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Adult intensive care nursing in the face of Advance Directives: qualitative research

Enfermagem de terapia intensiva adulto frente às Diretivas Antecipadas de Vontade: pesquisa qualitativa

Enfermería de cuidados intensivos de adultos cuando enfrentan las Directivas Anticipadas de Voluntad: investigación cualitativa

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Abstract

Objective: To understand the knowledge and practices of the Adult Intensive Care nursing team about the Advance Directives. **Methods**: Qualitative research carried out with 14 nursing professionals from an Adult Intensive Care Unit in the Northeast region of the state of Rio Grande do Sul. Data were collected through semi-structured interviews, between May and June 2022 and submitted to Content Analysis. **Results**: Three thematic categories emerged: Knowledge of the nursing team about the Advance Directives (directives related to care; nursing technicians are unaware of the concept of directives); Practice of the nursing team related to the wishes and desires of the patient (there is a sensitivity of nursing to the care of the Advance Directives of the patient, by communication and discussion in a multidisciplinary round) and Decisions of medical professionals or family members: (dis)respect for the autonomy of the patient (physicians and family members do not respect the prior decision of the patient and the invisibility of the nursing team by physicians, regarding compliance with the directives, was evidenced). **Conclusion**: There was little knowledge about Advance Directives by nursing technicians in Adult Intensive Care. The patient's wishes are met by affective care. In the present institution, it is recommended that the directives are not guided by the physician, as in the current situation they tend to make care unidirectional and hierarchical.

Descriptors: Nursing; Advance Directives; Hospital Care; Intensive Care Units; Nursing Team.

Whats is already known on this?
Advance Directives (AD) are considered strategies for the individual to express his wishes and desires in the face of a situation of disability.

What this study adds?
The lack of preparation of the professional team to respect the AD and how much they are neglected, focusing on the need to promote discussions on the subject.

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Resumo

Objectivo: *compreender os saberes e práticas da equipe de enfermagem de Terapia Intensiva Adulto acerca das Diretivas Antecipadas de Vontade.* ***Método:*** *pesquisa qualitativa, realizada com 14 profissionais de enfermagem de uma Unidade de Terapia Intensiva Adulto, da região Nordeste do estado do Rio Grande do Sul. Os dados foram coletados por entrevista semiestruturada, entre maio e junho de 2022 e submetidos à Análise de Conteúdo.* ***Resultados:*** *emergiram três categorias temáticas: Saberes da equipe de enfermagem sobre as Diretivas Antecipadas de Vontade (diretivas relacionadas à assistência; técnicos de enfermagem desconhecem o conceito das diretivas); Prática da equipe de enfermagem relacionada aos desejos e vontades do paciente (há uma sensibilidade da enfermagem para o atendimento Diretivas Antecipadas de Vontade do paciente, pela comunicação e discussão em round multidisciplinar) e Decisões dos profissionais médicos ou dos familiares: (des)respeito à autonomia do paciente (médicos e familiares não respeitam a decisão prévia do paciente e a invisibilidade da equipe de enfermagem pelos médicos acerca do cumprimento das diretivas, foi evidenciada).* ***Conclusão:*** *observou-se o reduzido conhecimento sobre Diretivas Antecipadas de Vontade pelos técnicos de enfermagem na Terapia Intensiva Adulto. As vontades do paciente são atendidas pelo cuidado afetivo. Na presente instituição, recomenda-se que as diretivas não sejam guiadas pelo médico, pois na atual conjuntura tendem a tornar a assistência unidirecional e hierárquica.*

Descritores: *Enfermagem; Diretivas Antecipadas; Assistência Hospitalar; Unidades de Terapia Intensiva; Equipe de Enfermagem.*

Resumén

Objetivo: *Comprender los conocimientos y prácticas del equipo de enfermería de Cuidados Intensivos del Adulto al tratar con las Directivas Anticipadas de Voluntad.* ***Métodos:*** *Investigación cualitativa, realizada con 14 profesionales de enfermería de una Unidad de Terapia Intensiva para Adultos, en la región Nordeste del estado de Rio Grande do Sul. Los datos fueron recolectados a través de entrevistas semiestructuradas, entre mayo y junio de 2022 y sometidos a Análisis de Contenido.* ***Resultados:*** *Emergieron tres categorías temáticas: Conocimiento del equipo de enfermería sobre las Directivas Anticipadas de Voluntad (directivas relacionadas al cuidado; los técnicos de enfermería desconocen el concepto de directivas); Práctica del equipo de enfermería relacionada con los anhelos y voluntades del paciente (existe una sensibilidad de enfermería al cuidado de las Directivas Anticipadas de Voluntad del paciente, a través de la comunicación y discusión en ronda multidisciplinaria) y Decisiones de profesionales médicos o familiares: (des)respeto para la autonomía del paciente (los médicos y familiares no respetan la decisión previa del paciente y se evidenció la invisibilidad del equipo de enfermería por parte de los médicos con respecto al cumplimiento de las directivas).* ***Conclusión:*** *Hubo poco conocimiento sobre las Directivas Anticipadas de Voluntad por parte de los técnicos de enfermería en Cuidados Intensivos de Adultos. Los deseos del paciente se satisfacen a través de la atención emocional. En esta institución se recomienda que las directivas no sean guiadas por el médico, ya que en la situación actual tienden a tornar la atención unidireccional y jerárquica.*

Descriptores: *Enfermería; Directivas Anticipadas; Atención Hospitalaria. Unidades de Cuidados Intensivos; Grupo de Enfermeira.*

INTRODUCTION

Nursing professionals are the actors who are closest to and dialogue with patients admitted to Intensive Care Units (ICUs), provide assistance 24 hours a day, determine Nursing Diagnoses (ND), plan expected results and interventions. Therefore, they need to be trained and specialized in patients who are going through the terminal phase, a very common profile in this sector, as well as need to align the multidisciplinary team based on an institutional protocol on the Advance Directives (AD).(1)

Despite being a subject that is still little known in Brazil, AD are already addressed in several Brazilian and international studies; but this lack of information on directives in care practice may result in difficulties for nurses in organizing a specific care plan, since the patient's refusal for treatments that prolong his life is not considered and documented.(2-3)

Intensive Care Units are characterized as hospital services for patients in critical life conditions, requiring complex care, which over time, there has been an improvement in technological support in this sector, contributing to greater survival of patients.(4) Advance Care Planning (ACP) and AD, therefore, are resources that enable the harmonization of personal values and preferences for health care that will be received in the end-of-life process.(3)

This process, also called the death process, generates situations and unforeseen events that people need to face. This coping occurs during the complexity of a negative and conservative prognosis of a terminal disease. It is up to the nursing professional to adopt qualified listening, to have knowledge about the ACP and AD to better guide the patients and their family, informing them about the possibility of preparing this document to express their decisions, respecting their fears and anxieties, becoming autonomous of their decisions in life".(4-5)

Through effective communication between professionals, patients and family, it is possible to implement AD, allowing a unique look at the care needs of patients to face the terminality of life, which facilitates the understanding and acceptance of the family, bringing comfort in the decisions to be made in the care plan.(2-5)

In this scenario, Palliative Care (PC) is inserted, aiming to prevent and relieve the suffering and pain of family members and patients with potentially fatal diseases, considering their physical, psychosocial and spiritual dimensions, aiming to improve the quality of life and offer autonomy to the individual who is experiencing his terminality process. Thus, it can be said that PC act in conjunction with AD, as they complement each other in objectives and actions, and need to be based on nursing care planning.(2-3,5)

However, there are some difficulties for the implementation of AD, such as the lack of institutional protocols, the lack of communication between professionals, family members and patients, the lack of understanding of human finitude as a natural process of life, the fact that it is not yet a legislation and the domain of medical power before a multidisciplinary team.(5)

In the turbulent context of bioethics, cultural and legal dilemmas are faced that aim to protect life, develop norms and legislations that consider the health conditions and illness of individuals, even with the Code of Ethics for Nursing Professionals (CEPE) defending AD. The fact that there is no specific legislation on these directives ends up generating insecurity for professionals, fearing ethical punishments for not meeting the wishes of patients.(3) The lack of knowledge of health professionals about PC hinders the implementation of AD in institutions, in view of the cultural denial of death and the desire to prolong life.

An example is dysthanasia, a common conduct in Brazil, which employs an excess of techniques justified as prolonging biological life, but without quality of life, through the implementation of a set of invasive artificial methods in the patient without a prognosis of cure, causing physical restriction, dependence, deterioration and risk of infection, a practice that needs to be highlighted in the scientific community, about its real need, including in ICUs, because most of the time it remains polarized to AD, prolonging suffering and not life.(6)

Another challenge to be faced in this context is effective communication between health professionals, avoiding to postpone the discourse about the end of life, in which the nursing team must recognize the patient as the protagonist of his treatment and value his care preferences,(3) always prioritizing aspects inherent to orthothanasia, a technique that offers comfort and well-being, focused on relieving pain and suffering in patients in PC, a favorable option to maintain human dignity in the face of the death-death process, which transcribes physical care, but little disseminated and prioritized in the care process.(6)

Therefore, through the problem presented, a question emerges: what are the knowledge and practices of the Adult Intensive Care nursing team about the Advance Directives?" To answer it, the study aimed to understand the knowledge and practices of the adult intensive care nursing team about the Advance Directives.

METHODS

This is a qualitative, descriptive and exploratory research, conducted according to the criteria of methodological rigor of the Consolidated Criteria for Reporting Qualitative Research (COREQ).(7) Nurses and nursing technicians participated in the research. The scenario was two Adult Intensive Care Units, one general and the other coronary, from a hospital in the Northeast region of the state of Rio Grande do Sul, Brazil.

The selection of participants occurred in an intentional and non-probabilistic way, adopting the inclusion criteria: being a nursing professional, having at least one year of professional experience in intensive care. Exclusion criteria were: being on leave, vacation or leave from work at the time of data collection.

Data were collected from May to June 2022, through a semi-structured interview, held in a reserved space in the hospital itself, on previously scheduled days and times. An interview script was developed with closed questions to characterize the sociodemographic profile of the participants and with semi-structured questions, namely: how do you act in front of the patient in Palliative Care? What do you understand about patient autonomy? What do you understand about Advance Directives? How do you act in the face of the patient's wishes and desires?

The interviews were recorded in audio and then transcribed with the help of the Transcriptor Software and later, the material was revised maintaining the fidelity of the information. The duration of the interviews ranged from 30 to 50 minutes.

The data were submitted to Content Analysis(8), considering the stages of pre-analysis (floating reading of the records), exploration of the material (in-depth reading to select the recording units and context) and treatment and interpretation of the data (subsidized by the relevant literature).(8)

The study is linked to the research project "Knowledge and practices of the nursing team in Intensive Care about Advance Directives", with the Certificate of Presentation of Ethical Appreciation 56829422.0.0000.5668 and Opinion 5,454,133. The participants signed the Informed Consent Form and were informed about the risks and benefits of the research. Their anonymity was guaranteed by the use of the alphanumeric system to identify them: the letter N (nurse) and T (technician) followed by a number according to the order of the interviews: N01, N02, T01, T02 and therefore.

Regarding compliance with the criteria of methodological rigor for writing the research, the COnsolidated criteria for REporting Qualitative research (COREQ) was used, an instrument of Enhancing the QUAlity and Transparency Of health Research (Equator).

RESULTS

Six nurses and eight nursing technicians participated in the research, 13 women and one man. They were in the age group between 20 and 50 years old. Regarding the training of nurses, all reported having specialization, ranging from urgency and emergency, intensive care, palliative care and auditing. Among the nursing technicians, none reported having additional training.

Data analysis allowed the organization of three thematic categories, which represent the experiences of the nursing team about AD and were described below.

Thematic Category 1 – Knowledge of the nursing team about the Advance Directives

It was identified that there is a distinction of knowledge between nurses and nursing technicians. One of the aspects addressed by nurses is that AD are based on a set of wishes and desires related to treatment, manifested by the patient to the physician and family members before being unable to express himself:

> [...] The patient tells his family, the team, and his attending physician what he wants to be done. (N02)
>
> [...] This is when the patient makes a statement before he has any condition that deteriorates his health. As long as he is psychologically, emotionally, and neurologically capable of deciding things for himself. (N04)
>
> [...] Deciding what he wants, in the case of him no longer being able to answer for himself. So, organ donation or intubation as well. We have even seen palliative patients who reach the end of their lives, where they had previously decided that they did not want to be intubated for any reason, so I think that is it. (N03).

One of the statements related AD to the patient's autonomy and whether they have the ability to say what their wishes are regarding the treatment they want or not:

> [...] In fact, it will involve the patient's desire for autonomy. It is his autonomy in relation to any measure that will happen to him in the face of illness. So this is an advance directive of will. (N01)

The nursing technicians reported not having knowledge, and never having heard in their work the term "Advance Directives", but when asked about how they meet the wishes and will of the patient, they related it to their practice in intensive care and exemplified it with simple attitudes:

> [...] There was a patient who we knew was not going to leave [the ICU] for the room. Then I felt like taking tonic and we went there and bought the tonic. We also try to see if there are some things like this here in the pantry. (T05)

> [...] They ask for a lot, but they have desires as soon as we stay, it's so simple they ask for rice and beans, they ask for water, they ask to see the Sun. (T07)

Thematic Category 2 – Practice of the nursing team related to the wishes and desires of the patient

Regarding the perception of the participants about the practice of AD, it was related to simple care at the bedside, such as the desire to eat something, drink or even the visit of a family member:

> [...] Sometimes we have patients with any kind of desire for food, music, or something else. I try to feed the patient's desire within our reach; sometimes we bring the family into the ICU, to do some kind of release. (N01)

> [...] Once we made a patient's dream come true; his dream was to drink coffee, because he knew he was leaving [dying], he drank it and soon after he passed away. (T04)

> [...] Many times during COVID-19, patients who wanted to see their family, we no longer had the psychologist to make the video calls, I did it myself with my cell phone, if they asked, I did it for everyone, regardless of what was happening, I stopped for five minutes to do it. (N04).

Communication is approached as an effective means to discover the patient's wishes and desires, but when the patient is unable to communicate as a result of his/her treatment regimen, such as intubation, tracheostomy or sedation, his/her family has a primary participation in the investigation of preferences:

> [...] We have visiting hours, although we don't spend much time with the patient before he or she is intubated, we always ask the family what he or she was like at home, if he or she was a nice person, what he or she likes to do, we always try to find a gentler way to get our answer. (T01)

> [...] I think that when the patient is lucid, he or she has an idea of his or her illness, he or she already knows more or less how things are going to flow, through conversation. (N05).

It was reported that, even identifying wishes and desires, these can only be applied with medical authorization or after discussion in a multidisciplinary round, so as not to harm the patient's treatment regimen:

> [...] We try to do what the patient wants, what the family wants, in the best possible way, and we try to fit this into our care. Of course, with the doctor's support, I will not do anything that will further jeopardize the patient's diagnosis; for example, I cannot give a cup of coffee to a patient who had a gastrectomy yesterday. (N02)

> [...] We try to address the patient's wishes in a multidisciplinary round to discuss it, but we are not always able to meet the patient's wishes because of the treatment regimen. (N06).

The presence of the palliative care physician in the ICU was positively addressed:

> [...] Since we have a physician who is in palliative care here in the ICU, at least from my side, I think the patient's wishes and desires are met. (N05)

> [...] The palliative care physician is always there, always accompanying the family, talking to the wife, trying to make her understand to what extent this

> suffering is valid. So I think the treatment has improved here at the hospital. (T02).

The sensitivity of the interviewees to the wishes and desires expressed by the patient was observed, becoming a positive point for the nursing team in view of the applicability of AD. All reported meeting the patient's request when they are within their reach:

> [...] There are times when they are intubated, and their last wish is to say I love you to their mother or child, so when we are able to pass on the information, we report what the patient said. So we never forget what they say to us, because sometimes it can be their last word. (T01)

> [...] I have asked the family to leave a little message that we can stick on the wall, and sometimes when people have a birthday, we sing happy birthday to them. (T03)

> [...] There was a mother with COVID-19, with two small children, she had been with us for days. We had to intubate her, I was scared, because she was lucid. First I explained to her about the intubation, but her request at that moment was to see her children, so we made a video call. I remember the child's little face saying goodbye, bye, mommy, but everything went wrong and she ended up dying. (N04).

The fact that there is a palliative care team working in the institution was reported as a facility to provide humanized, autonomous care to the patients:

> [...] We have a protocol that allows us to have a lot of autonomy. We identify the patient's wishes, any weaknesses. I talk to the patient, identify something and pass it on to the physician, but we can release it with his [physician's] authorization.” (N01)

> [...] Here we realize that palliative care is being worked on a lot. I will never forget this humanized side. I once heard that every person deserves to have a good death. (T02).

Thematic Category 3 – Decisions of professionals and/or family members: (dis)respect for patient autonomy

Different participants saw as a limiting factor for the implementation of AD in the ICU, the conduct of some physicians who sometimes decide for the patients what is the best treatment, without respecting their opinion. In addition, they also do not take into account the positioning of the nursing team, which works for longer with the patients, knowing their wishes and desires:

> [...] I think the biggest challenge is not care, because in this regard, I try to talk to patients and families, but it depends a lot on the medical team that is on duty or that ends up receiving this patient, of not agreeing with the wishes and desires of the patient or family and taking the actions that they decide are most appropriate [...]. So I think I can't implement [AD] because of these limitations related to the medical staff. (N01)

> [...] We end up not having much of an active voice in the medical opinion, despite them saying that we should give our opinions, make changes that we are with the patients all the time, but, bring a different opinion to them? They don't accept it at all. We, technicians, become invisible to some opinions, so we pass it on to the nurses to try. (T01)

> [...] The patient didn't want to be intubated, the family said so, but it ended up being a medical decision and he died, the family was very angry. (T08)

The family does not always respect the desires expressed by the terminally ill patient and this was mentioned by some interviewees, for reasons ranging from lack of knowledge about the treatment or for not accepting the clinical situation of the family member:

> [...] A patient who is on the kidney transplant list comes to the ICU with ventilatory failure, and the question remains: should he be intubated or not? The patient does not want to be intubated, but sometimes the family understands that it is a necessary measure. The patient ends up losing his autonomy. (N01)

> [...] It has happened that the family did not want the intubation, preventing the patient from receiving a little more comfort and time to live. The family understands that if the patient starts mechanical ventilation, he will never get off, especially the older adults. (N02)

Advance Directives were also related to the loss of autonomy of the patient, because when admitted to an ICU, almost all independence in carrying out daily activities without assistance was lost, such as bathing:

> [...] The first thing we lose when we enter the hospital is autonomy. They'll give you medication, baths; you can't go to the bathroom. (N04)

The lack of a legal document in which the patient can write his treatment wishes was addressed, which hinders the applicability of AD:

> [...] The patient ends up not signing any legal documents, so it depends on the physician who is here, the family member who comes, but it is as if it were a consensus. Depending on the case, it is not the patient's autonomy, it is a consensus. (N05).

DISCUSSION

As for the nursing team's knowledge about AD, it was noticed that nurses have a general understanding of the subject, associating it with patient autonomy. This autonomy refers to the right to accept or refuse treatments that prolong biological life, without necessarily ensuring quality of life.(9-10) From this perspective, it can be said that they have some knowledge for the applicability of AD within the ICU. Nursing technicians, on the other hand, address the practices related to AD, but do not have knowledge about the term.

The data found in two thematic categories demonstrate that there is a culture of subordination of nursing to the medical team, in more complex sectors with the ICUs, since decision-making is unidirectional and provocative to the patient's desire for the medical professional, in addition to reports on the silencing and erasure of nursing technicians in the face of a conduct on implementing or not a AD, proving the need for nursing to position itself as a science basing its care on Evidence-Based Practice (EBP).

The analyzed statements of the interviewees prove the need for nurses to create protocols on the different processes of deaths such as social, psychological and spiritual, among others, to propagate an anti- dysthanasia culture, to promote specializations of the type residency in PC linked to the service, to train the care team and to sensitize managers about the importance of complying with bioethics, in which living with quality and without excessive artifices can be a trend in intensive care practices, in the public, private and philanthropic sectors.

Deciding which procedures to perform or not to perform in the treatment of terminally ill patients remains a challenge, especially because, in Brazil, AD are still not widespread in the health area.(10) One of the obstacles to the implementation of AD is the lack of institutional protocols, allowing professionals to adopt their own conduct, a fact that makes it impossible for the team to understand the wishes and desires of patients in advance.⁽⁵⁾

Respect for the wishes and desires of the patients is supported by the Code of Ethics of Nursing Professionals (CEPE), which determines that professionals need to work for the care of the requested AD, since the data show that nurses were able to express definitions that fit the theoretical concept of such directives; however, technicians are unaware of the term, despite having manifested that they perform simple and empathetic care requested by patients in Palliative Care, relating such attitudes to the concept of AD, which requires investment in the training and development sector, for the dissemination of knowledge, including because it is a sector that deals with this problem on a daily basis.

Participants described the practice related to AD with empathy and sensitivity, often demonstrating emotion during interviews. They associated simple actions, guided by the wishes and desires of terminally ill patients, with nursing care, emphasizing the essential importance of this approach. End-of-life patients need active and comprehensive support, as they have diseases that experience chronic, progressive and irreversible illness, not responding to curative treatments. Therefore, it is essential to offer comfort, pain control and other care, with a view to alleviating suffering in the face of the conditions inherent to physical, emotional and spiritual illness.(11)

The team that works within the ICU faces situations that require reflection on the ethical principles that underlie their actions, the understanding of the terminality and finitude of life as something important in guiding their actions,(12) because the fact that the nursing team enables comfort through end-of-life care is affirmed as an ease in the application of AD.

Nurses working in the ICU face patients submitted to PC daily, a demand that needs the elaboration of problems, known as Nursing Diagnoses (ND), expected results and systematic and specialized care, which can be explored in the main taxonomic domains focused on this type of care, so that care plans are feasible, individual, independent and dynamic.

The multiprofessional constitution of active PC in the institution where the research took place, in which the role of a palliative care physician in the ICU was mentioned, becomes a facilitator to discover the wishes and desires of the patient and family, as an investigation is carried out through communication. PC professionals have more knowledge to manage information and research patients' preferences regarding treatment.(12-13) Listening to and meeting the needs of a patient is characterized as a way to demonstrate respect, affection and attention, as well as encouraging the patient to be the protagonist of his own care.

Advance Directives can be considered appropriate tools to protect the autonomy and ethical dignity of the patients.(9) When its guidelines are addressed in the therapeutic treatment of patients in PC, the expression of desires is allowed, with a view to being met, facilitating decision making in difficult situations. Thus, ACP can be included as a strategy to assist in the conduct of safe and qualified care for patients and families,(5) since specialized professionals working in ICUs, especially nurses, seem to be a facilitator for the development of AD, as they promote qualified listening with patients and families.

Communication with the patient was cited as the way used to investigate wishes and desires, since the fact that the patient understands his clinical situation and the degree of evolution of the disease is essential for him to participate in decision-making about end-of-life care and express his preferences.(11-12) Communication is essential within the ICU to use standardized practices, identify people on the multidisciplinary team and family members, organize schedules for daily meetings, raise the main clinical care needs, prioritize the wishes and desires of the patient in a concise and consistent manner, actions that will provide improved care to patients.(14)

Often, the patient admitted to the ICU is unable to talk, so applying effective non-verbal communication while it is possible becomes a priority and the family has an active participation in this dialogue, since at times it can be the voice of this patient.(14)

The performance of professionals in front of a patient in finitude of life is a challenge, because deciding which is the most appropriate care for the patient should not be only a technical issue or exclusive to medical professionals. In the context of PC, bioethical principles must be guaranteed to the patient, giving him the right to information and clarification about treatments, prognoses, risks, harms and benefits of each conduct. Thus, it is up to the nurses, a reference professional of the multidisciplinary team, to empower themselves with a theoretical-practical-scientific contribution to help the patient develop an autonomous position, as it is not enough for the person to be free of moral constraints contrary to his opinions, but also to promote autonomy through qualified, transparent and understandable information.(13-15)

When healthcare professionals understand the binding nature of AD, decision making about treatment becomes simpler. This is particularly important as patients often struggle to understand their clinical condition and therapeutic options. Providing clear and accessible information contributes to aligning patient expectations, strengthening the care provided.(10-11) For patients admitted to an ICU, it is essential that they respect his autonomy in the principles of bioethics, because even if he is partially or totally dependent on someone, he deserves to have his last wishes met.

The family often becomes the legal representative of the patient in PC and in some situations, they do not respect the will of their loved one because they do not accept their diagnosis, subjecting them to unnecessary treatments that generate pain and emotional exhaustion.(15-16) In general, in ICUs, the focus on living is on the combination of elements that make up the human being, determining it only by the biological factor, since it is possible to keep a person alive using devices in permanent excess, maintaining the biochemical component of the person in the first place by an artificial life support system; however, the psychological, spiritual and social components of the person are no longer present and cannot be reestablished, in view of the clinical picture, issues that need to be reviewed from a bioethical perspective.(17)

The terminality of life refers to a condition of serious illness with no cure, adopting an approach that places the patient and his family at the center of care. This perspective challenges the biological model focused exclusively on the disease, seeking to value the human condition and promote comprehensive health care.(18-19) The acceptance of the family before an end-of-life patient will always be a challenge for the application of AD, because it will never be easy to convince someone that the best option for his loved one is death accompanied with comfort, a situation in which communication becomes a great helper so that the health professional can explain the harms and the real chances of treatment.

In view of the ethical aspects, the support of the legislation on AD was analyzed, which refers to the wishes and desires of a terminally ill patient, and must be respected. According to the Federal Council of Medicine, AD comprise a set of previous wishes and desires expressed by the patients about the care and treatments they want or do not want to receive, if they are incapacitated. The code of ethics of Nursing Professionals mentions AD and establishes that they are respected.(20-21) These facts still do not bring security to the interviewed professionals, due to lack of knowledge or legislation that protects the health professional in the face of a situation in which he goes against the legal representative of a patient unable to decide for himself.

The limitations of the study are the absence of participation of physical therapists, nutritionists, pharmacists and physicians. Another fact is the lack of clarity about the term “Advance Directives” and this limitation serves as a suggestion for further studies on the subject. The legislation applied to the practice of nursing is also limited in relation to AD, they need to be reformulated and advance in this knowledge.

This research will contribute to an expanded view of the knowledge of the ICU nursing team about AD, pointing out points that facilitate and hinder their applicability, and from this, new research may emerge to build tools that facilitate nursing care, focusing on the wishes and desires of the terminally ill patients.

Strategies such as institutional protocols, implementation of assertive communication between professionals, family members and patients, anchoring of nursing care in Evidence-Based Practice, in-service instruction on human finitude and its ethical and legal aspects, in addition to awakening the need for popular education on the breaking of stigma and prejudice that exists in society about palliative care, become potential measures to be implemented by adult intensive care nursing.

CONCLUSION

In the present study, knowledge and practices about AD were related to patient autonomy, bioethics of care, his wishes and desires and always respecting the ethical-legal aspects of terminality, observing great sensitivity on the part of the nursing team and a palliative care specialist in relation to the end of life.

However, some obstacles found need to be overcome for the implementation of AD in ICUs, such as the lack of knowledge of the technical team; the lack of a legal document, in which the terminally ill patients can record their wishes and desires; and the disrespect of medical professionals in the face of patient autonomy and nursing care guided by medical conduct, as it makes care unidirectional and hierarchical, since nursing is an autonomous and independent profession.

CONTRIBUITIONS

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REFERENCES

1. Trarieux-Signol S, Bordessoule D, Ceccaldi J, Malak S, Polomeni A, Fargeas JB. Advance directives from haematology departments: the patient's freedom of choice and communication with families: a qualitative analysis of 35 written documents. the patient's freedom of choice and communication with families: a qualitative analysis of 35 written documents [Internet]. Available from:https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-017-0265-1.

2. Saioron I, Ramos FRS, Scheneider DG, Silveira RS, Silveira LR. Diretivas antecipadas de vontade: percepções de enfermeiros sobre os benefícios e novas demandas. Revista Escola Anna Nery [Internet]. 2017 [acesso em 11 jan 2023]; 21(4). Available from:https://www.scielo.br/j/ean/a/c4t4GsLg38y59mdvcRrLYDs/?format=html

3. Ramos FR, Saioron I, Amadigi FR, Diaz PS. Diretivas antecipadas de vontade: desafios legais e educacionais na visão de enfermeiros. Rev. Eletr. Enferm [Internet]. 2017 [acesso em 14 mar 2023]; 19-44. DOI: https://doi.org/10.5216/ree.v19.43587

4. Leite CDS, Fernandes CA. Desfechos do Planejamento Antecipado de Cuidado e Diretivas Antecipadas em Unidade de Terapia Intensiva: Revisão Integrativa. Rev. SBPH [Internet]. 2021 [acesso em 17 mar 2023]; 24(1):28-38. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_abstract&pid=S1516-08582021000100004

5. Nogario ACD, Barlema EL, Barlem JGT, Silveira RS, Cogo SB, Carvalho DP. Implementação de diretivas antecipadas de vontade: facilidades e dificuldades vivenciadas por equipes de cuidados paliativos. Rev Gaúcha Enferm [Internet]. 2020 [acesso em 20 mar 2023]; 41. DOI: https://doi.org/10.1590/1983-1447.2020.20190399

6. Cano CW A, *et al*. Finitude da vida: compreensão conceitual da eutanásia, distanásia e ortotanásia. Revista Bioética [Internet]. 2020 [citado 2023 dez 4]; DOI https://doi.org/10.1590/1983-80422020282399

7. Souza VR, Marziale MH, Silva GT, Nascimento PL. Tradução e validação para a língua portuguesa e avaliação do guia COREQ. Acta Paul Enferm [Internet]. 2021 [acesso em 23 mar 2023]; 34. DOI: http://dx.doi.org/10.37689/acta-ape/2021ao02631

8. Bardin L. Análise de conteúdo. 2016; 70.

9. Ojedoyin OE, Jegede AS. A quantitative study of nurses perception to advance directive in selected private and public secondary healthcare facilities in Ibadan, Nigeria. BMC Med Ethics [Internet]. 2022 [acesso em mar 26 2023]; 23(1):87. DOI: https://doi.org/10.1186/s12910-022-00825-5

10. Hassegawa LCU, Rubira MC, Vieira SM, Rubira APA, Katsuragawa TH, Gallo JH, et. al. Approaches and reflexions on advance healthcare directives in Brazil. Rev Bras Enferm [Internet]. 2019 [acesso em 29 mar 2023]; 72(1):256-64. DOI:http://dx.doi.org/10.1590/0034-7167-2018-0347

11. Eggenberger T, Howard H, Prescott D, Luck G. Exploring quality of life in end-of-life discussions. Am J Hosp Palliat Care [Internet]. 2020 [acesso em 01 de abr 2023]; 37(6):465-73. DOI: 10.1177/1049909119890606

12. Macchi MJ, Pérez MV, Alonso JP. Planificación de los cuidados en el final de la vida: perspectivas de profesionales de oncología y cuidados paliativos. Sex Salud Soc [Internet]. 2020 [acesso em 04 abr 2023]; 35: 218-36. DOI: http://doi.org/10.1590/1984-6487.sess.2020.35.11.a

13. Medeiros MO, Meire MV, Frafa FMR, Sobrinho CLN, Rosa DO, Silva RS. Conflitos bioéticos nos cuidados de fim de vida. Revista Bioética [Internet]. 2020 [acesso 07 abr 2023]; 28(1): 128-34. DOI: https://doi.org/10.1590/1983-80422020281375

14. Sousa GM, Lustosa MA, Carvalho VS. Dilemas de profissionais de unidade de terapia intensiva diante da terminalidade. Revista bioética [Internet]. 2019 [acesso 10 abr 2023];27(3):516-27. DOI: https://doi.org/10.1590/1983-80422019273336.

15. Cappell K, Sundaram V, Park A, Shiraz P, Gupta R, Jenkis P, *et al*. Advance directive utilization is associated with less aggressive end-of-life care in patients undergoing allogenic hematopoietic cell transplantation. Biol Blood Marrow Transplant [Internet]. 2018 [acesso em 13 abr 2023]; 24(5):1035-40. Disponível: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6364975/pdf/nihms-938817.pdf

16. Kuczmarski TM, Odejide OO. Goal of a "Good Death" in End-of-Life Care for Patients with Hematologic Malignancies-Are We Close? Curr Hematol Malig Rep [Internet]. 2021 [acesso em 16 abr 2023]; 16(2):117-125. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8409152/pdf/nihms-1727658.pdf

17. Shu W, Miao Q, Feng J, Liang G, Zhang J, Zhang J. Exploring the needs and barriers for death education in China: Getting answers from heart transplant recipients' inner experience of death. Front Public Health. [Internet] 2023 [acesso em 19 abr 2023]; 13:11. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9968799/pdf/fpubh-11-1082979.pdf

18. Cardin VS, Nery LMG. Até quando prolongar a sua vida? Revista Brasileira de Sociologia do Direito [Internet]. 2021 [acesso em 22 abr 2023]; 8(1): 18-3. DOI: https://doi.org/10.21910/rbsd.v8i1.386

19. Cogo SB, Nietsche EA, Badck MR, Sehnem GD, Salbego C, Ramos TK, Antunes AP, Ilha AG, Malheiros LCS. Diretivas antecipadas de vontade na assistência hospitalar: perspectiva de enfermeiros. Rev. Bioética [Internet]. 2021 [acesso em 25 abr 2023]; 29(1):139-47. DOI: https://doi.org/10.1590/1983-80422021291454

20. Oriakhi M, Sealy C, Adenote A, Alabi O, Ahluwalia M. Improving residents' skills and confidence on advance directive discussion: a quality improvement project. J Community Hosp Intern Med Perspect [Internet].2019 [acesso em 29 abr 2023]; ;9(5):419-21. DOI: https://doi.org/10.1080/20009666.2019.1643218

21. Moore N, Detering KM, Low T, Nolte L, Fraser S, Sellars M. Doctors' perspectives on adhering to advance care directives when making medical decisions for patients: an Australian interview study. BMJ Open [Internet]. 2019 [acesso em 02 jan de 2023];9(10):1-11. Available from:https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6830700/pdf/bmjopen-2019-032638.pdf

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