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Residents facing finitude and the therapeutic decision-making process: a qualitative study

O residente diante da finitude e o processo da tomada de decisão terapêutica: estudo qualitativo

El residente frente a la finitud y el proceso de toma de decisiones terapéuticas: estudio cualitativo

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ABSTRACT

Objective: based on multi-disciplinary residents' testimonies, to analyze the therapeutic decision-making process for end-of-life patients in their practice setting, with Beauchamp and Childress' theory of principles as bioethical resource for the analysis. **Method:** a qualitative study with a sample comprised by 25 residents from three hospitals, using the “snowball” technique. Data collection was conducted in-person and online from July to October 2022. The data were processed using thematic-categorical content analysis. All ethical principles were respected. **Results:** three categories emerged: The decision-making process for end-of-life patients; Bioethical grounds used to guide decision-making; and the ideal and real worlds in the decision-making process. **Final considerations:** when used, Beauchamp and Childress' bioethical principles contribute as a guiding beacon for end-of-life therapeutic decision-making.

Descriptors: Bioethics; Patient Care Team; Palliative Care; Clinical Decision-Making.

RESUMO

Objetivo: analisar, a partir do discurso do residente multidisciplinar, o processo de tomada de decisão terapêutica junto a pacientes em fim de vida em seu cenário de prática, trazendo como recurso bioético de análise a teoria por princípios de Beauchamp e Childress. **Método:** estudo qualitativo, com amostra composta por 25 residentes de três hospitais, utilizando a técnica *snow ball*. A coleta dos dados ocorreu de forma presencial e virtual no período de julho a outubro de 2022. Os dados foram tratados utilizando a análise de conteúdo temático-categorial. Os princípios éticos foram respeitados. **Resultados:** emergiram três categorias: o processo de tomada de decisão com pacientes em fim de vida; bases bioéticas utilizadas para nortear a tomada de decisão e; o mundo ideal e o mundo real do processo de tomada de decisão. **Considerações finais:** os princípios bioéticos de Beauchamp e Childress, quando utilizados, contribuem como norteador para a tomada de decisão terapêutica em fim de vida.

Descritores: Bioética; Equipe Interdisciplinar de Saúde; Cuidados Paliativos; Tomada de Decisão Clínica.

RESUMEN

Objetivo: analizar, a partir del discurso de residentes multidisciplinarios, el proceso de toma de decisiones terapéuticas con pacientes al final de la vida en la práctica clínica, utilizando como recurso bioético la teoría de los principios de Beauchamp y Childress. Método: estudio cualitativo, con una muestra de 25 residentes de tres hospitales, utilizando la técnica de bola de nieve. La recolección de datos se realizó de forma presencial y virtual de julio a octubre de 2022. Los datos se procesaron mediante análisis de contenido temático-categórico. Se respetaron los principios éticos. Resultados: surgieron tres categorías: el proceso de toma de decisiones con pacientes al final de la vida; las bases bioéticas utilizadas para orientar la toma de decisiones; y el mundo ideal y el mundo real del proceso de toma de decisiones. Consideraciones finales: los principios bioéticos de Beauchamp y Childress, cuando se utilizan, ayudan a orientar la toma de decisiones terapéuticas al final de la vida.

Descriptores: Bioética; Grupo de Atención al Paciente; Cuidados Paliativos; Toma de Decisiones Clínicas.

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INTRODUCTION

The epidemiological transition that took place in the last few decades as a result of technological advances in terms of diagnostic methods, consequently exerting impacts on progress of disease treatments and access to health services, as well as the demographic transition due to various social phenomena such as reduction in the birth rate and increased longevity, influenced an increase in the prevalence of non-communicable chronic diseases and in the demand for health care involving multi-disciplinary and shared decision-making among health teams, families and patients[1].

This article derives from the MSc dissertation entitled “Therapeutic decisions for end-of-life patients: the residents’ view”, presented at the Graduate Program in Bioethics, Applied Ethics and Collective Health of *Universidade Federal do Rio de Janeiro*, in association with *Universidade Federal do Rio de Janeiro*, the Oswaldo Cruz Foundation and *Universidade Federal Fluminense* (2023).

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Currently, non-communicable chronic diseases are characterized as with the highest morbidity and mortality incidence, resulting in an important public health problem that needs to be addressed with health promotion, prevention, treatment and recovery policies, as well as in good-quality monitoring of people suffering from extended illness and chronicity processes until their final outcome[2].

All these issues point to an epidemiological setting that announces significant challenges for health assistance, with a need to restructure and adapt the health system to meet this emerging demand and to customize and adapt care measures focused on people's actual needs, in addition to training and updating the professionals already working in those services.

From this perspective, it is necessary to change the hospital-centered and cure-focused paradigm in which we are organized to enable patient-centered compassionate and comfort care, given that it is no longer possible to cure or control the diseases in question in many cases[3].

Palliative Care presents itself as a possible path for this change in paradigm, as it preserves respect for patients' autonomy, adequate control of their symptoms and search for quality of life without postponing death, in addition to enabling strategies to enhance efficiency in improving the patients' and their families' experiences in facing these disease processes until its final outcome[4].

Nevertheless, despite the early possibility to implement Palliative Care since diagnosis already experienced and settled in other countries, Brazil is characterized by a still incipient scope of this care modality and the approach to these patients and families has been slow and heterogeneous in the national territory[5].

A number of studies evidence the importance of a comprehensive and multi-professional approach centered on individuals under Palliative Care, highlighting the promotion of shared decision-making as fundamental to improve the patients' and their family members' quality of life, reducing distress and optimizing the way in which health system resources are used[5-9]. There is also the need to conduct studies that assist in training the future professionals that will take part in the process to implement Palliative Care for patients and family members[6].

In this context, from undergraduate studies and later on during residency programs, professional training plays a crucial role because it is in this period that the future specialists develop essential skills and attitudes for the clinical practice.

Integrating teachings about Palliative Care and shared decision-making in the multi-professionals teams that will work with the patients and family members can contribute to developing the residents' technical capabilities and to promoting an approach aligned to the patients' needs and preferences[10]. Therefore, it is vital to investigate these practices from the residents' perspective to promote a clinical practice that respects the patients' autonomy and improves the overall care outcomes.

Given the above, the objective of this study was as follows: based on multi-disciplinary residents' testimonies, to analyze the therapeutic decision-making process for end-of-life patients in their practice setting, with Beauchamp and Childress' theory of principles[11] as bioethical resource for the analysis.

THEORETICAL FRAMEWORK

Proposed at the end of the 1970s, Beauchamp and Childress' theory of principles provides a bioethical structure widely used in the medical practice and in health research. This approach is based on four fundamental principles that guide ethical decision-making and the clinical practice: Respect for autonomy, Beneficence, Non-maleficence and Justice. Each principle plays a crucial role in protecting the patients’ rights and promoting fair and egalitarian health practices[11].

The Autonomy principle highlights the importance of respecting the patients' ability to make informed decisions about their own treatments. This implies ensuring that they can access all the necessary information and understand the available options. Autonomy emphasizes the need for informed consents and the importance of respecting the patients' personal choices, even if they do not coincide with the medical recommendations[11].

In turn, Beneficence focuses on the moral duty of promoting the patients' well-being and maximizing the benefits offered by the treatments. This principle requires health professionals to act in a way to promote the patients' health and quality of life, taking into account their individual needs and preferences. Beneficence is directly related to a commitment towards efficacy and safety of the medical interventions[12].

The non-maleficence principle complements Beneficence because it requires professionals to avoid causing harms to the patients. This principle guides the clinical practice to prevent and minimize treatment-associated risks. In addition to that, it highlights the importance of assessing the potential adverse effects of the interventions and ensuring that the benefits outdo the risks[11,12].

Finally, the Justice principle addresses egalitarian distribution of resources and the need to treat all patients in an unbiased and equal way. This principle requires health professionals and systems to ensure that all resources are fairly allocated and that all patients can enjoy impartial access to the necessary treatments and care measures. Justice also encompasses considering the social and economic inequalities that may exert impacts on equality in access to health[11].

These four principles are not hierarchized and are considered *prima facie* and, therefore, as interacting with each other, which requires a careful and balanced assessment in terms of ethical health decisions and practices. Consequently, Beauchamp and Childress' theory of principles provides solid grounds for an ethical analysis and to implement practices that respect the patients' rights and promote fair and effective assistance[11].

METHOD

This is a descriptive study with a qualitative approach, following the quality and transparency recommendations for research in health set forth in the *Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups*[13].

The participants were selected using the “snowball” technique. Choice of this technique was due to the facts that the population was specific, that its size was not accurately known *a priori* and that data generalization based on different residency programs was sought, with this technique representing an indicated alternative considering these specificities[14].

The sample was comprised by professionals from the multi-professional residency programs at three hospitals located in the state of Rio de Janeiro. The eligibility criteria were as follows: residents from multi-professional and medical residency programs, in second year of the courses onward and working in non-intensive hospitalization units providing care to end-of-life patients.

The first group participant was the seed contact; in other words, the first person selected for the research and, in the case of this individual, considering the second-year residents from the lead researcher's work environment, with the possibility of later on selecting second-year residents from any other multi-professional or medical residency program in Brazil. The seed selected as first participant accepted to take part in the research and indicated a second participant. From that moment, all the participants were indicated by their predecessors, with the first contact to participate made by the previous interviewee, who shared the appointed contact with the researcher in charge after due authorization. After the indications, 25 residents were invited to take part in the study, with no refusals or withdrawals.

Before initiating the interviews with the study participants, a pilot test was carried out in order to verify if the interview script did not induce any answers in the participants and if it met the study objective. After making the necessary adjustments, the script consisted in three parts: characterization of the participants; previous professional experience; and emphasis on end-of-life care, the therapeutic decisions made by multi-professional teams and the ethical and bioethical nuances involved.

The following questions were explored by means of the interview script: How was the theme of death and dying dealt with in your undergraduate studies? How was the theme of the care to be provided to end-of-life patients addressed? In which academic subjects? In two words, define the decision-making process for patients on end-of-life care. Were you presented any theoretical content about bioethics and end of life during the residency? During the residency and up to now, have you already taken part in any discussion about therapeutic courses of action for end-of-life patients? How would you describe your participation in the decision-making process? And the other residents' participation? And the one by the professionals from the sector? Did you identify any ethical/bioethical principle grounding the decisions made? Were you able to recognize them or were them explicitly mentioned? According to you, which were these principles? How would you describe the patients' and/or families' participation in this decision-making process? From your stance as a resident, who makes the final decision about end-of-life therapeutic courses of action in the clinical hospitalization practice setting? Do you agree with this dynamics? Why? According to you, are these decisions kept and followed by all the health professionals from that unit? Why? According to you, how should end-of-life therapeutic decisions be made in an ideal hypothetical world?

Data collection took place between July 20th and October 25th 2022, both in-person and online. The Zoom® and Google Meet® platforms were used in the online modality for the participants that requested this type of approach. Both in the in-person and online modalities, the individual interviews were conducted by the lead researcher (a nurse, MSc in Ethics and Bioethics), recorded in a digital device and lasted a mean of 20 minutes. Subsequently, the testimonies were transcribed in full by the lead researcher and checked by a second one, not returning them to the participants for correction purposes.

Thematic-categorical content analysis was used for data analysis, enabling exploring the material, processing the results and interpreting them. Thematic-categorical analysis is divided into three stages: Pre-analysis, Exploration of the material or Coding, and Treatment of the results (inference and interpretation). Some preparatory operations were performed in the Pre-analysis phase, before actually analyzing the data. In this stage, the interviews were transcribed and thoroughly analyzed following the floating reading technique, in addition to formulating the (preliminary) hypotheses in line with the objectives of this study[15].

During the Coding stage, the unprocessed data were systematically transformed into registration units (RUs), units of meaning, subcategories and, finally, categories. The registration units are a segmentation or clipping from which the text *corpus* is segmented for the analysis. The units of meaning refer to the text segments that allow understanding what the registration units mean, relocating them in their context and always trying for them to be larger than the RUs. The subcategories are classes that gather a set of elements under a generic title; this grouping is made according to the characteristics common to these elements. The subcategories are grouped into categories, which considers the full text in the analysis, subjecting it to a classification and quantification screen according to the presence or absence frequency corresponding to the meaning items[15].

For treating and interpreting the results, the unprocessed data were systematically transformed into registration and meaning units. Based on the Treatment of the results stage, inferences were made about the content and interpretation of the testimonies from the categories created to quantify them so that it was possible to present the final data by comparing them to the theoretical framework and by discussing the findings.

The research protocol was approved by the Research Ethics Committee of the proposing institution. All the ethical principles governing research studies with human beings were respected. The participants were identified with the letter “R”, followed by consecutive numbers according to the order in which they were interviewed. It is noted that the participants signed a Free and Informed Consent Form and an Authorization to use their testimonies, both in the in-person and online modalities.

RESULTS

The study participants were 25 residents: seven nurses, three speech therapists, three social workers, two physical therapists, two nutritionists, two occupational therapists, three psychologists and three physicians. As for self-declared gender, there was predominance of females: 19 participants.

The interviewees' time since graduation was less than five years and were still in their professional improvement phase. In turn, 14 participants stated having other previous qualifications or concomitant with their residency: three reported having other previous undergraduate degrees, 13 assert having attended or being in the final phase of graduate studies in the *lato sensu* modality, and one in the *stricto sensu* modality, at the MSc level.

In this study, the unprocessed data were transformed into 694 registration units, which were grouped into 39 units of meaning; this allowed subsequently describing with more accuracy the characteristics of the content presented in the text and formulating thirteen subcategories. After structuring the analysis by grouping the analysis subcategories, the result was three categories.

These three categories emerging from that analysis will be discussed below: The decision-making process for end-of-life patients; Bioethical grounds used to guide decision-making; and The ideal and real worlds in the decision-making process.

The decision-making process for end-of-life patients

This category encompasses 262 registration units (RUs) and five subcategories (presented in Figure 1) that deal with the residents' perception regarding the leading role of medical professionals in the decision-making process for end-of-life patients.

Topics/Units of meaning	RUs (n)	RUs (%)	Subcategories	Category
Legally and socially, who makes the final decision according to the residents?	37	100	Centralized decision-making	**The decision-making process for end-of-life patients**
Residents' lack of autonomy to suggest courses of action	45	62.5	Residents' difficulties participating in the decision-making process	
Medical teams not adopting suggestions	27	37.5		
Multi-disciplinary decision-making	32	100	Multi-disciplinary decision-making	
Shared decision-making	66	75.9	Decision-making is shared with patients and family members	
Decision-making is not a shared process	21	24.1		
The patient doesn't want to take part in decision-making	4	11.8	Other challenges related to decision-making	
Participation of the professionals from the sector in the decision-making process	19	55.9		
Palliative Care is associated with the end of life	5	14.7		
Decision-making is delegated (letting the family decide the “therapeutic plan” technical part)	6	17.6		

Notes: RUs – Registration Units
Figure 1: Construction of the analytical categories: The decision-making process for end-of-life patients. Rio de Janeiro, RJ, Brazil, 2024.

This leading role is not only present in the form of leadership and articulation of the inter-disciplinary teams' various knowledge areas, but mainly in centralized decision-making. This hierarchical and uneven distribution in the teams' power relations give rise to noticeable discontent in the residents, as we can see in the following testimonies:

> *[...] unfortunately it stands out, I don't think that's true, but the medical team certainly stands out in the decision [...] (R4)*
>
> *[...] theoretically, it'd be a multi team to make palliative decisions, but what I see the most is the doctor coming and gaining ground, calling the family and telling them what's going to happen [...] (R5)*
>
> *[...] it's the medical team that always makes the final decision. Everything needs to have the medical team's green light [...] (R6)*

Bioethical grounds used to guide decision-making

This category encompasses 170 RUs and 04 subcategories that explore what residents know about bioethical grounds as aids for Palliative Care (Figure 2).

Topics/Units of meaning	RUs(n)	RUs (%)	Subcategories	Category
Respect for the patients' autonomy	77	63	Respect for autonomy: A principle under construction	**Bioethical grounds used to guide decision-making**
Patients' heteronomy in cases where it is impossible to make a decision	13	10		
Clinical impossibility to fulfill the patients' wish	4	3		
Using Ethics/Bioethics in decision-making	30	24		
Difficulty making decisions for non-cancer patients	5	38.5	Non-maleficence does not fight dysthanasia	
Eating as a type of care or abandonment (no diet)	8	61.5		
Moral conflict/distress in decision-making	8	40	Beneficence as a moral imperative of health categories	
Customization of the institutional routine in an individualized way for end-of-life patients	12	60		
Presence of a Palliative Care team	13	100	Complex incorporation of Justice in decision-making	

Notes: RUs – Registration Units
Figure 2: Construction of the analytical categories: Bioethical grounds used to guide decision-making. Rio de Janeiro, RJ, Brazil, 2024.

Decision-making for end-of-life patients can give rise to moral and ethical conflicts in the health professionals involved. For these conflicts to be properly handled, it is important to employ a bioethical resource or tool to solve them, or at least mitigate them.

The testimonies evidence certain unawareness regarding the bioethical principles and difficulties in their practical applicability in decision-making for end-of-life patients; however, they make it clear that respect and autonomy are seen as an extremely important principle:

> *[...] I always have to respect the patient's will [...] as I also said, if the patient is lucid, oriented, he has to be there, he needs to decide for himself, I think the companion has to provide support there, due to the patient's issue, whichever it was. (R1)*
>
> *[...] the Bioethics class really got a hook on me, it made me reflect on these death issues and what mainly drew my attention in the classes was understanding that the dying process can also be the patient's decision [...]. (R3)*
>
> *[...] he (patient) wants to know what's happening, even about the diagnosis, sometimes the family speaks so as not to talk [...]. (R4)*
>
> *[...] in relation to end-of-life care, I remember the professor commenting more in relation to the decision of not implementing invasive measures for example, no resuscitation maneuvers, that this has to be consulted with the family, recorded in the medical history. I think it's more to protect health professionals in relation to stances and problems right away. (R12)*

The ideal and real worlds in the decision-making process

This category encompasses 265 RUs and 04 subcategories that signal issues related to the importance of joint work and inter-disciplinary approaches in the assistance provided to the patients (Figure 3).

Topics/Units of meaning	RUs (n)	RUs (%)	Subcategories	Category
Multi-disciplinary performance is seen as a care ideal	43	50.6	The ideal decision-making process according to the residents	**The ideal and real worlds in the decision-making process**
Communication as an important care factor	17	20		
Adapting language for the patients and families to understand	7	8.2		
Presence of a preceptor as a way to optimize the residents' learning	4	4.7		
Patients' right to receive information	9	10.6		
Palliative Care early initiation	5	5.9		
Patients' heteronomy in cases where it is impossible to make a decision	13	14.1	The decision-making process reality according to the residents	
Errors in courses of action due to lack of communication	14	15.2		
Poor interpersonal relationships across different categories, hindering therapeutic courses of action	7	7.6		
Death as a taboo topic	7	7.6		
Cure-focused model	22	24.2		
Poor communication skills to approach the patients and families	13	14.1		
The team questioning decisions	11	11.9		
Insufficient number of professionals	2	2.1		
Rounds are implemented in Collective Nursing (breach in information confidentiality)	3	3.2		
Contact with the topic of death and dying during undergraduate studies	25	44.6	Flaws in teaching about how to manage end-of-life patients during undergraduate studies and residency	
Contact with the topic of care for end-of-life patients during undergraduate studies	26	46.4		
Contact with the topic of care for end-of-life patients during the residency	3	5.3		
Change in the perspective towards decisions after having contact with theoretical knowledge about Bioethics	2	3.7		
Presence of content on Bioethics during the residency	32	100	Limited Bioethics teaching during the health area multi-professional residency	

Notes: RUs – Registration Units
Figure 3: Construction of the analytical categories: The ideal and real worlds in the decision-making process. Rio de Janeiro, 2024.

The need stands out for multi-disciplinary teams to discuss the decisions regarding the patients' treatments, communication, the patients' right to receive information and early referring those with advanced-stage and irreversible diseases to the institutions' Palliative Care services and to break away from the hospital-centered and cure-focused paradigm despite progress in knowledge about Palliative Care, with the approach to life finitude in academic teaching presenting itself as the ideal way to make decisions in the case of end-of-life patients:

> *[...] I think they should be jointly made, even because the patient's clinical condition is complex. It's not just Nursing there in care; there are other categories, other knowledge areas and other approaches. (R23)*
>
> *[...] I believe there's a problem there and that lack of communication is the most severe situation here in the hospital. That's what I think. And lack of communication doesn't lead to discussing cases [...]. (R03)*
>
> *[...] I know it's not a simple protocol thing, but teaching some techniques to give bad news. I know there are protocols and other things. But anyway, for us to have some model to follow. (R08)*
>
> *[...] We can even handle how this news will be given, when and with what aid, but I think it's very complicated to deny the user's health information without him having requested so. (R06)*
>
> *[...] even patients with chronic conditions, where we know that the outcome won't be a cure, we postpone and don't refer to Palliative Care. (R16)*
>
> *[...] The other residents too, I don't see them talking about this. I don't see them at all. I think they also find it awkward to talk about Palliative Care, I don't see them talking about that. (R15)*
>
> *[...] I was trying to prolong life, but not quality of life, just time. It was pretty much like that. (R04)*
>
> *[...] This theme wasn't worked on; as it's a generalist profession, it encompasses various social policies, we can work in various fields and health is one of the main ones, but when we take part even in the specific disciplines, we end up addressing the issue of the SUS legislation more, we don't deepen much on the practice in relation to finitude and don't address this theme (R06)*

DISCUSSION

As for characterization of the sample, despite having concluded their undergraduate studies a few years before entering the residency program, the participants included in this study stand out for their qualifications. The qualifications presented show the participants' high investment in the initial years of their careers to better complement their training and expanding their performance field.

The decision-making process for end-of-life patients was the first category analyzed based on the testimonies. In the scope of the decision-making process for end-of-life patients it is important to note the singularity inherent to this moment for all those involved (patients, family members and multi-professional teams). On one side, there is the patient with his/her entire past and a family that wishes to perpetuate his/her life[16]. On the other, we find the figure of the physicians and the multi-disciplinary teams with the tough mission of helping lead this terminality process in the best way possible without giving rise to any rupture of ethical paradigms or even to judicialization by the families.

The testimonies reveal that, currently and in contrast to the entire development of the health area professional categories, the medical category still holds not only the responsibility but also the moral and social duty of deciding the outcome in most of the cases involving end-of-life patients. In this sense, it is necessary to foster ways to modify this situation, as several studies point to the importance of interdisciplinarity and its "gold standard" in the care and management of end-of-life patients and their families[12,17,18].

On the other hand, the fact that interdisciplinarity is not yet a reality directly affects the outcome of the decisions made by the medical category, as these decisions can emerge as strong paternalism[11,19]. In other words, decision-making by health professionals (at first aiming at the patients' well-being) but totally disregarding their values, wishes and competence to make decisions related to their own case.

This power centralization in the medical category, namely these preceptors (staff members) or even the medical residents themselves, can be associated with the biotechnoscientific, cure-focused and hospital-centered culture on which training in the health area is based. In this sense, physicians are ill-prepared to deal both with end-of-life patients and with the implementation of due care and persist in obstinate therapeutic measures to maintain life at any cost[16].

A scoping review that included 40 studies mapped the diverse evidence on how multi-disciplinary teams make decisions about identifying patients in imminent death conditions, detecting that decision-making included disagreements between the team members and the fact that physicians were frequently considered as final or only decision-makers[18]. Therefore, it is not clear how each physician's experiences can be affected by discussing the issue with other professionals in team meetings. From this perspective, the perception is that centralization of the decisions in medical teams is a reality present in multi-disciplinary performance fields and which affects the outcomes in end-of-life patients.

As for the bioethical grounds used to guide decision-making for end-of-life patients, they can give rise to moral and ethical conflicts in the health professionals involved. For these conflicts to be properly handled, it is important to employ a bioethical resource or tool as guideline. The testimonies state certain unawareness regarding the bioethical principles and difficulties in their practical applicability in decision-making for end-of-life patients.

In its discussion, the study by Motta *et al.* includes a summary of some methods for decision-making in Clinical Bioethics. A thorough analysis of each clinical case in question is recommended to then apply the bioethical decision-making model comprised by seven stages (Identifying the problem; Analyzing the facts: the clearer they are, the easier the ethical analysis; Identifying the values involved; Identifying the values in conflict; Reformulating the problem; Identifying the fundamental conflict; Deliberating on the fundamental conflict; Decision-making; Safety criteria [defending the decision publicly and verifying whether it is against the law])[20]. This proposal foresees some interaction among Beauchamp and Childress' bioethical principles, with the possibility of being used as a guide for decision-making.

A study aimed at identifying the factors influencing health professionals' decision-making in the case of end-of-life patients evidenced some concern among the team members about respecting the patients' autonomy, safeguarding their dignity, acting with non-maleficence and preserving shared decisions. However, the results show the need for more discussions and training in Palliative Care to reduce ethical conflicts to a minimum[16].

The health professionals in contact with end-of-life patients should employ Bioethics in decision-making, respecting the patients' autonomy. They have to provide the necessary information and perspectives so that the patients can make informed decisions about the future of their treatments and how to improve their quality of life. In addition to that, these professionals should avoid causing unnecessary harms to the patients, thus preventing significant distress during the treatment.

Bioethically-based reflection about therapeutic decisions requires going beyond the Non-maleficence principle, as professionals should not only abstain from performing harmful actions but also adopt positive measures to assist the patients and their families. Therefore, acting in a way that benefits the patients while performing the profession becomes a moral duty to be pursued and not a mere medical moral ideal[11].

As in the case of Non-maleficence, we can infer that in order to attain the patients' full good, there needs to be an efficient communication process, argumentation and recording of these patients' values and principles so that the decisions to be made and the courses of action to be implemented can reach the maximum benefit possible considering the case in question, taking into account the technical and structural limitations inherent to the institutions where the patients are.

As for the “Ideal and real worlds” category in the decision-making process, the residents state that multi-disciplinary performance and shared decision-making present themselves as optimum way to make decisions for end-of-life patients; on the other hand, ineffective communication stands out as a factor intervening in the decision-making process.

The communication process is of utmost importance in health services, as it not only allows information exchanges among the various team members but also eases actions and decision-making when facing patients and family members. Not in vain, improving communication is one of the nationwide patient safety goals currently pursued and with certainly a lot to improve[21].

In the context of managing end-of-life patients, there is most often the need to convey hard news that will entirely change the patients' and family members' future perspectives. However, omitting critical information in the communication process can lead patients and family members to delay important decisions or even make them for not exactly knowing how the disease is evolving or the patients' current clinical condition.

In this relationship inherent to the management of end-of-life patients and their family members, the communication issue can be directly related to Beauchamp and Childress' bioethical principles[11], hurting respect for their autonomy or their right to receive information by limiting such information for better informed decision-making; or even the Non-maleficence principle since, in an attempt to reduce the patients' distress by omitting certain data, they may be harmed by non-decision-making due to lack of adequate information.

Another perception that stands out consists in the testimonies reporting about early referring patients with advanced-stage and irreversible diseases to institutional Palliative Care services. It is important to highlight that this referral is not merely transferring care between a healing team and a Palliative Care one, as early referral becomes fundamental to plan treatments, aiming at reducing the patients' and their family members' distress[8,22,23].

In this same line of thought, in partnership with the World Health Organization, the Worldwide Palliative Care Alliance (WPCA) launched the first version of the Global Atlas of Palliative Care at the End of Life, highlighting that referrals should be made early in time (well before the terminal phase) and encompass a wide range of chronic conditions at the global level[24].

Another important aspect for the ‘ideal world’ is breaking away from a paradigm centered on the cure-focused model on which health assistance is still based, scarcely adapted to the issues related to end-of-life patients. Palliative Care services should be provided by multi- and inter-disciplinary teams in a humanized and individualized way. Its focus is not curing a disease but comprehensively caring for the person[25].

A review study identified that the professionals seek to ground their actions on the bioethical principles; however, although guided by a common principle, there is certain difficulty promoting such actions due to essentially cure-focused training, in addition to a variety of personal actions and views that can exert an influence on decision-making[26].

The testimonies reveal that the bioethical principles are either superficially addressed or not addressed at all during the professional training process, hindering their application for assertive and ethical decision-making. GM/MS Ordinance No. 3,681 of May 7th, 2024, was recently enacted in Brazil. it instituted the National Palliative Care Policy (*Política Nacional de Cuidados Paliativos*, PNCP) in the scope of the Unified Health System (*Sistema Único de Saúde*, SUS), with stimulating continued training and education, appreciation, provision and management of the Palliative Care work force in the SUS scope as one of its objectives, in addition to encouraging continued training and education of professionals[27].

For good-quality inter-disciplinary care, it is understood that the bioethical principles need to be included in health professionals' routine as a guide for decision-making; to such end, it is of utmost importance to incorporate or optimize this knowledge both in undergraduate courses and in multi-professional residency programs and as part of continuing education for the professional already working in the area.

Beauchamp and Childress' bioethical principles provide ethical grounds to implement a practice that respect the patients' rights and promotes dignified end-of-life assistance[11,26]. However, the residents' testimonies reveal superficial knowledge, resulting in limited performance with end-of-life patients.

Therefore, leveraging the results of this study will not only contribute to expanding knowledge in this topic area but also to future research studies. In the academic teaching area, the research will contribute by providing a reflection on the multi-professional and medical residency students' in-service training regarding end-of-life patient care, with the possibility of enabling improvements in academic articulation on the theme and optimizing the curricular structures of these important in-service graduate programs.

Study limitations

This study was conducted with students from three residency programs in a single Brazilian state; in addition, it is not possible to generalize the results according to the scientific method, thus requiring further studies on this theme to confirm or refute these data.

The management of end-of-life patients requires significant interaction between multi-disciplinary team professionals, patients and family members, with a significant emotional burden involved that can give rise to understanding conflicts, disagreements in courses of action and health judicialization.

FINAL CONSIDERATIONS

This study allowed performing an analysis based on the residents' testimonies about the therapeutic decision-making process for end-of-life patients in the light of Beauchamp and Childress' bioethical principles. It is considered that this reflection becomes necessary from the professional training and specialization process, and the model proposed by Beauchamp and Childress serves as a guiding beacon for the therapeutic decision-making process for end-of-life patients.

The testimonies reveal that, even if the care provided to end-of-life patients should be multi-disciplinary, the therapeutic decision-making process is centered on medical professionals. In addition, they evidence superficial knowledge about the bioethical principles, which can give rise to moral and ethical conflicts for the health professionals involved.

So that these conflicts can be adequately handled, it is important to implement team discussions about the decisions regarding the patients' treatments, improve communication between professionals, patients and family members, respect the bioethical principles and early refer patients with advanced-stage and irreversible diseases to Palliative Care. To such end, it becomes necessary to advance towards breaking away from the hospital-centered and cure-focused paradigm already during academic training, which emerges as the ideal way to make decisions related to end-of-life patients.

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Author's contributions

Conceptualization, F.G.F. and C.M.A.C; methodology, F.G.F., C.M.A.C. and B.D.C.; formal analysis, C.M.A.C., L.A.C.T. and A.S.C.; investigation, F.G.F.; data curation, C.M.A.C. and A.S.C.; manuscript writing, F.G.F. and C.M.A.C.; review and editing, F.G.F., C.M.A.C., B.D.C., L.A.C.T. and A.S.C.; visualization, , F.G.F., C.M.A.C., B.D.C., L.A.C.T. and A.S.C.; supervision, C.M.A.C., L.A.C.T. and A.S.C.; Project administration, F.G.F., C.M.A.C. and B.D.C. All authors read and agreed with the published version of the manuscript.

Use of artificial intelligence tools

Authors declare that no artificial intelligence tools were used in the composition of the manuscript "*Residents facing finitude and the therapeutic decision-making process: a qualitative study*".