

If it stops, it stopped: Ethical implications and conduct in the Do Not Resuscitate Order in Intensive Care Unit

Amanda do Socorro Furtado Silva¹, Naiade Moreira de Oliveira², Tatiane Peniche da Silva¹, Anne Caroline Gonçalves Lima³, Danielle Oliveira Maciel⁴, Raquel Fernandes Costa⁵, Marcio Almeida Lins¹, Eimar Neri de Oliveira Junior¹, Elen Priscila Garcia Assunção de Castro¹, Milena Oliveira Saldanha Pacífico², Niceane dos Santos Figueiredo Teixeira⁶, Felipe Natan Verde Ferreira⁶, Joelma Conceição Silva Costa⁶, Lucas Garcia Rodrigues⁶, Juliete Andryws Silva Sarges⁶, Diélig Teixeira⁶, Letícia Barbosa Alves⁶, Guilherme Evaristo Dutra Barreto⁶, Fábio Manoel Gomes da Silva⁶, Hennã Cardoso de Lima⁶, Daniel de Sarges Rodrigues⁶, Nara Regina Barbosa Dantas⁶, Milk dos santos Fernandes de Oliveira⁶, Gabriela Cristine Neves Magno⁶, Maressa dos Santos Castro⁷, Maria Lucia Costa dos Santos⁷, Valdenira de Aragão Damasceno⁷, Bruna Carolina da Trindade Monteiro da Silva⁷, Felipe da Silva Reis⁷, Wilmara das Neves Bentes⁷, Fabiane Cristina Nunes da Silva⁷, Thais Cristina Borges Farias⁷, Tamires de Cassia Silva da Cruz⁷, Ana Alice Gomes Da Silva Costa⁷, Elias Costa Monteiro⁸, Elcilane Gomes Silva⁹, Alfredo Cardoso Costa¹⁰, Gilvana Rodrigues de Oliveira¹¹, Jéssica Maíra do Socorro de Moraes Ribeiro¹¹, Mirian Fernandes Custódio¹¹, Yasmin Gino e Silva¹¹, Carla Fernanda Milhomem Soares¹², Remo Rodrigues Carneiro¹³, Josielma Neco Pina⁶, Paulo Samuel Linhares Figueira⁶, Tatiana Virgolino Guimarães⁶, Bianca Blois Pinheiro Camboim⁶, Márcia Cristina Monteiro dos Reis⁶, Glauce Kelly Ribeiro de Souza⁶, Elaine Cristina Pacheco de Oliveira¹⁴, Sheyla Cristina Ferreira de Magalhães¹⁴, Elyade Nelly Pires Rocha Camacho¹⁵, Marcelo Williams Oliveira de Souza¹⁶, Enderson Vasconcelos de Lima¹⁷, Leidiane Araújo Silva¹⁷, Thamyris Abreu Marinho¹⁸, Raimunda de Fátima Carvalho Prestes¹⁹, Vanessa Pimentel Lobato²⁰, Patrick Roberto Gomes Abdoral²¹, Larissa Siqueira Rodrigues²², Larissa Pereira de Barros Borges²³, Gleyce Pinto Girard²⁴, Francisco Rodrigues Martins²⁵, Karla Patrícia Figueirôa Silva²⁶, Francinéa de Nazaré Ferreira de Castilho²⁷, Djeane Kathe Mascote Leite²⁸, Maria Elizabete de Castro Rassy²⁹, Nathália Menezes Dias³⁰, Wanda Carla Conde Rodrigues³¹, Thicianne da Silva Roque³², Carolina de Souza Carvalho Serpa Santos³², Everson Vando Melo Matos³³, Andreia Oliveira Corrêa³⁴, Elisângela Claudia de Medeiros Moreira³⁵, Simone Aguiar da Silva Figueira³⁶, Samantha Lara da Silva Torres Anaisse³⁷, Pollyanne Aparecida Ferreira da Silva³⁸, Giselly de Lourdes da Silva Santana³⁹, Adriana de Oliveira Lameira Veríssimo⁴⁰,

Ranná Barros Souza⁴¹, Victória Fernanda Barbosa⁴¹, Geordana Galvão Feitosa⁴¹, Diego Teles Borges Leal⁴², Camila Ferreira Corrêa⁴³, Cleia Nunes Estumano¹⁹, Maicon de Araujo Nogueira^{44*}

¹Nurse. Metropolitan University Center of the Amazon (UniFAMAZ), Belem, Para, Brazil.

²Doctor, Federal University of Pará (UFPA), Belem, Para, Brazil.

³Nurse at the University of the State of Para (UEPA). Master in Public Health from the Facultad Interamericana de Ciencias Sociales, Asunción, Paraguay, revalidated by the Federal University of Rio de Janeiro (UFRJ), Rio de Janeiro, Brazil.

⁴Nurse, João Barros Barreto University Hospital (HUJBB), Federal University of Para (UFPA), Belem, Para, Brazil.

⁵Nurse, assistant nurse at the Hospital de Clínicas, Federal University of Minas Gerais (UFMG), Minas Gerais, Brazil.

⁶Nurse, University of Amazon (UNAMA), Belem, Para, Brazil.

⁷Nursing student, Escola Superior da Amazônia (ESAMAZ), Belem, Para, Brazil.

⁸Nursing student, Faculdade Pan Amazônica (FAPAN), Belem, Para, Brazil.

⁹Doctor. PhD student, Stricto Sensu Graduate Program, Professional Doctorate in Health Education in the Amazon (ESA), University of the State of Para (UEPA). Professor at the UEPA, Belem, Para, Brazil.

¹⁰Biologist. PhD student, Stricto Sensu Graduate Program, Professional Doctorate in Health Education in the Amazon (ESA), University of the State of Para (UEPA). Professor at the UEPA, Belem, Para, Brazil.

¹¹Nurse, Faculty of Theology, Philosophy and Human Sciences Gamaliel (FATEFIG), Tucuruí, Para, Brazil.

¹²Nurse, Specialist in Urgency and Emergency Nursing, Faculdade Madre Tereza, Amapá, Brazil.

¹³Nurse, Master in Education, Training and Management for Nursing Care Practice, Stricto Sensu Graduate Program in Nursing (PPGENF), Federal University of Para (UFPA), Professor of the University of the State of Para (UEPA), Belem, Para, Brazil.

¹⁴Nurse, University of the State of Para (UEPA), Belem, Para, Brazil.

¹⁵Master in Nursing, Federal University of Para (UFPA). PhD in Tropical Diseases, Postgraduate Program in Tropical Diseases (PGDT), Nucleus of Tropical Medicine (NMT / UFPA), Belem, Para, Brazil.

¹⁶Nurse. Doctoral student of the Stricto Sensu Graduate Program, Doctorate in Biology of Infectious and Parasitic Agents (BAIP), Federal University of Para (UFPA), Belem, Para, Brazil.

¹⁷Nursing student, Estacio Castanhal Faculty, Castanhal, Para, Brazil.

¹⁸Nurse, Post graduate. Stricto Sensu Graduate Program in Nursing, Federal University of Para (UFPA), Coordinator of the Study Center, Hospital Pronto Socorro Municipal Mário Pinotti, Belem, Para, Brazil.

¹⁹Nurse, Universidade Paulista (UNIP), Belem, Para, Brazil.

²⁰Social worker. Hospital Pronto Socorro Municipal Mário Pinotti, Belem, Para, Brazil.

²¹Physiotherapist, Faculdade Cosmopolita, Belem, Para, Brazil.

²²Physiotherapist, University of Amazon (UNAMA), Belem, Para, Brazil.

²³Nursing student, Faculdade Cosmopolita, Belem, Para, Brazil.

²⁴Nurse, Master in Health Education in the Amazon (ESA), Stricto Sensu Postgraduate Program, Professional Master in Health Education in the Amazon, State University of Para (UEPA), Belem, Para, Brazil.

²⁵Nurse, Hospital Universitário da Universidade Federal da Grande Dourados, Mato Grosso do Sul, Brazil.

²⁶Nurse, Hospital das Clínicas da Universidade Federal de Pernambuco, Brazil.

²⁷Nurse. Master in Business Management, Lusófona University of Humanities and Technologies, Lisboa, Portugal.

²⁸Nurse, Federal University of Para (UFPA), Belem, Para, Brazil.

²⁹Nurse, University of the State of Para (UEPA). PhD in Nursing from the Federal University of Rio de Janeiro (UFRJ). Professor at the Postgraduate Program Stricto Sensu, Professional Master's Degree in Management and Health Services in the Amazon, Fundação Santa Casa de Misericórdia do Para (FSCMPA), Belem, Para, Brazil.

³⁰Nurse by the Doctum Educational Institute of Technology. Master's Student by the Professional Program of Surgery and Experimental Research (CIPE), State University of Para (UEPA), Belem, Para, Brazil.

³¹Physiotherapist. Master. Metropolitan University Center of the Amazon (UniFAMAZ), Belem, Para, Brazil.

³²Nurse. Master in Nursing. Doctoral Student in Nursing at the Federal University of Rio Grande (FURG), Rio Grande do Sul, Brazil.

³³Nurse. Master in Public Health UFPA. Doctoral Student in Nursing at the Federal University of Paraná (UFPR), Paraná, Brazil.

³⁴Nurse, Faculdade Integrada Brasil Amazônia (FIBRA), Belem, Para, Brazil.

³⁵Psychologist, PhD in Tropical Diseases, Postgraduate Program Stricto Sensu, Tropical Medicine Nucleus, Federal University of Para (UFPA), Belem, Para, Brazil.

³⁶Nurse, Master in Health Education in the Amazon, PhD student, Stricto Sensu Graduate Program, Professional Doctor degree in Health Education in the Amazon (ESA), State University of Para (UEPA). Professor at the State University of Para (UEPA), Campus Santarem, Para, Brazil.

³⁷Nurse at Maria Aparecida Pedrossian University Hospital (HUMAP), Federal University of Mato Grosso do Sul (UFMS), Campo Grande, Mato Grosso do Sul, Brazil.

³⁸Physiotherapist. Escola Superior da Amazônia (ESAMAZ), Belem, Para, Brazil.

³⁹Physiotherapist, doctoral student, Stricto Sensu Graduate Program in Parasitic Biology in the Amazon (UEPA / Instituto Evandro Chagas-IEC), Belem, Para, Brazil.

⁴⁰Physiotherapist, Master in Health, Society and Endemics in the Amazon, Federal University of Para (UFPA), Belem, Para Brazil.

⁴¹Physiotherapy student. Escola Superior da Amazônia (ESAMAZ), Belem, Para, Brazil.

⁴²Medicine student. Metropolitan University Center of the Amazon (UniFAMAZ), Belem, Para, Brazil.

⁴³Nurse. Coordinator of the Care Program: Palliative and Home Care at the Emergency Hospital Complex - Nurse coordinator of the CARE Program: Palliative and Home Care at the Emergency Hospital Complex - Hospital Infantil FHEMIG João Paulo II, Minas Gerais, Brazil.

⁴⁴Nurse, Master in Health Education in the Amazon, PhD student, Stricto Sensu Postgraduate Program, Professional Doctor degree in Health Education in the Amazon, State University of Pará. Professor at the University of the Amazon, Belem, Para, Brazil. *E-mail: profmaiconnogueira@gmail.com +55 (91) 980436368

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Keywords– Critical Care. Intensive Care Units. Death. Heart Arrest. Cardiopulmonary Resuscitation. Resuscitation Orders.

Abstract— Objective: To map the production of knowledge and make considerations about the main updates and recommendations available in the literature for the management and conducts in front of a patient in Cardiopulmonary Arrest with a Do Not Resuscitate Order (NOR) in an Intensive Care Unit. Method: narrative literature review. The source of information consisted of relevant publications in the literature, carried out from June to July 2021, based on the narrative synthesis of evidence on the updates contained in the main guidelines and official recommendations published by bodies linked to the Brazilian and international health area. Results: the results pointed to the difficulty of doctors and health professionals in talking about the subject, however, it was found that they believe in the patient's autonomy as a fundamental factor in the decision process, as well as the participation of family members and staff multidisciplinary. Conclusion: the consent to implement the ONR must be a joint decision, in which the objective must always offer the best for the patient and their families, supporting such decision in ethical precepts. Respect for the dignity and autonomy of the patient is the main factor that must be considered in decision making, not only for the implementation of the ONR, but for any procedure that may be performed on the patient.

I. INTRODUCTION

Cardiopulmonary resuscitation (CPR) is not indicated for all patients who present Cardiopulmonary Arrest (CPA), and may be refused by patients and their legal guardians and not instituted by health professionals in specific situations in the health care context. The Do Not Resuscitate Order (ONR) consists of the authorization of the patient or spouse, representative or family members not to adopt CPR measures in case of CPA in the terminal phase of an incurable disease or in circumstances that make recovery irreversible. The decision not to resuscitate is adopted by the medical professional after analyzing the risks and benefits, and discussing with the multidisciplinary team the uselessness of such maneuvers¹.

ONR consists of the careful decision not to perform CPR maneuvers in patients in the terminal stage of life, with irreversible loss of consciousness or those who may have untreated CPA². It is a conduct aimed at not using Advanced Life Support (ALS) to maintain vital signs in cases where efforts to prolong life are not clinically and ethically justified³.

The ONR has been part of the Medical Ethics Code of the American Association (AMA) since 1992. In Europe, between 50 and 60% of patients who died in a non-sudden manner in hospitals in countries such as the Netherlands, Switzerland, Denmark and Sweden declared an individual decision and autonomous from non-resuscitation. However, the global panorama regarding the conduct of professionals is not uniform, due to marked differences in

cultural factors and the lack of consensus in global guidelines².

In the 70s, the first guidelines and policies that recommended not adopting CPR measures in this context emerged in the world. However, the ethical complexity involved in the application of such measures meant that acceptance was not universal and immediate. In the United States of America (USA), Australia and some countries in Europe, aiming to meet one of the main paradigms of bioethics, with the maintenance of the autonomy of the patient and their families, the prior elaboration of the ONR was allowed, to prevent the submission of these individuals to advanced resuscitation measures that prolong vital functions in an unjustified way¹.

In Brazil, according to Resolution n. 1,805/2006 of the Federal Council of Medicine (CFM), in the terminal phase of illnesses, the physician is allowed to limit procedures and treatments that prolong life, guaranteeing relief from symptoms that lead to suffering, which guarantees comprehensive care, respecting the will and autonomy of the patient and/or their legal representative. It is reiterated that according to article 41, sole paragraph of the Code of Medical Ethics, non-resuscitation is justified in cases of incurable and terminal illness, however the physician must offer palliative care, taking into account the wishes of the patient and/or their representative cool⁴.

In the Brazilian scenario, the ethical discussion has covered the last two decades, being driven by CFM actions that motivated the debate about the terminality of life. These initiatives are evidenced mainly by the publication of CFM resolutions n. 1,805/2006 and 1,995/2012, which deal, respectively, with the therapeutic limitation of care for terminally ill patients and the advance directives of will (known in Brazil as living will). It should be noted that in public health, the refusal of treatment is an integral part of the Charter of Health Users' Rights, issued by the Ministry of Health (MS). In this context, the ONR is presented as a complement to the living will for a specific situation in which the patient expresses his desire for not resuscitation in case of CPA².

In view of this reality, the care provided to critical patients in the context of intensive care emerges. According to the Brazilian Ministry of Health, Intensive Care Units (ICUs) are hospital units for the care of critically ill or at-risk patients, who have uninterrupted medical and nursing care, with specific equipment and specialized human resources, in addition to access to technologies for diagnosis and therapy. Death is a constant presence in this hospital sector and professionals are in routine contact with the dying process, and sometimes the technical resources, knowledge and competence of

intensive care providers are limited, given the advance of the disease, especially when the cure it is not possible, with the diagnosis of out of therapeutic possibilities of cure⁵.

In Brazil, ONR is not a practice specifically recognized in the scope of Medical Ethics, however, the limitation of procedures is supported by federal ethical and legal provisions, among which CFM Resolution n. 1805/2006 of the CFM and the Health Users' Rights Charter of the Ministry of Health as already mentioned. However, even though it is not officially recognized, this approach is routinely adopted in clinical practice¹.

In this scenario, terminal patients, those considered out of therapeutic or cure possibilities are or should be the protagonists. Terminal patient is defined as one who, at a certain point in the evolution of their disease, is no longer salvageable, even if they have all the therapeutic resources available, therefore, they are in the process of unavoidable death. It appears that in front of these patients, professionals in a desperate attempt to reject the imminent death, so terrifying and uncomfortable, focus on machines and procedures, offering robotic and depersonalized care, fighting a fight against death. Thus, they propose an excessive, abusive and disproportionate therapeutic care, known as dysthanasia⁶.

The discussion around a "good death" in the ICU is recurrent and (re)emerging, and the topic has become an ethical dilemma. For intensivists, the "comfort" to the patient is provided by the introduction of an advanced airway (orotracheal intubation, for example), the institution of mechanical ventilation and the use of sedative drugs. This condition is opposed to what is prioritized in processes involving assistance in Palliative Care, in which the focus is on maintaining the patient's autonomy, pain and symptom control, preferably without invasive interventions. The discourse on the concept of producing a "good death" focuses on the awareness of the maintenance of individual identity and acceptance of the death process. However, the implementation of this palliative model in the ICU is complex in practice; because it is multifaceted, loaded with myths and ethical and legal conflicts. When a death occurs in the ICU, it is usually marked by the sick person's vulnerability and extreme physical dependence. Such picture results from the severity of their clinical condition, and sometimes as a result of the induction of coma, by the action of drugs to relieve symptoms and the discomfort produced by the conducts performed in intensive care⁵.

In the routine of ICUs, there is a difference between death and CPA. The terms are distinguished by the decision (or not) of resuscitation. When a patient receives

a diagnosis in which there are no therapeutic possibilities for a cure, the team assesses that the priority has changed, and no longer resides in investing in the use of resources to maintain their life. The assistant medical team communicates that "if the patient stops, it stopped-SPP". The medical record contains guidance on the conduct of comfort, which means not performing any procedure with the goal of cure. In the case of CPA, the order is not to perform CPR maneuvers, and thus the death is defined with the ONR registered in the medical record and communicated to the entire multidisciplinary team⁵.

It should be noted that there are no specific ethical standards on ONR in force in Brazil, however the procedure is evident in hospitals, as evidenced by the records in medical records described in the literature. In this way, it seeks to elucidate the ethical and moral principles and dilemmas, both of health professionals themselves and of patients who are faced with a watershed, life and death. In this context, the objective of this study was to map the production of knowledge and to make considerations about the main updates and recommendations available in the literature for the management and conducts in front of a patient in Cardiopulmonary Arrest (CPA) with a Do Not Resuscitate Order (ONR) in a Emergency Unit. Intensive Care (ICU).

II. METHOD

Narrative literature review. The source of information was composed of relevant publications in the literature, carried out from June to June 2021, from the narrative synthesis of evidence on the main updates for the management and conducts in front of patients in Cardiopulmonary Arrest (CPA) with a No Order Resuscitate (ONR) in ICU. Opinions, works, articles, dissertations, theses, event proceedings, editorials, conventions and legislation were included as bibliographic sources. The texts found were read, organized and synthesized, and the synthesis presented below.

III. RESULTS AND DISCUSSION

Intensivists work with highly serious patients, so they are in constant contact with death. However, in this sector, the dying process is usually called in different ways, namely: death and CPA. This differentiation brings with it also different forms of action, as well as the expression or not of feelings. Death is understood as an expected death, when all professionals wait for the sick person to die in a few hours or in a few days. The team does nothing to revert the patient's condition.

Professionals do not express so much suffering when death actually takes place. While in CPA, intensivists perform all possible measures so that the patient survives with minimal or no sequelae, using all available resources. When there is a return to spontaneous circulation and survival, there is great satisfaction from the team. On the contrary, when death occurs, professionals tend to express the feeling of failure, failure and impotence, considering that it is an unexpected death⁵.

In an attempt to deny the existence of human finitude and driven by the moral principle of preserving life, the health professional decides to use a therapeutic arsenal to prolong the time of death, configuring dysthanasia. Dysthanasia is, therefore, a term that can be synonymous with obstinacy or therapeutic futility, where technology is used to painfully and uselessly prolong the process of death. It is dedicated to prolonging the maximum amount of lifespan, fighting death as the greatest and last enemy⁶.

The non-resuscitation of patients in the terminal phase of progressive disease is a humanistic act that aims to meet the bioethical principle of non-maleficence, with the essential purpose of minimizing human suffering and avoiding the practice of dysthanasia. It is considered that the moment is opportune for debate, and for ethical, clinical and legal guidelines on the order not to resuscitate in Brazil to be elaborated, filling the existing normative gap in the country².

The ICU is considered a restricted and closed unit, both in its physical space, with closed windows and doors, central air conditioning, artificial lights, which keep the external environment outside, as well as the super-specialization characteristic of its care team, which deals with high-tech equipment aimed at the care of critically ill patients. Due to these characteristics, the intensive care team tends to be considered "better" than that of other sectors of the hospital, both by the intensivists themselves and by professionals from other sectors. The service routine is marked by an organization of the team, aiming to maintain as much control as possible over the patient's clinical conditions and vital functions, which is kept under constant monitoring by electronic equipment and by the nursing staff. It is a space for maintaining life in order to avoid death whenever possible⁵.

In this context, how is the No Resuscitation Order operated? An issue that raises many debates both in the medical and legal areas is the possibility of the patient to decide autonomously about their resuscitation or not, in case of CPA, since the Federal Constitution ensures the right to life and the protection of human dignity⁷.

In the United Kingdom, the document “End-of-life treatment and care: good practice in decision-making”, carried out by the British Medical Association, the Resuscitation Council and the Royal College of Nursing, identifies three situations in which CPR should be refused: when clinical evaluation concludes that CPR will not be successful in restoring cardiopulmonary function, circulation, and neurological function; when, after detailed discussion with the patient (or family members/legal representative), an agreement is reached that the benefits of CPR are outweighed by the costs and risks of carrying it out; and when the patient has an advance directive of will or makes an informed decision to refuse CPR⁸.

In Portugal, on April 13, 2012, the National Executive Council of the Medical Association approved a document on the ONR, whose proposal has been the subject of in-depth discussions since 2007, following a meeting between the medical teams of the Intensive Care Units and the Ethics Committee and Resuscitation Committee of Hospital Fernando da Fonseca. The document was intended to be a source of guidance for recommended procedures in defining ONR and not a set of imposed standards. It proposes the ONR for various clinical conditions, namely: patient with chronic renal failure on hemodialysis and with an incurable chronic disease with expected survival of less than three months, or metastatic neoplasm (depending on the type of neoplasm and prognosis) and patient with advanced and irreversible oncological disease that, due to its evolution, has led to a progressive degradation of physical status and/or activity in recent times. This document also adds that, if possible, use should be made of assessments of the patient's performance status based on predictive scales, such as the Palliative Performance Scale (PPS), which allows the formulation of a prognosis and a time estimate of survival of a patient in Palliative Care⁸.

It should be noted that the philosophy of Palliative Care is to integrate death in the progression of life and opposes the firm therapeutic obstinacy and the idolatrous cult with the biological dimensions. It does not intend at any time to abbreviate or postpone death, it seeks relief from pain and other symptoms, integrating the social and psychological aspects of comprehensive care⁹.

In this context, to end this important dynamic that involves death and dying, given the need to provide autonomy to patients and their families in the face of a diagnosis of short-term impossibility, advance directives of will emerge and, in this perspective, the possibility of registering the will vital.

The living will originated in the United States of America (USA), precisely in 1969, when LuisKutner proposed the adoption of the living will, known in Brazil as the living will, a document that would serve to protect the individual right of the human person and allow death. In other words, the living will proposed by Kutner was based on the assumption that the patient has the right to refuse to undergo medical treatment whose objective is, strictly, to prolong his life, when his clinical condition is irreversible or in vegetative state with no possibility of recovering their faculties, currently known as persistent vegetative state⁹.

In countries with a legal tradition similar to Brazil, such as Spain, DAV can be public or private. The first modality admits two forms of registration: a) in a registry office, by means of a public deed, without the presence of witnesses; b) in front of an employee working for the Administration, designated by the Health Council. In the second, the document must be signed by three capable witnesses, and of these, two cannot have a family relationship or a pre-established legal relationship with the grantor. It is noteworthy that the justification for the second possibility is to avoid having to resort to third parties, such as witnesses or notaries, for an act that falls within the sphere of personal autonomy and intimacy of people⁹.

The current state of knowledge has allowed the development of a range of technical, technological and therapeutic possibilities that can be used in the most varied clinical situations. However, since the 1970s, CPR has not been considered an eligible therapy for all critically ill patients. Due to the irreversibility of the clinical prognosis in certain clinical situations, limits are imposed on the health care team in the fight for a cure. From this postulate, ONR emerges, the first measure capable of refusing a specific therapeutic intervention. The ONR is a matter of marked importance, which assumes clear and significant importance in promoting respect for the dignity of human beings in such a delicate phase of life, such as the terminal phase. Their discussion is understandably uncomfortable, given their duality between being able to assume death in case of CPA and the responsibility to prevent taking a futile attitude, that is, carrying out a harmful intervention, contrary to the person's interest⁸.

It is described that physicians feel insecure about adopting ONR, although there is a consensus that the decision to implement such conduct in medical practice is essential. The insecurity comes from the lack of a guideline, as the legal aspects intimidate many professionals who fear lawsuits for omission of help. In view of this fact, the need for a clear guiding directive is

evident, in which respect for the patient's autonomy should be in the foreground. CFM Resolution n. 1995/2012, addressed the need for the existence of a regulation of advance directives of the patient's will in the context of Brazilian medical ethics. It also considers the relevance of medical behavior in the face of critical situations experienced by terminal patients. The CFM Resolution n. 1805/2006, gives the physician the power to decide whether resuscitation procedures are necessary or not when the patient is in a serious condition^{3,9}.

The Federal Council of Medicine (CFM) published Resolution No. 1995/2012, which establishes guidelines for any patient, as long as they are of legal age and fully conscious, to define with their physician what therapeutic limits they wish to receive during terminally ill and unable to decide on their care. Under this resolution, the physician must, when informing the patient of this possibility, always observe the dictates of the Code of Medical Ethics, and that such provisions of the patient will prevail over any other non-medical opinion, including the wishes of family members. In addition, the physician must record in the medical record such advance directives of will⁷.

The advance directives of will can be defined as written instructions in which the person, freely and properly clarified, exposes their wishes and positions, in order to guide future decisions regarding their health. They are carried out from the moment there is medical proof that the patient is unable to make decisions, and can be written by all adult individuals, regardless of their current state of health. Within this scenario, there are two types of advance directives, namely: the lasting mandate and the living will. The lasting term corresponds to the appointment, by the person, of someone he trusts to make decisions about his health care, in case he becomes incapable. The living will is a legal document, in which the patient defines the type of treatment and medical procedure he wishes to undergo when the reversal of his clinical condition is no longer possible and he is not able to make decisions¹⁰.

In general terms, this document is a form of manifestation of previous wishes, in case someone is diagnosed with terminal illnesses that make it impossible to make a conscious decision. The living will may deal with the refusal and/or acceptance of treatments that artificially prolong life, provision for organ donation and the appointment of a representative. However, the patient cannot refuse palliative care, as they are considered essential for maintaining the ethical and constitutional principles of human dignity⁷.

Making decisions based on the best evidence for good health practices, which enable the best results for patients when they are unable to effectively communicate their wishes is a daily occurrence in the daily lives of many professionals, especially physicians. The importance of informed decision-making shared by the health professional who attends the patient is essential for the quality of care and, above all, for good results. Literature shows that patient participation in treatment leads to better results, which is in line with the understanding that for the maintenance of the health of a sick person, the basis of care is a good and comfortable relationship between the professional and the patient¹¹.

In 1991, the US Congress passed the federal "Patient Self-Determination Act", a law that recognized the patient's right to self-determination. By the mid-1990s, all US states had expressly recognized the legality of such a document. In the meantime, there were two types of advance will directives: living will and durable power of attorney for healthcare (DPAHC). While the living will consisted of the document by which the individual manifested the refusal of treatments in the face of a terminal diagnosis or proof of Persistent Vegetative Status, the DPAHC, translated as a lasting mandate, consisted in the appointment of people to make decisions regarding treatments for health for which this individual would want to submit to the condition in which he was no longer able to respond consciously, due to permanent or temporary incapacity¹².

In Latin America, Puerto Rico was the first country to legislate on DAV and, more recently, Argentina and Uruguay have also done so. Although Brazil has not yet legislated on this topic, on August 31, 2012, the Federal Council of Medicine (CFM) approved Resolution CFM n. 1995, recognizing the patient's right to express his will on medical treatments and appoint a representative for such purpose, as well as the physician's duty to comply with the patient's wishes or their legal representative. This resolution corroborated to heat up the debate, especially on the need for legislative regulation of advance directives of will. This is because, as a professional body, the resolution has normative force only among physicians, not having the legal force to regulate essential aspects of the subject among other professional categories and other segments of society, such as formalization, content, capacity of grantors, the validity period and the creation of a national registry¹².

In Brazil, ONR are not supported by legislation, which obliges health professionals to apply CPR in all cases, except when death is unquestionable. This creates space for debate on the eminent and unquestionable need to build, based on scientific evidence and consensus in the

literature, standardized behaviors that support the work of professionals, taking into account the moral and ethical aspects of each situation and always bearing in mind the well-being of the people involved. Physicians are not required to perform CPR maneuvers on patients with clear signs of death (cadaverous stiffness, decapitation, decomposition, or cadaveric livor), even when requested by family members. Other criteria for not starting CPR maneuvers are prior court order not to resuscitate; absence of physiological benefit due to deterioration of vital functions despite the best available treatment and neonates whose pregnancy, low birth weight or congenital anomalies are associated with early death⁹.

Finally, the class character of the CFM resolution does not detract from its merit, on the contrary, it turns the eyes of society in general to the debate on this extremely important issue, given that many Brazilian citizens have already sought out the notary offices, seeking to register its advance directives, showing that the theme has social importance to justify the debate^{12,13}.

IV. CONCLUSION

The results pointed to the difficulty of doctors and health professionals in talking about the subject, however, it was found that they believe in the patient's autonomy as a fundamental factor in the decision process, as well as the participation of family members and a multidisciplinary team. It was possible to observe reports that professionals do not agree with disproportionate procedures when dealing with patients with terminal illnesses and have a clear notion about the importance of palliative care in clinical practice.

The physician has a duty to always respect the opinion of the patient and their families, and this is strongly recommended and accepted in the guidelines and ethical principles. When a doctor or hospital goes to court, it is because the case needs special attention. The same happens when a family member takes action against a doctor's decision.

The decision to implement ONR should be something that starts to be part of the medical routine, but before that there needs to be legislation in force for this purpose, so that, in this way, the medical team can make the necessary decisions with legal support, without the fear of losing your record due to unnecessary processes.

The decision-making process related to the end of life involves a series of cultural issues that make the debate on the subject difficult, such as the process of denying death and the desire to fight for life, at any cost.

In the Brazilian scenario, there is still no tradition that values patient autonomy, as happens in other countries, and,

therefore, the final decision often ends up being taken by the medical team and multidisciplinary team, which most often seek to assist to ethical principles to ensure greater well-being and quality of life for patients and their families, as well as the end of life with minimal discomfort, pain and suffering.

The end of life tends to be a conflicting, controversial and complex period, in which the central figure, the individual in the process of death, and others involved experience intense feelings and emotions, which should be debated based on ethical principles shared between the patient, family members and health professionals.

The unquestionable advances in the process of managing the well-being of terminal patients achieved in recent years have made it possible to prolong the lives of many people. However, it brought a dilemma, it is complex to increase longevity without extending the suffering. The euphoria that arises with the longer life expectancy conflicts with concomitant problems that present themselves over the years, especially in the health area. In this scenario, the dignity and autonomy of the human person in the terminal stage emerge as guiding and guiding elements, fundamental in decision-making that involves this stage of life. In short, the discussion about ONR raises different issues, not only of a clinical, legal and economic nature, but also of an ethical nature, which we believe are far from consensus.

Despite being over 40 years old, the ONR is still unclear, which is why it is inferred that there is still a long way to go, both in terms of educating the population and, above all, health professionals, as well as in terms of standardization this decision-making in legal terms, so that its discussion and application becomes transversal and independent of the figure of the doctor or the institution.

Above all, the need to promote a multidisciplinary debate about the issues that permeate the end of life is highlighted, given the current and growing technical and technological capacity of science to prolong life. We believe that it is increasingly important for palliative medicine to grow, so that the end of life is increasingly provided with greater comfort and quality, but above all, with greater dignity and autonomy.

The consent for the implementation of the ONR must be a joint decision, in which, the objective, must always offer the best for the patient and their families, supporting such decision in ethical precepts. Respect for the dignity and autonomy of the patient is the main factor that must be considered in decision making, not only for the implementation of the ONR, but for any procedure that may be performed on the patient.

Finally, we recommend that the inclusion of debates on the end of life should be carried out in such a way that it starts to generate interest on the part of health professionals. We consider it important that the terminality of life theme is better addressed during graduation, not only in the theoretical context, but mainly in practice, which may be the object of other studies.

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