.

RESUMEN

Objetivo: conocer las experiencias de ortotanasia por profesionales de la salud de una unidad de Terapia Intensiva. ***Método:*** estudio cualitativo, de carácter exploratorio, con datos recogidos por entrevistas semiestructuradas con 14 profesionales en la UTI de un Hospital Universitario en el extremo sur de Brasil. ***Resultados:*** la información clara es la base para conductos y decisiones seguras, pero diferencias de pensamiento y acción individual, prevalecen y generan conflictos; son reconocidos prácticas de obstinación terapéutica y experiencias de angustia e impotencia ante el sufrimiento innecesario. La empatía es elemento del cuidado humanizado y la espiritualidad apoya la confrontación del enfermo en fase terminal. ***Conclusión:*** la práctica profesional y formación no favorecen los procesos de deliberación moral y trabajo en equipo, intensificando las dificultades de abordaje del proceso de morir. ***Descriptores*:** Ética**;** Terapia Intensiva; Óbito; Profesionales de la Salud.

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INTRODUCTION

In recent decades, there has been a significant development of technological advances in the area of health and, in parallel, the increase in the prevalence of chronic-degenerative diseases and disabling acute diseases that can progress to a prolonged death process.[1-2] The exacerbated use of these technologies can emerge a series of social, institutional, professional, ethical and even legal dilemmas, especially when applied to patients outside the possibility of cure, since, if the health professionals who are involved cannot understand death as a stage of human existence, this may influence the posture and performance of these workers due to insecurity in relation to situations involving termination.[3]

Although the available technology facilitates care and allows greater survival to the diseases, it also appears, making it difficult to resilience to the impossibility of cure and terminality. The training of health professionals, especially nurses and doctors, is strongly linked to curing illnesses and saving lives, and when saving lives is not feasible, there is frustration. The weaknesses and limits of professional intervention alone would justify a greater relevance of the finiteness and care approach to it in the training processes, in order to promote a safer action against the death of patients.[4]

The impotence experienced before death is associated not only with the lack of approach to this ethical question in professional formation, but also with other personal factors such as religion, which clearly influence the definition of morality of an individual and has repercussions on the professional, significantly interfering in the posture of these workers in the face of controversial issues that involve ethical conflicts. [5]

These particularities of each professional, in relation to the way he experiences death on a daily basis, can interfere in the practice of orthotanasia, which can be defined as the process of "artificial prolongation of the death process", conceived as natural, without subjecting the terminal patient to disproportionate and abusive treatments, with a multiprofessional approach to effective care, accepting the termination of life and providing the fundamental care so that the dignity of the patient is maintained intact, through palliative care, that is, without subjecting the terminal patient to disproportionate and abusive treatment. In orthotanasia, the patient evolves to death due to his / her health condition, that is, there is no intervention in the sense of prolonging life beyond what is allowed by its natural state, while taking no action to anticipate the death of the patient, being adopted only conducts that aim at comfort and allow the dignity of the patient in this moment of finitude.[6:84,1]

Although orthotanasia is a specific practice of medical professionals, authorized by the Federal Council of Medicine, by Resolution No. 1. 805, dated November 9, 2006,7 it should be noted that there is a multidisciplinary team working in this reality. Ethical and legal dilemmas permeate all the professionals involved in this process: nurses, technicians and nursing assistants are usually close to the patient and their family. It is understood that the Intensive Care Unit (ICU) is the place where conflicts and ethical dilemmas about orthotanasia are more present, because it is a characteristically critical, complex and intense environment and, mainly, for caring for patients in finitude of life.[8]

Despite recognizing the advances in the practice of orthotanasia, it is believed that this is still poorly understood by health professionals, especially those of the ICUs. This is probably due to the still dominant culture of fear of death associated with professional training, which emphasizes the goal of saving lives by not always confronting or balancing it with other goals as important as this. Thus, this article aimed to know how the health professionals of an ICU of a University Hospital in the extreme south of Brazil face the process of orthotanasia in their professional practice. Thus, this article aimed to know the experiences of orthotanasia by health professionals of an Intensive Care Unit.

METHOD

Exploratory study, of qualitative character. The context of this research was an Intensive Care Unit (ICU) of a University Hospital located in the extreme south of Brazil and counted with the participation of the health professionals who made up the multidisciplinary team of the sector. The team consisted of six nurses, 13 nursing technicians, six nursing assistants, eight physicians, three physiotherapists, one nutritionist, one nutrition technician, and one psychologist. For data collection, the following inclusion criteria were used: being a health worker and working in the ICU for a minimum period of three months. Temporary workers who were on leave for health treatment or on leave, as well as trainees and residents, were excluded. Thus, 14 professionals from the morning, afternoon and

evening shifts who previously agreed to participate in the study were enrolled in the study by signing the Informed Consent Term.

The research project was approved by the Research Ethics Committee in the Health Area of the Federal University of Rio Grande, opinion nº44 / 2014, as directed by Resolution No. 466/2012 of the National Health Council.[9]

Data collection took place from May to June 2014, through a written semi-structured interview, after previous contact with the participants at their place of work and their respective shifts. Each interview was held in private, previously scheduled with participants, to ensure privacy and prevent embarrassment.

The data were transcribed in full and read in detail so that it was possible to know the experience of the ICU health professionals. The Discursive Textual Analysis was used, proceeding to a thorough reading of the material, followed by the process of fragmentation and unitization of the data. In the process of establishing relationships, the data were classified and grouped by similarity, in order to choose the categories.[10]

RESULTS

The results express that: safe and sound decisions and decisions are sought; the team develops ways of acting more or less shared, but the conduct of the on-call physician still prevails; thus, individual differences (values, formation, postures and feelings) are seen as decisive and generating conflicts; personal conflicts and anguish are experienced in the face of suffering considered unnecessary in the prolongation of life or the impotence to define a course different from that followed, and some experience of dysthanasia is confirmed; empathy is reported as an element of humanized care in terminality, which is valued in the decisions and reflections that involve work; spirituality supports the confrontation on the part of the professionals, although not always linked to a specific religion.

Some interviewees exposed the importance of clear and well-documented information to favor the decisions that propitiate the practice of orthothanasia in the intensive care setting:

> *[...] if the patient has been well investigated, it is well documented that it has no therapeutic possibility, I think it is easy to keep comfortable only [...] Terminal patients have no indication of investment [...] patients arriving at the ICU, we always invest [...] you put in ventilation, started vasopressor and finds out that it is a terminal, how to send to infirmary if it is in ventilation? [...] If you take it out of the ventilation it will die, there, it's something else ... It should be well analyzed before coming to ICU because this causes problem. (TS10)*

> *When the patient is in the ICU and it goes so far as to say that there is nothing else to do, it is a long process, many exams, these decisions are not individual, there is a group consensus, there is a routine in which the cases are discussed, and if one arrives at these conclusions ... a well-defined and well-documented record leaves no room for doubt. (TS03)*

The confrontation of the terminality of a patient shows itself to be variable among the professionals, who demonstrate experiencing different individual conflicts that involve both, as well as repercussions in the organization of the unit, in the team's relations with each other, with the patient and their families:

> *We have precise indications for taking a patient to the ICU, but there is the direct opinion of the attending physician [...] if he says "I want my patient to go to the ICU," unless there is a very obvious contraindication, I can not say no [...] Each case is a case, we are also influenced by the way each one deals with death ... Deciding that there is nothing else to do is very difficult and has to be difficult because if it is solved, very easy, it is wrong, there is doubt [...]. (TS03)*

> *[...] the conduct changes according to the doctor who is on duty [...] there is some difficulty in defining the patient's profile that requires palliative care [...] There is also the emotional issue of the professional [...] .] A young patient, child, as we have already had, shakes anyone ... the terminal patient ends up being sedated, is an older patient, a patient who has several pathologies [...] I do not know how it would be mine Relationship with an awake terminal patient who is aware of what is happening to him, maybe I would react differently [...] the time of profession helps me, gives me wisdom to deal with that kind of thing. (TS02)*

> *We work in a multidisciplinary team, with several professionals, each one has basic training in some values, depends a lot on the belief of each one, the formation of character, identity ... In some terminal illnesses in younger patients we are He feels more powerless, more distressed than when he is a patient who already has a life trajectory, who already has a wear and tear of his own advanced disease ... At first, I was shaken, but today there are almost 20 years of profession, you've matured these things over the years. Of course, the loss of a younger patient is more painful. (TS01)*

> *If it's a new patient ... there's no way we should not get it wrong ... I think that anyone, even with all the years of their profession, will always have cases and cases [...] There will always be a situation in which we will reflect more, but not all are not. I do not think I can think about it, otherwise, we're not going to live. I have so much ease that I leave and I do not remember the patients name. (TS12)*
>
> *[...] the team that enters into an agreement that will no longer be invested, only comfort measures will be given, there a new person arrives and changes that behavior. ... It bothers us a lot because we go there, talk about it with the family, try to explain what palliative care is ... it's unfair, we're working the whole issue of death and a there allows unnecessary suffering ... the patient has no decision [...] (TS14)*

Virtually all subjects in the study have witnessed, at least once in their careers, the practice of dysthanasia in the intensive care setting. The practice of dysthanasia, which is also defined as therapeutic futility, supports the prolongation of the terminal patient's life at all costs, as can be seen in the following statements:

> *Each caller makes a decision, so I often realize that unnecessary care and procedures are performed on patients who would only be given palliative care. (TS02)*
>
> *If you try to talk, but the ICU does not work very well with the participation of a multidisciplinary team in the question of the type of treatment decision. [...] Most of the time, we are not heard. [...] I am extremely distressed when I realize that they are doing things that will prolong the suffering and will not give comfort ... Maybe even in the ICU should not be. (TS06)*
>
> *Often this death is prevented by maintaining intensive measures that would no longer be necessary, which prolong the suffering ... it is a wear and tear for the team, it wears out the patient, it wears out the family, it is a financial expense for the institution. (TS01)*
>
> *It has improved a lot [...] if you talk about investing or not, but being heard is something else. The truth is no one wants to bother. Everyone is afraid that the familiar will question, will sue and does not say "there is nothing more to do". And then, if it is at the mercy. You arrive, see the prescription and how ?! Are you going to continue a lot of antibiotics, dear ?! Pox, it's a public institution, something should be seen in that sense [...] Terminal patient we have, but he does not just stay with palliative care, they keep investing. (TS12)*

Some participants of the research reported that showing empathy with the patient or his / her family members may contribute to the development of a humanized care, favoring the process of orthostasis and an ethical action in this environment:

> *[...] The same as what you do best for your child, your brother, you have to do for the other, you have to have that empathy, otherwise, if you would not act like this with a relative there is something wrong with you. (TS03)*
>
> *I always think: if it was me, if it was with a relative of mine, what would I like it to be done? I think it's the premise that we have to use for everything. (TS10)*
>
> *Awaken some reflections, you put yourself in the family's place. You put yourself in the other's shoes, imagine what it would be like if it were you in that situation. (TS09)*

Although most participants have stated that they do not practice a religion, there is evidence in their reports that they have a spiritual belief, that is, a belief in the continuity of existence in a non-material, disembodied form. This manifestation of spirituality seems to help professionals to live with death and to accept death in professional work:

> *[...] I do not see this as the end of everything. I believe in spirituality, it comforts me. (TS04)*
>
> *[...] I have a good family and religious background; I see death as a natural thing [...] I believe there is life after death, so I see it as a finitude of life on earth, but not the end of people's existence. (TS06)*
>
> *I think the spiritual part influences me a lot. I was a Catholic and went to spiritism during college and it helped me to face death a little better. (TS09)*

DISCUSSION

The need for access to reliable information is not new, and has stimulated the implantation of electronic records in several hospital units, given their importance and practicality, with contributions, not only in decision-making, but also in the continuity of care and in the continuity of care and the creation of indicators of quality and safety of the patient through these records. However, in this study, it can be shown that not only the lack of reliable information, but also the insecurity of the professionals and the difficulty of making decisions to the practice of orthothanasia, favor therapeutic futility.

It is noted that the lack of homogenous behaviors, criticized in the team's statements, may be related to the internal conflicts of professionals with regard to death, individuality and the way each worker faces terminality and death. It seems that some professionals feel "obliged" to heal patients,

understanding death as failure. Likewise, when procedures performed with the patient without a cure are not shared with the whole team, that is, when there is no homogeneity in decisions or there is no consensus about the behaviors taken, it seems to intensify the stress, since the workers feel obliged to participate in conduct with which they do not agree, [12] because they face their values, which can cause them moral suffering.

Although these professionals are human beings who coexist with death and stressful situations, they appear to be "charged" with superhuman attitudes, such as not showing a shock in the face of certain situations. The empathy shown by some may be an individual form of escape, a way found by health professionals to expose their human dimension and, at the same time, to perform a humanized care, distancing themselves from technicality and impersonality, since empathy stimulates search for ways of coping with problems, although this may lead to a relatively passive coping, making problem solving difficult. But rather than a reflex response, empathy can be seen as a learned / developed ability, where one sensitizes oneself to the private life of another, establishing affective and cognitive bonding.[13] This may be related to the idea of cognitive and affective empathy. While cognitive empathy stimulates the search for and development of ways to deal with problems, affective empathy can lead to relatively passive coping strategies or the tendency not to cope with them, as distress shows a negative correlation with critical thinking and problem-solving process. [14-15] Possibly, if health professional training institutions proposed to work in a planned and systemic way, the theme of death and its implications, not only for health users but also for workers, there could be a better confronting of this reality, favoring those who experience terminality, patients and families, and health professionals themselves. Still, collective strategies are needed, from the team and from the institution itself, in order to confront terminality, since this confrontation seems to be carried out by means of individualistic, isolated and silent actions (such as empathy) with patients under their care.[16]

The professionals experience processes of mourning, appearing defense mechanisms, some unconscious, [12] such as accommodation and distancing[17] in relation to the patient (limited to technicality) and, at the same time, the development of empathy and the search for comfort by religiosity. The representations of health professionals about religiosity during care of the terminally ill patient are of significant relevance, since they interfere in the well-being and in the behaviors of the workers, and may even favor humanized care.[17] Research has shown that although half of the participants did not practice religious activities, 85% of them revealed a high degree of spirituality.[18] As this is an important facilitator to be considered in facing the terminality, it is possible to corroborate the need to focus reflections on the religiosity / spirituality of the health professionals themselves.

It is essential to advance the understanding about the coping strategies that have been studied by Nursing. Although this study has not been based on the concept of coping, it has been used to understand the set of strategies that can be used by people to face stressful situations.[19-20] Perhaps the practical application of normative laws helps in these stressful conditions, Possible sufferings due to falling ill and dying.[21] The findings portray the experience of orthothanasis by professionals, involving limits, conflicts and also ways to face the demands for ethically and technically competent decisions, which may point to the interest in deepening this concept (coping) in these realities of work.

CONCLUSION

The importance of clear information and homogeneous behaviors is perceived on the part of the team to favor an effective process of orthopathy, since disagreements favor the confrontation of many dilemmatic situations, from the individuality of each professional. Each brings with it values, beliefs and professional training of its own, and although there is a general consensus that professionals should be impartial and free from prejudice, it is known that taking purely rational conduct is very difficult, since it is a relative request of annulment of the humanity of the health professional. On the other hand, nothing more human than the capacity for judgment and rational decision, pondering between different arguments and values and also the development of these capabilities throughout life, considering the experience and opportunities for maturation and critical reflection.

A strictly technical training in graduation does not prepare the professional to face the death. This fragility in their preparation favors these workers to engage in misconduct, such as unnecessary investment in terminally ill patients, and the sedation of these patients by the apparent need to spare them the knowledge of the terminality prognosis. In

addition, the practice seems to reinforce the difficulties of developing effective processes of moral deliberation, leading to constant changes in therapeutic behavior due to the lack of a joint decision. While expressing the insecurity of a professional who acts weakly and alone in the face of imminent death, the lack of teamwork, which could develop to expand capabilities, only reinforces the enclacking of experience.

Participants show that, because of the difficulties of joint decision-making about team conduct, they take individual or individual forms of confrontation, often based on their spirituality, as being empathic and seeking to offer humanized care.

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