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Assisted suicide: Perception of nursing students about professional performance on this topic

Suicidio asistido: percepción de los estudiantes de enfermería sobre el desempeño profesional en este tema

Suicídio assistido: percepção dos estudantes de enfermagem sobre o desempenho profissional neste tema

D. Timóteo-Costa[a1*], V. Marinalva-de Barros[b2], D.M. Rodrigues-da Silva[c2], I.D. Lima-Cavalcanti[d1], J.M. de Aquino[e2], C.A. Domingues-do Nascimento[f2]

ORCID

[a] 0000-0001-6311-0846
[b] 0000-0002-6895-2855
[c] 0000-0001-9111-6380
[d] 0000-0001-6625-8395
[e] 0000-0002-6949-7217
[f] 0000-0002-0097-8303

[1] Federal University of Pernambuco, Recife, Pernambuco, Brazil
[2] University of Pernambuco, Recife, Pernambuco, Brazil

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ABSTRACT

Introduction: Assisted suicide is considered an action in which a patient, wishes to terminate his/her life due to the pain and suffering caused by a disease and requests the necessary help from the healthcare professionals. The right to decide about ending one's own life and the impact attributed to the experienced suffering are the main questions regarding assisted suicide.

*Corresponding author. E mail: diogotcosta2@gmail.com
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Objective: Characterize the perceptions of nursing students about professional performance in the face of assisted suicide.

Methods: The research comprised a descriptive analysis with a qualitative approach, based on the application of semi-structured interviews on nursing students enrolled in the curricular 9th period, during 2014, in the city of Recife-PE, Brazil. The sample consisted of 19 students. The data, were analyzed and categorized using the Collective Subject Discourse (CSD) method.

Results and Discussion: The obtained data suggest that students consider assisted suicide as a way of preserving dignity in the face of procedures that will make the death an inevitably painful process. Indicate that euthanasia and assisted suicide should remain illegal, and they would not get involved professionally. But others assured their willingness to participate because they would be satisfying the patient's wishes, however, for its legalization it is necessary to create principles that would guide the execution of these procedures.

Conclusion: The students consider, that the professional can eliminate real possibilities of treatment and recovery of the patient by accepting his request for suicide. However, some students are in favor of this procedure, arguing that the patient is free to conduct his own life.

Keywords: **Death; suicide, assisted; students, nursing; euthanasia; nursing care; Brazil.**

RESUMEN

Introducción: El suicidio asistido se considera una acción en la que un paciente, desea poner fin a su vida debido al dolor y sufrimiento causado por una enfermedad y solicita la ayuda necesaria de los profesionales sanitarios. El derecho a decidir sobre el fin de la propia vida y el impacto atribuido al sufrimiento experimentado, son las principales cuestiones relativas al suicidio asistido.

Objetivo: Caracterizar las percepciones de los estudiantes de enfermería sobre la actuación profesional ante el suicidio asistido.

Métodos: La investigación comprendió un análisis descriptivo con enfoque cualitativo, basado en la aplicación de entrevistas semiestructuradas a estudiantes de enfermería matriculados en el noveno periodo curricular, durante 2014, en la ciudad de Recife-PE, Brasil. La muestra estuvo constituida por 19 estudiantes. Los datos fueron analizados y categorizados con el método de Discurso del Sujeto Colectivo.

Resultados y Discusión: Los datos obtenidos sugieren que los estudiantes consideran el suicidio asistido como una forma de preservar la dignidad ante procedimientos que harán de la muerte un proceso inevitablemente doloroso. Indican que la eutanasia y el suicidio asistido deben seguir siendo ilegales y no participarían profesionalmente. Otros afirmaron que participarían porque estarían satisfaciendo los deseos del paciente; sin embargo, para su legalización es necesario la creación de principios que guíen la ejecución de estos procedimientos.

Conclusión: Los estudiantes consideran que el profesional puede eliminar las posibilidades reales de tratamiento y recuperación del paciente al aceptar su solicitud de suicidio. Sin embargo, algunos estudiantes están a favor de este procedimiento argumentando que el paciente es libre de conducir su propia vida.

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Palabras clave: **Muerte; suicidio asistido; estudiantes de enfermería; eutanasia; cuidado de enfermería; Brasil.**

RESUMO

Introdução: O suicídio assistido considera-se uma ação em que um paciente, deseja acabar com a sua vida devido à dor e sofrimento causado por uma doença e solicita a ajuda necessária dos profissionais de saúde especializados. O direito a decidir sobre o fim da própria vida e o impacto atribuído ao sofrimento experimentado, são as principais questões relativas ao suicídio assistido.

Objetivo: Caracterizar as percepções dos estudantes de enfermagem sobre a atuação profissional frente ao suicídio assistido.

Metodologia: A pesquisa incluiu uma análise descritiva com enfoque qualitativo, baseada na aplicação de entrevistas semiestruturadas a estudantes de enfermagem matriculados no nono período curricular, durante 2014, na cidade de Recife-PE, Brasil. A amostra esteve composta por 19 estudantes de enfermagem. Os dados foram analisados e categorizados com o método de Discurso do Sujeito Coletivo.

Resultados e Discussão: Os dados obtidos sugerem que os estudantes consideram o suicídio assistido como uma forma de preservar a dignidade frente a procedimentos e cuidados que tornarão a morte um processo inevitavelmente doloroso. Eles indicam que a eutanásia e o suicídio assistido devem seguir sendo ilegais e que não participariam profissionalmente. Outros afirmaram que participariam porque estariam satisfazendo os desejos do paciente; porém, para sua legalização é necessário a criação de princípios que norteiem a execução destes procedimentos.

Conclusão: Os estudantes de enfermagem consideram que o profissional pode eliminar as reais possibilidades de tratamento e recuperação do paciente ao aceitar seu pedido de suicídio. Porém, alguns estudantes são a favor desse procedimento argumentando que o paciente é livre para dirigir sua própria vida.

Palavras chave: **Morte; suicídio assistido; estudantes de enfermagem; eutanásia; cuidados de enfermagem; Brasil.**

INTRODUCTION

In modern times, with technological advances in the field of health, death is seen as a failure, which expresses the therapeutic impotence before the process of dying, a process accelerated by the severity and irreversibility of the disease. In addition, when the methods used to revert the patient's state of health are no longer effective, where death is the only way to end suffering, relatives manifest feelings of pain, anguish and incomprehension because of the non-acceptance of the end of life[1]. Therefore, when thinking about caring for patients with no possibility of cure, it must be recognized that the resolution of the needs of these individuals can't be based only on a technical-positivist approach, for which the ideal of using techniques and procedures prevails that prolong life, regardless of suffering.

The desire to maintain the survival of the patient who is in the process of dying opens space for discussions, based on arguments linked to the bioethical dimension, which involves the legalization

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of alternative practices related to the end of life, such as euthanasia and its derivations, among which we have assisted suicide[2]. The act of committing suicide has generated a wide discussion in several areas of knowledge, being these, in sociology, philosophy, anthropology and psychology as well as it is perceived under various spectra to consider the attitude that led the individual to cause his own death[3]. Even though there are several reasons that lead the subject to suicide, such phenomenon is understood as a solution to crisis or problematic situations that generate a state of suffering and despair[4,5].

In cases where there is a therapeutic impossibility, assisted suicide is a technique of euthanasia, the occurrence of which is conditioned to the explicit request of the patient for a health professional to assist him, for example, by ingesting some drug, in promoting his own death. In this circumstance, the patient consciously expresses the desire for death, unlike other forms of euthanasia, where the patient may not be consciously and explicitly manifesting his own will to die[6].

Thus, it is observed that the subject of assisted suicide involves ethical, moral and institutional aspects, which makes the discussion ample and complex. In this context, it is relevant that the nursing student is aware of these discussions and their possible implications in the assistance, since the Code of Ethics of this professional expresses prohibition of the practice of euthanasia or any other that anticipates the death of the client[7]. A prohibition that extends to actions that lead to assisted suicide.

It is, therefore, a necessary reflection on the academic training environment of health professionals, particularly nurses, where there is a lack of knowledge of the concept and favorable and unfavorable arguments regarding this practice, ethical-moral conflicts may arise in situations where the patient and his/her relatives express, clearly and intentionally, the desire for their own death. To support this reflection, the present study sought to characterize the perceptions of nursing students about professional performance in the face of assisted suicide.

METHODS

The research comprised a descriptive analysis with a qualitative approach. The study was carried out in the second semester of 2014, in a Nursing course, located in the city of Recife, in the state of Pernambuco, Brazil. We emphasize that in this state, assisted suicide is not allowed by law. The research included, as an inclusion criterion, the students enrolled in the curricular 9th period, once, already had studied the theoretical subjects (subjects taught by teachers not included in this research, to avoid possible influence on the students' responses) and carried out the internship, therefore, they attended the conditions on the curricular knowledge of the subject of death, the dying process, and assisted suicide as well as the possible experience of death situations. As a criterion for exclusion, it was considered, on the one hand, the existence of specific training on the subject of death and palliative care in courses, seminars, congresses, etc., and, on the other hand, if women, were in the gestational period .

The number of the participants, because it was a qualitative study, obeyed the criterion of content saturation, thus, the sample consisted of 19 students. In order to conduct the interviews, there was a prior appointment made in person or by telephone. The interview, of the semi-structured type, approached the perceptions of the students on the following guiding questions: a) euthanasia, b) suicide, c) assisted suicide and d) moral conceptions about euthanasia and assisted suicide. The interviews were conducted individually and in different places, but always in adequate

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environmental conditions of lighting, temperature, sound, stealth, etc. The interviews being conducted by only one researcher, to obtain homogeneity in data collection.

The data, after transcription of the interviews, were analyzed and categorized by 3 researchers, using the Collective Subject Discourse (CSD) method, whose methodological figures rescue and organize collective meaning based on the articulation and relationship of those individuals. Therefore, we have the following steps: a) Identification of Key Expressions (E-Key): passages that better identify and describe the significant and common content for the various individuals; b) Synthesis of the Central Ideas (CIs): synthetic formulas that describe the meaning (common, complementary or opposite) present in speeches; c) Establishment of Anchors (ACs): synthetic formulations, deriving from the discursive marks that allow to identify and articulate the ideological context, underlying the discourse formulated and d) Edition of Collective Subject Discourses (CSDs): articulation of E-Keys and their respective CIs and/or ACs by editing texts in the first person singular, which are representative of individuals and the group[8].

During the analysis, each researcher individually performed the preliminary identification of E-Key and CIs, which, once compared, led to the establishment of the definitive ones. As a function of these, the CSDs were first edited by each researcher, and then compared, for the final edition. In this context, the CIs/CSDs are synthetic formulations, which express, in relation to patients with leukemia, their significations about the process of illness.

The focusing of the content, whose target is the subjective dimension, allowed to disregard the analysis of the anchorage marks. Constituted the set of CSDs, all the researchers, considering the bibliographical research carried out and the inferences raised, contributed to the discussion of the results.

The study was submitted to the Human Research Ethics Committee (CEP) of the HUOC/PROCAPE Hospital Complex, which, in compliance with the ethical principles of human research established by the National Health Council through Resolution 196/96, issued a favorable opinion (CAAE-33839714.7.0000.5192). Participants were duly informed about the objectives of the research, the confidentiality, the need to register and disseminate the results. All authorized their participation through the Informed Consent Form (TCLE), not having no withdrawal.

RESULTS AND DISCUSSION

Among the participants in the study were 4 males and 15 females, ranging from 21 to 28 years old, all of whom were unmarried. As far as religion is concerned, 11 are Catholics, 3 Spiritists and 5 Evangelicals. The interviews allowed the edition of 10 CIs with their respective CSDs: Suicide as a disinvestment in life, suicide as an act of ending suffering, conceptualizing assisted suicide, the right to own death, autonomy and legalization of euthanasia and assisted suicide, legalization of assisted suicide, professional autonomy in not participating, banalization of the practices, emotional impact in relation to behaviors and acceptance of assisted suicide.

Suicide is a problem that raises discussions among professionals in the most diverse areas of knowledge, whether psychologists, sociologists, health professionals and the humanities science, because it is a complex issue that involves the influence of biological, sociological, psychological, cultural and environmental. Ten central ideas were constructed with their respective discourses of the collective subject[9,10].

Conceptions are attributed to suicide that relate perspectives such as the desire to withdraw one's life, and the desire to execute one's own death. In this sense, it is a phenomenon that generates

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intense suffering to the individual associated with feelings that cause emotional maladjustment, such as lack of hope and protection[11]. Study participants refer to suicide as a fact triggered by emotional disturbances that influence the decision-making to practice death against oneself:

> **CSD I: Suicide as disinvestment in life:** It is the act of taking one's life. It is when a person simply decides to no longer live and she arranges a way to take her life, where they use some kind of instrument that she knows can take her life. It is a moment of desperation that you really are lost in your life, some strong moment that you are going through, but you would rather end your life than try to solve the problem.

Suicide is an intriguing, polemic and challenging phenomenon for understanding human functioning by encompassing the desire in which man manifests self-destructive behavior, whether by presenting suicidal ideas and attempts or by concretizing the very act of death. In addition, it is worth considering that this type of behavior should be signaled as a conduct in which the subject expresses signs of anguish and an exacerbation of suffering, and that is influenced by the individual nature, family structure and social context[12,13]. The belief adopted by academics seems to be that generally adopted in Western culture, where suicide corresponds to a psychopathological behavior in which a deep emotional maladjustment is experienced.

In this way, it is necessary to understand the circumstances and peculiarities of each situation experienced by the individual through the analysis of factors that may lead to the suicide act, such as family maladjustment, mental illness, social alienation, among others[5]. These factors point out that the act of withdrawing one's life is characterized as the desire to break the psychic pain. Being this attitude dimensioned by the will to extinguish the psychic suffering, being the death a way to eliminate the anguishes and conflicts, and the suicidal attitude manifests itself before the extreme choice to end the suffering ending with the own life[14,15].

> **CSD II: Suicide as an act of ending suffering:** I think that they are sick people, who are in a state of intense suffering, in a moment of despair, a lot of anguish and pain that end up not being able to put that get out. The situation of life has become so unsustainable that he believes that the other side will be better for him. It's like a relief.

The term assisted suicide refers to a situation in which a patient consciously expresses the desire for death due to the limitations that illness imposes. In this sense, when choosing not to want to feel anguish and intense pain during the dying process, the patient asks for help from health professionals so that a substance is prescribed in order to help him in the realization of his own death[16]. Thus, in addition to the proper understanding of the concept, it was emphasized by the participants that patients who choose to withdraw their own lives are psychically fit for decision making, even in a compromised state of health:

> **CSD III: Conceptualizing Assisted Suicide:** Assisted suicide is when a patient, with his mental faculties preserved, chooses to withdraw his own life. It is when the professional favors the death of the patient who wishes to die. It helps the patient to die, but this death is performed directly by the patient with the contribution of the health professional who will instruct him on how he will proceed to take his own life.

In addition, they emphasize that the decision by suicide, when in a terminal state, is an inalienable right of the individual, complementing also the motivations that leads him to decide by the procedure that accelerates the process of dying. It is also observed that this procedure contrasts with the non-desire to pass through conducts that prolong the natural process of death, being, then,

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practices that denigrate the physical and emotional integrity of the one who is suffering. Therefore, for certain participants, assisted suicide is an attitude of preservation of human dignity:

CSD IV: The right in the own death: Assisted suicide is a right that the human being has to put an end to his own suffering, like wanting to get rid of the moment of difficulty. It is when a patient, already in terminal stage, that there was no further treatment, and decided that he did not want to wait any longer, he wanted to end the suffering and decided to die. It's like wanting to get rid of the moment of trouble, not wanting to die when you're in the worst part of the illness, but when he's still fine.

In favor of assisted suicide there is also the argument of the principle of autonomy. On this, it is pointed out that the freedom of the individual is preserved in opting for what is best and important for his life, which includes the process of dying, so that his existence does not become unbearable[6]. Thus, this principle points to the need to encourage patients to choose according to the information transmitted by health professionals, whether agreeing or rejecting any proposed measure even if such a choice results in negative consequences for their health[17]. This happens due to the influence of the increase in medicalization in the therapeutic process because, in some cases, it can harm the quality of life of patients who are in the final moments of life[18]. It is also necessary to create definitions with the objective of implementing the application of euthanasia and assisted suicide in situations that are really appropriate, in order to ensure the legal exercise of these procedures.

In Belgian legislation, for example, the following criteria are met: a) clear understanding, on the part of the doctor, that the patient makes the request for life abbreviation in a conscious and voluntary way; b) the patient's clinical condition will not be reversed for improvement and his suffering is intolerable; c) the patient is aware of his health condition and prognosis; d) patient and doctor conclude that there is no viable therapeutic option for the patient's clinical condition; e) consultation with another doctor to issue an opinion, in writing, if the criteria in force in A and D were met; f) practice medical actions to shorten the patient's life or assist him in his[19]. In their acceptance of legalization, the students seem to evoke the principle of autonomy over legal parameters:

> **CSD V: Autonomy and legalization of euthanasia and assisted suicide:** They should be legalized. Because everyone has the right to decide how they want to live and why there are cases that really it's necessary their application. This requires establishing a standard operating procedure, a series of very rigorous protocols, to define the necessary cases. In the case of assisted suicide, it could only be done in those patients who are actually terminally ill, that there is no longer any treatment that can take effect and that they agree not to suffer more, end their suffering. And in euthanasia it would be a little more complicated, but if a series of protocols, such as brain death, were followed, if the protocols were followed correctly, if several teams analyzed the case, the family authorized, were really beneficial for that patient to end their suffering. Even though I agree or disagree, I think it should be legalized. Only the one who knows is the one who passes, when he is in the moment of difficulty, at the moment of illness. If the patient is suffering, there is no way, then it is up to each of us to decide what is best for us. I believe that this is the way to even exercise what is called free will, to be able to lead your life as you should or as you think correct.

Thus, they admit their performance in health services through professional training. Similarly, students at a university in Spain were in favor of preserving the patient's freedom to decide on the moment of dying as well as receiving help to achieve their own death[20]. On the other hand, they

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emphasize the necessity of technical principles that guide the professional decision, allowing to discern on the situations in which assisted suicide should be applied:

> **CSD VI: Legalization of assisted suicide:** I think it should be legalized because it is simply abbreviating the suffering of the person, you know, the person who chooses. If you have the opportunity, the ability to choose the best way you die, then I think interesting. It may be a procedure that is necessary for the patient since he will have the diagnosis or prognosis already closed. It is a way that can be worked, but if you have a standard procedure and also have professionals, both doctors and nurses and technicians, a health team that is well qualified to be able to define which cases should be performed.

The acceptance of assisted suicide may be related to cultural differences, as it was identified that the levels of acceptance were higher in European and North American countries. That is why the relevance of passing on all information about the clinical status and viable therapeutic alternatives is pointed out since health systems value practices that preserve the patient's self-determination. In addition, bodily autonomy was established in Article 8 of the European Convention on Human Rights[17].

However, in Asian countries, which have paternalistic traditions, lower levels of acceptability were perceived in the face of this procedure[21]. In another study conducted in Brazil, there was great acceptance, by students and health professionals, regarding the authorization of assisted suicide for patients with terminal illnesses[2].

This is not a consensual position. The participants raised unfavorable arguments related to non-acceptance of the anticipation of death, as well as interpreting suicide as an attitude in which the professional is responsible for determining when the terminally ill patient should live, which is also in opposition to religious beliefs. They emphasize the autonomy of the patient in deciding the course of his life, however, they affirm that such choices can not impose the participation of the professional, who must also be respected in his autonomy to refuse to participate in such a procedure:

> **CSD VII: Professional autonomy in not participating:** I am against it because I believe we do not know the time of death of the patient. I do not think that you anticipate his death, if you still do not die is because you are not in the moment, you have to go through it. This patient, to the professional to do this, loses all possibilities of a possible recovery. And even if recovery is possible, I do not agree, because to God nothing is impossible. It is not in the power of man's action to decide when to withdraw his life, it is up to God alone. It is as if one wants to be God, to say when to die or not. Of course the one who chooses is the patient, but you do not have to agree with that. If I were faced with a situation where someone wanted to take their own lives, I would reserve the right not to participate in this action.

Corroborating this discourse with the existence of a law that would legalize euthanasia and assisted suicide, health professionals categorically stated that they would not participate in this procedure, that is, they would not assist patients in carrying out their own death, nor would they exercise practices that accelerate the death of a Brazil[2].

It is important to note that, in the Brazilian Penal Code, euthanasia is linked to the definition of privileged homicide motivated by relevant social value or violent emotion, based on 1 of article 121, called pious homicide. Assisted suicide, on the other hand, falls under Article 122, which contemplates the fact that the individual induces, instigates, or helps another person to commit suicide[2].

Something that can justify such attitudes would be the fact of attributing a religious meaning to human existence, where the act of conceiving life and withdrawing it would be under the power

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of divine authority. This may be related to the fact that Brazilians value the spiritual dimension and religious beliefs because they consider it relevant to be at spiritual peace in the last moments of life[22]:

> **CSD VIII: Banalization of the practices:** I think these procedures should remain illegal. Because once legalized, I think that the banalization of the practice could occur. If you have the law, I will use the law to favor myself, I do not want this burden of taking care of the patient bedridden, chronic. I believe that if there is the possibility of having dignity in its last moments this scenario could be different. And this does not exist to anticipate the death of anybody, we are not God to anticipate the death of anybody, not even the person can. I think there is a God who gave our lives and we should not define whether or not that person should die.

The debate about the legality of assisted suicide, as well as euthanasia, involves antagonistic arguments based on principles of a religious order, as well as opinions based on bioethical principles. When expressing disagreement regarding the legalization of euthanasia and assisted suicide, it is observed that the students supported the fact that perhaps the deliberate use of such practices occurs. Such an argument was expressed by the European Association of Palliative Care, citing that it would be deflagrated the *slippery slope*[23].

In this situation, the procedures that lead to the end of life would be applied, according to the judgment of health professionals, considering the irreversibility of the disease and the patient's strenuous suffering, especially those who are elderly or have special needs, abdicating of the palliative care. In this perspective, the lives of these people could no longer make sense because a feeling of non-belonging could emerge due to the judgment of other people regarding the health status of these vulnerable people, as well as the fact that the sense of cooperation and care for others is perceived as a burden[17].

Within this context, there would be a difficulty in establishing justifiable limits between decisions to perform euthanasia or assisted suicide because it would reduce the life span of those who would not have a quality of life, either due to congenital conditions or due to the irreversibility of the clinical condition. In these situations, it could be difficult to maintain the criteria so that non-voluntary euthanasia is not practiced, in which the patient does not present conditions for decision making; involuntary euthanasia, in which it would be against the patient's will; finally, in coercing the patient to commit assisted suicide[24].

However, in Belgium, a country that legalized euthanasia and assisted suicide in 2002, decisions on the use of these procedures do not convey the lack of palliative care, leading to the belief that life-anticipate measures are carried out from the perspective of palliative care. In the Netherlands, in 2001, 2.6% and 0.2% of the deaths represented the deaths resulting from the practice of euthanasia and assisted suicide, respectively, in relation to the total number of deaths in this country. After legalization, in 2005, there was a reduction in the number of deaths resulting from these practices, of which 1.7% were related to euthanasia and 0.1% of assisted suicide[23,25]. There is no evidence of a direct relationship between the legalization of assisted suicide and the increase in its occurrence.

Students who are against achievement feel emotionally unprepared to perform such a procedure, which is perceived in a very distressing way. They would be feeling as coadjuvant in inducing death, even if it was the will of the subject, triggering feelings of sadness and intense emotional discomfort. This idea is linked to the fact that the participants, when projecting themselves as future professionals, will make use of all the knowledge acquired during the graduation with the

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purpose of reestablishing the vital state of the individual, and that, in this perspective, professional performance would be based solely on assisting in the healing process of the subject, and death would be characterized as a failure of professional and personal practices. This is how one can observe a shocking emotional condition from the supposition that, for whatever reason, they collaborate with this procedure:

> **CSD IX: Emotional impact in relation to conduct:** I would not participate at all, deny all such situations, never act in assisted suicide, nor in euthanasia. The moment he was authorized by the family, and even if the service made him do it, I would refuse. I would not act on these practices for a personal reasons, it is against my ethical and religious principles to accept this kind of conduct. If he (*the patient*) wanted to die, he could die otherwise, not with the help of a professional. I know he wants to, but I do not have the courage and the heart for it. Even in the case of euthanasia, I think it's worse because I'm going to be deciding for someone else. Did not that person want to live longer, to invest more so he could have a chance? It would be a very painful situation, I would feel extremely uncomfortable, it would not do me any good, I would be sad. And if I was in the moment, I would feel myself co-responsible for that, taking the life of another person, even the person wanting it. I would not feel like a homicidal, but rather I would be playing a role that is not mine, that goes beyond my nursing profession, my future profession.

For those who accept, conceiving that they are attending to the patient's will, one observes the belief of greater ease in dealing with the situation. The professional is only the one who guides and facilitates the fulfillment of the patient's desire:

> **CSD X: Acceptance of assistance to Assisted Suicide:** If the patient is unconscious and there is family support, yes. And if the patient wants it too, if it were legalized, I would do it, doing the will of my patient. Because, in assisted suicide, who will go self-medicate will be the person. So you would just accompany the person to be there together. Regarding euthanasia is also a way of caring for the nursing professional to be there together with the person at the decisive moment for him. In euthanasia, the patient will not be conscious, many times he has left the will to his family. So it is important for the professional, even to guide, to try to explain the why of that person's choice. At first it would be kind of shocking to me, it would be difficult for me to be able to participate in this procedure. However, I think everything learns, that everything is a matter of adaptation.

CONCLUSION

This study shows that, for students, professional eliminates real possibilities of treatment and recovery of the patient to consent to his request for suicide. He also showed that some students were in favor of this procedure, arguing that the patient is free to conduct his own life. From this point of view, some students affirm that they would participate in both euthanasia and assisted suicide and that such practices should be legalized within the context of care.

The discourse based on a religious perspective was reiterated as an argument to keep euthanasia and assisted suicide as illegal procedures, as well as something that justifies the non-participation, as future professionals, in the accomplishment and/or aid in these procedures.

It is believed that the present study can contribute to broadening the discussion in the academic environment, in order to collaborate with a critical-reflexive formation of the student of the health area, especially of the nursing. As a consequence, reflection will be based on ethical action when it

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comes to an assistance based on humanized attitudes, specifically in situations where the student may encounter the patient's finitude.

LIMITATIONS OF THE STUDY

The present study did not contemplate students from other periods, being able to suppose that other perspectives could be pointed in front of this thematic that provokes reflection.

RECOMMENDATIONS FOR PRACTICE, POLICY, AND FUTURE RESEARCH

It is recommended that future research be conducted to address the theme of this study in the academic environment, in order to stimulate students' critical thinking in the face of bioethical dilemmas that challenge professional practice.

ETHICAL RESPONSIBILITIES

Protection of people and animals. No human or animal experiments were conducted in this study.
Confidentiality. In this research, no personal data appears to allow the identification of the participants, who were guaranteed the anonymity and confidentiality of the information.
Conflict of interests. The authors declare no conflict of interest.
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