
TERMINALITY IN THE ICU: THE EMOTIONAL AND ETHICAL DIMENSIONS OF THE MEDICAL CARE OF THE INTENSIVIST¹

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ABSTRACT. The purpose of this article is to discuss the emotional and ethical dimensions involved in the medical care for terminally ill patients held in Intensive Care Unit (ICU). We conducted a qualitative research in which we interviewed six members of the intensivist medical staff of a medium-sized private hospital. Six theme categories emerged from the content analysis: perception of the patient in terminal condition; emotions towards death and dying; ethical conflicts; family facing terminality; communicating bad news; and the doctor-family relation in the decision making process. In this study we will present the first three categories. The results showed that death and dying are phenomena that cause uneasiness in the intensivist doctor, since he/she expects to save the life of the patient and counts with the help of advanced life support equipment. The complexity involved in the definition of terminality, combined with advances in medical techniques – such as mechanical ventilation, hemodialysis, enteral or parenteral nutrition, among others – may favor the promotion of dysthanasia in ICU, establishing a suitable scenario for the emergence of conflicts between the family and medical staff.

Keywords: Terminally ill patients; intensive care units; physicians.

TERMINALIDADE EM UTI: DIMENSÕES EMOCIONAIS E ÉTICAS DO CUIDADO DO MÉDICO INTENSIVISTA

RESUMO. Este artigo se propõe a discutir as dimensões emocionais e éticas envolvidas no cuidado do médico com o paciente em situação de terminalidade em UTI. Realizou-se uma pesquisa qualitativa, na qual foram entrevistados seis membros da equipe médica intensivista de um hospital privado de médio porte. Da análise do conteúdo das entrevistas, emergiram seis categorias temáticas: *percepção sobre o paciente em situação de terminalidade; emoções frente à morte e ao morrer; conflitos éticos; família diante da terminalidade; comunicando más notícias e relação médico-família no processo de tomada de decisões.* Neste trabalho, são apresentadas as três primeiras categorias. Os resultados apontaram que a morte e o morrer são fenômenos que causam estranheza ao médico intensivista, pois este espera conseguir salvar a vida do paciente e conta com equipamentos de suporte avançado de vida. A complexidade envolvida na definição da terminalidade, aliada ao avanço das técnicas da medicina como ventilação mecânica, hemodiálise, nutrição enteral e parenteral, entre outras, podem favorecer a promoção da distanásia em UTI, constituindo um cenário propício para o surgimento de conflitos entre a família e a equipe médica.

Palavras-chave: Pacientes terminais; unidades de terapia intensiva; médicos.

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TERMINALIDAD EN UCI: LAS DIMENSIONES EMOCIONALES Y ÉTICAS DEL CUIDADO DEL MÉDICO INTENSIVISTA

RESUMEN. Este artículo se propone a discutir las dimensiones emocionales y éticas involucradas en el cuidado del médico con el paciente en situación terminal en UCI. Se realizó una encuesta cualitativa en la cual se entrevistaron a seis miembros del equipo médico intensivista de un hospital privado de porte mediano. Del análisis del contenido de las entrevistas emergieron seis categorías temáticas: percepción sobre el paciente en situación terminal; emociones ante la muerte y al morir; conflictos éticos; familia ante la terminalidad; comunicando malas noticias; y la relación médico-familia en el proceso de toma de decisiones. En este estudio, se presentarán las tres primeras categorías. Los resultados apuntaron que la muerte y el morir son fenómenos que causan extrañeza al médico intensivista, pues éste espera lograr salvar la vida del paciente, y cuenta con equipamientos de soporte avanzado de vida. La complejidad involucrada en la definición de la terminalidad, aliada al avance de las técnicas de la medicina, como ventilación mecánica, hemodiálisis, nutrición enteral y parenteral, entre otras, pueden favorecer la promoción de la distanasia en UCI, constituyendo un escenario propicio para el surgimiento de conflictos entre la familia y el equipo médico.

Palabras-clave: Pacientes terminales; unidades de cuidados intensivo; médicos.

Introduction

The intensive care unit (ICU) is intended for the care of severe patients or at risk of death, who require medical and nursing care, in addition to the continuous monitoring, including qualified human resources and advanced and sophisticated technological devices (Alcantara, Sant'anna & Souza, 2013). The biotechnological advances in medicine, the medicalization process of death and dying, the increase of life expectancy and chronic-degenerative diseases, have contributed to change the profile of this sector. In the contemporary western society, the hospital centralizes the patient and moribund care, appropriating of these cares through the institutionalization of the medical knowledge. In the general, between 15 and 35% of the patients admitted to the ICU die during the hospitalization (Menezes, 2006; Oliveira et al., 2010).

Despite the practice in this sector to presuppose the existence of a multi-professional team, the doctor assumes the responsibility for the life of the patient, being the central actor in the scenario of the intensive care. The power of the intensive-care physician comes from his dominion over the process of dying referred to the possible regulation and control of death, linked to the technical knowledge and the practical experience in managing the technological resources (Menezes, 2006).

The death of the patient brings to the members of the medical team the possibility to enter in contact with their processes of death and finitude (Kovács, 2010; 2011). These anguish themselves for having to save the life of the patient at all costs, for having to take decisions about refusal or suspension of the treatment and, frequently, they feel alone, powerless and with difficulties in addressing the family members, who ask constant questions about the evolution of the patient.

The death reversed, interdicted, described by Ariès (1990) as being the predominant attitude in the 20th century, has the shame, failure and medical error as its attributes and leads to the perception of the limits in the search for the cure or the prolongation of live, which causes suffering to the professionals involved. The ICU is representative of the model of "modern death", which is concealed, routinized and trivialized – where the individual dies alone, isolated and connected to tubes and devices. The routines are organized to allow the best technical efficiency possible, in order to silence the emotional expression of the social actors – patients, family members and members of the health team (Menezes, 2005).

The death of the patients admitted in ICU is classified in the medical literature of two forms: a) unexpected death (when occurs even after using all available therapeutics, e.g., that death resulting from the trauma or septic shock) and b) expected death (occurs after long unsuccessful treatments, as in the cases of incurable tumors, chronic diseases and presence of multiple organ failure) (Lago, Garros & Piva, 2007). However, terminality is very complex to be defined, because this must be anchored in objective data, for instance, examination results such as magnetic resonance, tomography and biopsy; subjective, such as lack of therapeutic response to certain treatment (when the health team

members understand differently the clinical evolution of the seriously ill patient) and personal data, fruits of previous experiences of each professional. The ascertainment of the irreversibility will be much more exact when based predominantly on objective data (Lago et al., 2007; Moritz et al., 2008).

If, on the one hand, the advanced life support devices present in the intensive care save lives, on the other hand, they prolong the process of dying, and postpone death, in patients with advanced, progressive and incurable diseases, bringing suffering to all involved and promoting dysthanasic attitudes. The dysthanasia is characterized by the maintenance of invasive treatments in patients without possibility of recovery, subjecting them to a process of slow, anxious and labored death. It always results of a particular medical action or intervention that, by denying the magnitude of the human mortality, ends up absolutizing the biological dimension of the human being (Kovács, 2003).

The challenges present in the context of terminality of life in ICU are countless, resulting from biotechnological advance, integration between several professional categories, teams, patients and family members, in addition to the presence of different references of moral value and judgement among the social actors (Menezes, 2009). Technology and its use by the team increased the distance between the professional, the patient, and his family, allowing the increase of the control over the time and the circumstances of death. In addition to transform the physicians into arbitrators of an artificial existence, as a function of the social delegation of the death charges, to them and to the medical institution (Quintana, Kegler, Santos & Lima, 2006). The process of medicalization of death brings in its core ethical questions linked to the medical practice – refusal and suspension of the treatment, therapeutic futility, cardiac resuscitation, among others – and the bioethics makes possible a discussion on these subjects as it considers that no longer exists a single principle accepted by all and allows that other moral principles to emerge based on a wider reality (Menezes, 2006). The ICUs present of peculiar form ethical dilemmas related to the limits of therapeutic actions in the face of the plurality of the values of the persons involved (Curtis & Vincent, 2010; Medeiros, Pereira, Silva & Silva, 2012).

In the face of this reality, it was carried out a quantitative research with the objective to understand the repercussions about the terminality of the patient in ICU among the medical team, focusing on the emotional and ethical dimensions.

Method

Participants

Six members of the medical team of the ICU of a private hospital of medium size participated in this study, being 5 physicians on duty and 1 routine physician (that responsible for the daily monitoring of patients and for ensuring the continuity of the treatment plan of each patient), 2 male and 4 female. The age ranged from 25 to 38 years. All were very familiar with the intensive care, being the average time of work in this unit of approximately 9 years. The selection criterion was to be part of the clinical body staff of the ICU of the hospital researched and of the assistance to the patient. In the presentation of the results, the physicians were named from 1 to 6, placing then the age of each of them.

Instruments

Interviews based on a semi-structured guidance were conducted. These encompassed the following themes: work experience in intensive care; the perception about the patient seriously ill and at risk of death; the perception about the family participation in situations of terminality; the aspects valued in the process of taking decisions; the perception about the communication of hard news and the conception about death and dying.

Procedures

In view of the insertion of the first author of this study in the multi-professional team of the ICU of the hospital in which the field research occurred, the access to the individuals of the research was

facilitated. The interviews were conducted individually during the afternoon period, in the doctors' room located in the ICU, and they were recorded and transcribed in full. All participants signed the Informed Consent Term (ICT), ensuring the ethical criteria established for researches with human beings. The research obtained approval by the Brazil Platform, under the number 13483713.0.0000.5259.

In order to proceed to the analysis of data collected through the interviews, it was elected the method of the content analysis proposed by Bardin (2011), with focus on the category-based analysis. From the discursive material, emerged 6 theme categories: perception about the patient in situation of terminality; emotions in the face of death and dying; ethical conflicts; family in the face of terminality; communicating bad news and physician-family relationship in the process of taking decisions. In this work, it will be discussed the three first categories.

Results e Discussion

Perception about the patient in situation of terminality

It is in the hospitals, more precisely in the ICUs, after changing the place of death in the present time, mainly, in the large cities, that the patients have their last moments of life, alarmed by the beeps from the monitors. The coexistence with critically ill patients, at risk of death, is a constant for the intensive medical team, naturalizing the place of death in this sector, as indicates the following report:

"I work in a unit with ill patients potentially serious. Many times, I realize that the society trivialize the ICU, because, today, it is very common to go and come from the ICU. However, every patient admitted here is very serious and can die. Therefore, we get used to treat this type of patient and we have all resources for that" (Physician 4, 30 years old).

The naturalization of the seriously ill patient relates to the type of patient expected in ICU, recognized as being a complex unit inside the hospital, specialized in the assistance to the critically ill patient, at risk of death, but, with possibility of recovery (Schettino, 2012; Alcantara et al., 2013). Patients with incurable diseases, resistant to the healing proposal and in an advanced stage, should not go to the ICU, but receive palliative care in the hospital room or at home (Schettino, 2012). However, the criterion for admission to the intensive care are not followed to the letter by the physicians, who admit patients, many times, in final stage of life and who do not benefit from the technological arsenal available in this unit. One of the interviews describes such paradox.

"I think that it is a little paradoxical, intensive care with end of life, because intensive care is not for end-of-life patients, this is for you to try as much as possible to restore the life of the seriously ill patients, because you have more resources. The patient that you will provide palliative care, support, should not be in intensive care. He ends up staying in the intensive care because I think here there is no such culture or an environment for that yet. And sometimes, the families are also not prepared for this, for supporting this situation 24 hours a day" (Physician 3, 27 years old).

The paradox referred above is present in the intensive care routine due to the difficulty to inform the exact moment of the death that, even when expected, as in the cases of patients with incurable tumors, is unclear/unknown in its time. As we have seen, the definition of terminality is complex and multifactorial, involving objective, subjective and personal data and differs between the professionals involved in each case (Lago et al., 2007; Moritz et al., 2008). Besides, we observed a profile change in the patients admitted in ICU as a function of the ageing population and the increase of chronic-degenerative diseases. There are also those patients belonging to the group classified as "unexpected death", carriers of acute diseases (victims of polytrauma or septic shock) that evolve with multiple organ and system failure and become terminal inside the ICU, despite all therapeutic investment. There are also, behind this paradox, socioeconomic questions that interfere with the admission of the patient in this unit and that carry some specificities, as reported below.

"I do not work in public ICU, but at the time I did residency, I stayed at an ICU of this type, which has a profile very different from private ICUs. It is for young patient, with the most different possible diseases, but extremely viable despite the extremely serious illnesses. Generally, in a public ICU you find practically all beds with total investment. Until the time we reach a point and say: 'ah yes, everything was really done and we have nothing more to do'. In private ICU, this line is hardly discernible, there is no such striking difference" (Physician 5, 32 years old).

In the face of the complexity involved in confirming the irreversibility of the clinical condition of the patient, the physicians are, frequently, exposed to the dilemma of when they are extending the dying instead of saving a life (Moritz, Rossini & Deicas, 2012). When dealing with patients with serious diseases that threaten life, it is important to establish limits between the best possible quality of life and the prolongation of this. In addition to this point, it is opened space for the discussion about Palliative Care in ICU that, as highlights D'Avila (2012), it may seem a contradiction or even a paradox to the eye of the intensivists, but, on the contrary, it is the ethical possibility of dying with dignity, without prolong the suffering through extraordinary measures. The current trend, in the case of patient with serious illness, is the integration between the curative and the palliative care since the moment of his hospitalization in the ICU.

In the Brazilian scenario, the physician Rachel Duarte Moritz (Moritz et al, 2008; 2011) has assumed a prominent role by proposing the integration of these specialties – palliative and intensive care medicine. The author defines palliative care in intensive therapy as the health care provided to the critically ill patient in terminal stage, when the cure is unattainable and, therefore, it ceases to be the focus of the assistance.

"The palliative care helps greatly to abbreviate the suffering of this type of patient, because you avoid being iatrogenic, extending the life of a patient that was not going to get better. It also abbreviates the suffering of the family, providing a dignified and decent end of life. I think it is worth considering, but I think that the patients must be selected. It is not possible to throw in the towel to all participants in intensive therapy. It is important to do as much as possible within the perspective of the lifetime of the patients with dignity, which is to do the patient reach the end of his life without feeling pain, without being excessively invaded, without being receiving a therapeutics that does not result in any gain in long-term. This is decent end of life, receiving the necessary care" (Physician 1, 25 years old).

To the interviewees, the primary objective in these cases, in which the cure is unattainable, is the well-being of the patient and the promotion of a decent and peaceful death avoiding futile measures, from the agreement with the family, corroborating the ideas of the authors studied (Moritz et al., 2008; 2011). In the ICU in which the research occurred, when the patient is considered terminal, this is then called "support" and actions such as sedation and analgesia are privileged in order to ensure the comfort of the patient. This, because there is already an orthothanasia culture (assurance of palliative care in cases of incurable and terminal disease, without the recurrence to futile treatments) being disseminated in the institution and among the professionals on duty.

However, we observe that, despite existing criteria to evaluate the status of terminality, to reach such conclusion is a difficult process, belonging to the intensivist physician to know interpret when the patient will not benefit from intensive treatment (Moritz et al., 2012). Thus, aiming at the accuracy, it is valued the decision based predominantly on objective data.

"It is necessary to be sure of the terminality in the examinations of the patient and through statistical data of the literature. It is necessary objectivity for you to know that the patient will not get better. If you want to cease the suffering of the patient, that is, if you want to increase a dosage of morphine, or sedate him more, you need of objective data that support you" (Physician 6, 38 years old).

The objectification of the critically ill patient is clarified through the severity rate elaborated to describe quantitatively the degree of organic dysfunction, allowing estimating the probability of death. The development of predictive tools, guided by algorithms and protocols, are an attempt to eradicate

the disagreement and prognostic inaccuracy, once, as mentioned above, the terminality involves a multiplicity of factors (Bonet, 2004; Silva & Gonçalves, 2012). Besides, the search for objectivity anchored on a discourse of generalizing, mechanistic and analytical character is proper to biomedicine (Camargo Jr, 2005) The biomedical practice, constituted by a double dimension (competence / care) carries a “structuring tension”, fruit of the interconnection of these two aspects. In the ICU, such tension is explained when producing a primacy of the competency, that is, of the knowledge, medical skills, technique, to the detriment of the care, related to the non-technical (Menezes, 2001). Making a parallel, we can say that in intensive therapy the objective data are preferred over the subjective data.

Following the objectivity, the classification of critically ill patients has been an imperative in intensive therapy in order to improve the quality of the assistance provided, and the severity is one of the most used parameters. Through the standardization of language, such parameters allow to perform several analyses and stratify the patients according to the severity and prognosis of disease (Silva & Gonçalves, 2012). The interviewees classify the patients in situation of terminality in a dichotomous way, using as criteria the type of disease (patient with acute disease x patient with chronic disease) and the age of the patient (young patient x elderly patient).

“The seriously ill patient has two main profile. That patient who was already seriously ill, with a limited expectation, and that patient who is young and who is seriously ill acutely. Both patients have social repercussions and impacts on us who assist different people. The elderly patient, who is expected to be more seriously ill, in the general the family accepts better the condition and the severity is better received. In addition, it is easier to us to deal with patient that who has no great perspective of life. On the other hand, when the patient is younger and is very seriously ill, it is much more difficult” (Physician 1, 25 years old).

We noticed that it is easier for the interviewees to accept the terminality in the cases of patients with advanced age and with chronic disease, because, probably, as a function of the context, these present more comorbidities and limitations, being the death a concrete possibility, an expected death. As for the patient with acute illness, mostly young people, it is difficult to understand the terminality, because is something unpredictable – unexpected death (Lago et al., 2007).

The classification of the patients through profiles facilitates the treatment optimization and allocation of resources, because it allows evaluating the cost-benefit of certain procedures especially with respect to the investment or not, that is, the limits of life support (Silva & Gonçalves, 2012).

Emotions in the face of death and dying

The intensivists physicians, prepared for the management and care of the seriously ill patient with illness that threatens life, are confronted with the death on a daily basis, experiencing intensive and varied feelings that cause a suffering almost always veiled and silent (Kovács, 2010; 2011; Santos, Aoki & Cardoso, 2013).

“To me it is natural; it is not something that brings me some particular feeling. It is something relatively natural because it is part of my daily routine, seriously ill patient in the ICU. I do this almost every day of the week. I get a little upset, even knowing that some patients have this possibility in view of all their comorbidities. So I get a little upset, a little disappointed, but it is part of our routine” (Physician 2, 36 years old).

The speech above denotes the naturalization of death, characterized by ambiguity, sometimes recognized as something natural and sometimes as something that disappoints and upsets. To protect itself from the tensions and conflicts coming from the contact with the death and its stigma, the team builds collectively defenses to mask them, keeping itself emotionally away from the ill patient and his family. Generally, the sensitization of the professional before the situation of the patients, which is perceived as a dissolution of the limits necessary to the ideal professional attitude, is not well regarded by the team, which organizes his routine in a way to maximize the use of the technical resources,

silencing the emotional expression of the professionals, ill patients and families. Thus, the death, so present, is silenced, trivialized and routinized (Menezes, 2006).

It is important to remember that in the medical training it is recommended not to be emotionally involved with the ill patient and his family.

"I do intensive care every day of my life. I wake up and come to the ICU. Everybody creates a certain shield against this, and the shield I created in my head is the following: in the past, I suffered a lot. I got home, I suffered, I cried, but not now. Thus, I think that many people feel bad because they feel a little guilty: I could have done different. I could not, because I know that I am able to do what I am doing. I learned to stop blame myself, do you understand? Because I have nothing to do with this. If the seriously ill patient, very seriously, was not in the ICU he would already be dead, because we can provide a support here, and replace some organs by machines" (Physician 4, 30 years old).

This *shield* mentioned by the physician is very commented among the medical team members who seem to clothe themselves in a protective cover, a sort of "armoring" impermeable to the emotions and feelings, translated as an apparent "coldness" in the contact with patients and people in general (Lucchesi, Macedo & Marco, 2008). It can be understood, according to the literature, as a defense mechanism in the face of the suffering of the patient and his family (Quintana et al., 2006; Lucchesi et al., 2008; Santos et al., 2013). Other defense mechanism present is the rationalization (Lucchesi et al., 2008).

"I am very rational and rationality helps me to some extent, but this does not mean that you being rational do not suffer. Yes, you do. However, I try to aim the suffering. Regarding the ill patient, in general, I suffer very little, but it bothers me to see the suffering of the family. I do not like to see the family undermined. The terminally ill patient is sedated, comfortable; to me it is easy to accept this. The anguish of the family is what bothers me, because it involves questions of affliction, anxiety, 'and how things will be from now on?'" (Physician 5, 32 years old).

It is interesting to note that the most anguishing for the interviewee is the suffering of the family, because the *"terminally ill patient is sedated and comfortable"*. We can say that the ill patient sedated is similar to the cadaver (a body without voice), dissected and studied by the physicians in the anatomy classes, during the training process, moment in which the process of expropriation of the feelings, of denial of the existential and symbolic aspects of death begins (Silva & Ayres, 2010; Santos et al., 2013). Whereas the family questions, inquires and suffers, putting in scene the dimension of the "care" poorly valued in the biomedical model. The previous report points out that, it is more difficult to deal with the continuous anguish of those who get on with their lives, as opposed to the body without voice/ill patient, in which the family has to appropriate of their pain without anesthesia and palliative in order to elaborate the mourning.

The medical team seeks to position themselves at an adequate distance from the patient and his suffering: neither so close, for not being identified with the drama lived, nor so distant to the point of avoiding a minimum of contact necessary for the development of a good relationship with the patient and his family (Menezes, 2005). However, we observe that young patients mobilize a lot the team emotionally, because the professionals end up being identified with these.

"Young patient affects me more. This can be due to identification. Today, for instance, when I see a woman between 35 and 40 years old with breast cancer, it is impossible not to be affected. However, always young patient, whether woman or men, is more difficult. We are not used to see an interruption of a life cycle so short" (Physician 6, 38 years old).

The physician needs to elaborate the loss of the patients, and this becomes more difficult when die those with whom he established connections that are more intensive or whom he has identified himself. The physicians notice that the death does not reach only the other, but is also able to reach them,

challenging their omnipotence before the inexorability of this phenomenon. They live daily mourning in their professional practice and they not always can share the suffering, because they experience the ambivalence between awareness, closeness and empathy and distancing as defense. Thus, death brings to the medical team members the possibility of contacting their process of death, loss and finitude, making them sensitive to the suffering of the persons under their care, playing the role of "wounded healer" (Kovács, 2011).

"Well, I have already been through this with my father, who had colon cancer. He died in 2009; I was in the last year of my studies. My father was physician, my mother was physician, I was also studying medicine and it is impressive because, it is different when it occurs with you. It is nice to speak this right now, 'ah, let's stop doing, stop investing, stop taking palliative care', but at the moment of doing, what happened to me was a great denial phase. Many times, I compare my situation with the pain of the family member, I go back, I make comparisons, I always remember and compare his situation with that I lived" (Physician 3, 27 years old).

The certainty of death is what we have in common with the other human beings; that is why the death of the other reaches us a lot, and we live it as if it was a part of us dying (Kovács, 2011). However, some interviewees seek an excuse, of religious, psychological or biological nature, to naturalize death, that is, to accept that the death is part of the life.

"It is a natural life process, to the family it is a loss, it is lost the coexistence with that person, but it is a necessary step, all of us will pass through this at the right moment. I am evangelical and this helps me to interpret the concept of life, death and perhaps after the death" (Physician 1, 25 years old).

Others found in religion a channel to deal with pain, death, suffering and uncertainties of living and dying, serving as help in confronting the questions that reach both the own professional and those who are under his care.

Ethical conflicts

The situation of terminality in ICU raise some ethical dilemmas related to the decision taken at the end of life, mainly in relation to the decisions concerning the refusal or suspension of treatments considered futile.

"The family cannot understand the terminality by several reasons and they want that everything can be done at any cost in order to keep the patient alive. So, the patient needs to dialyze, between quotation marks, and ends up dialyzing. This because the family wants that he dialyzes even knowing that later he will die and will not benefit from the hemodialysis; or they want that he transfuses, they want him subjected to invasive procedures that generate suffering to him, prolonging a life with a nil quality. Sometimes he is a patient who barely is aware of what is happening, and this is prolonged in a futile way" (Physician 2, 36 years old).

The physicians mention the difficulty of the family in understanding and accepting the terminality as being one of the factors responsible for the dysthanasia. Such difficulty can be related to several factors, such as the need of adaptation of the families to the situation of imminent death and the physician-family communication process. By convening the family to participate of the decision-making process, it is important to respect the timing of each member, his need of hope and understanding that the family advances and moves back in steps during their adaptation to the situation of terminality. When receiving the information about the severity of their close relative, the family members generally experience a whirlwind of feelings; frequently, they do not understand what is happening to their relative, they do not know whom to ask or how they should behave, which gives rise to fear and helplessness (Ferreira & Mendes, 2013). In these situations, it seems that the physician ends up encountering the defensive mechanisms of the family, promoting impasses in the physician-family communication.

Other aspect promoter of dysthanasia, according to the physicians, is the lack of technical support and the fear of legal proceedings:

“Other difficulty that we have concerns the credibility of the palliative care, which is not yet well published and disseminated here in Brazil. In the USA, and in other places outside the country, you can cease the therapeutics, place a morphine dripping, extubate the patient previously intubated, so he can die comfortably obviously. One thing that here we do not have legal support yet. Therefore, there is always this threat of prosecution. Then what will you do? Will you suspend the antibiotics? Will you stop to dialyze? This I think is one of the greatest fears and impediments when it comes the time to cease the efforts. Although this depends on the relationship that you have with the family” (Physician 3, 27 years old).

Due to the cultural characteristics and the great taboo that involve death, the decision of the professionals is largely based on the fear of the legal repercussion, judicial (Biondi & Ribeiro, 2013). There is also an unpreparedness by the intensivists team in recommending the palliative approach, as well as a lack of knowledge about the ethical-legal aspects involved (Silva, Souza, Pedreira, Santos & Faustino, 2013). In response to the new demands emerged from the medical advances, the Federal Council of Medicine elaborated the Resolution CFM 1805/06 and legitimized in its new Code of Medical Ethics the practice of orthothanasia. In both documents, the physicians find credibility for the palliative actions in cases of incurable and terminal illness (Bussinguer & Barcellos, 2013).

The ethical dilemmas in ICU related to the limits of the therapeutic action collide with the plurality of the values of the people involved, being more difficult to reach an agreement (Curtis & Vincent, 2010; Medeiros et al., 2012).

“When is it futile? When I think in a treatment to make something better, but I know that the ill patient is going to die soon. However, I cannot throw in the towel when I do not know the prognosis with certainty. If he is a terminal patient, he is already at the end of the line before to go to the ICU. If he catches a pneumonia, will you treat with the most powerful antibiotics to remove him from the respirator and then die? At this time, it is easier for you to throw in the towel when you know that the base disease is progressive and terminal and the previous condition is not good. However, sometimes I think that it is important to invest in futility to give time for the family to face the truth, it is also important to respect the time of the family” (Physician 4, 30 years old).

The discourse above denotes a relativism of the concept of futility. While the interviewee criticizes dysthanasia, by the suffering imposed to the patient with progressive and terminal illness, she allows that it happens, in order to ease the suffering of the family and give time for them to get accustomed to the situation. Although criticizing dysthanasia, sometimes they allow it, with the intention of giving time to the family to get themselves prepared for the loss of their loved one. However, does the right of the patient to a decent death is being respected? After all, whose life is it? Is the suffering of the family greater than the suffering of the patient? In short, questions to be considered in the of decision taking.

As usually occurs, the patient in ICU is sedated in his final moments of life, being required by the family and the medical team the decision of the type of death, with orthothanasic or dythanasic attitudes. A solution for these dilemmas is the use of Advance Directives, also called Living Will (legitimized through the resolution CFM 1995 / 2012), which starts being disseminated in Brazil and that has as protagonist the patient and his will (Bussinguer & Barcellos, 2013). However, it will be necessary a cultural and institutional change, because we still have the physician as the holder of the ultimate knowledge.

Final considerations

The vicissitudes of terminality, the biotechnological advance in medicine, the unpreparedness of the intensivists team in recommending the palliative approach and the lack of knowledge about the ethical and legal aspects involved in the end-of-life care, constitute a fertile ground for the promotion of

dysthanasia in ICU and for the emergence of conflicts between the family and the medical team. On the other hand, the results of this research reveals the integration of the palliative care with the intensive care in ICU, mainly in situations of terminality, in which the focus must be the patient's well-being, the promotion of a decent death and the avoidance of futile measures, from the agreement with the family. This is thought to be probably due to the fact that all patients hospitalized in the referred institution possess an assistant physician, responsible for all processes of hospitalization and clinical decisions taken together with the family.

It is also highlighted the primacy of competency at the expense of the care. The medical conducts and actions are based strictly on objective parameters, clarified from the severity indices, protocols and algorithms. Following the objectivity, we have the classification of the patients in situation of terminality, in order to facilitate the optimization of the treatment and allocation of resources.

The esteem of the intensivists for technology and their privileged place inside the hospital lead them to assume power and dominion in the management of the seriously ill patient and in the use of the equipment of advanced life support, indicating, in many situations, an attitude of omnipotence, called into question in the face of the inexorability of death. In contact with the finitude of the patient, they experience an ambivalence between awareness, closeness and empathy and the distancing. The defense mechanisms most used by the interviewees were rationalization; distancing and denial of feelings; and depersonalization and denial of the importance of the individual. They experience mourning for the loss of the patients, especially, the youngsters, with whom they identify themselves, but they seek to naturalize the feelings and emotions awakened in the face of death and dying.

Because of all these aspects involved in terminality, the interdisciplinary and collaborative work between the health team members take on great importance.

It is highlighted the importance to create spaces to listen in the hospitals, especially in the ICUs, which include the health professionals, mostly the physicians – institutional spaces that address the pain of the “wounded healer”. Based on the results of this research, it is also suggested the expansion of the discussion on death and dying in the society, including ethical and bioethical aspects – euthanasia, dysthanasia, orthothanasia, living will –, and the dissemination of the palliative care and its philosophy that contemplates the ill patient in his totality.

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