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REVIEW

Intensive Care and Death with Dignity: Ethical, Clinical and Regulatory Aspects at the End of Life

Cuidados Intensivos y Muerte Digna: Aspectos Éticos, Clínicos y Normativos en el Final de la Vida

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ABSTRACT

Introduction: Intensive care units (ICUs) were designed to care for critically ill patients who require continuous monitoring and specialized care. These units use advanced technology, such as mechanical ventilation and hemodialysis, to sustain vital functions. However, prolonging life in critical situations raises ethical dilemmas, especially in cases of terminal or brain-dead patients. The implementation of disproportionate measures may prevent a dignified death, diverting natural death. In this context, the right to a dignified death, regulated in countries such as Argentina by Law No. 26742, which protects patient autonomy in the final stage of life, was discussed.
Development: Studies analyzed the application of regulations on dignified death and palliative care in different contexts. The results indicated that many professionals were unaware of key aspects of the legislation, although they respected basic ethical principles. Protocols for diagnosing brain death were based on rigorous clinical criteria and confirmatory techniques such as electroencephalogram. However, barriers to ensuring a dignified death included the lack of training in ethical and cultural aspects, the absence of updated protocols, and difficulties in communicating with family members. These factors limited the effective implementation of advance directives and informed consent.
Conclusions: ICU care and end-of-life management required a combination of technical expertise and ethical sensitivity. Continuing education of healthcare personnel, development of clear protocols, and promotion of a humanized approach were essential to respect patient dignity and autonomy, providing adequate palliative care and allowing informed decisions in terminal situations.

Keywords: death with dignity; critical patients; palliative care; medical ethics; patient autonomy.

RESUMEN

Introducción: Las unidades de cuidados intensivos (UCI) se diseñaron para atender a pacientes críticos que requieren monitoreo continuo y atención especializada. Estas unidades utilizan tecnología avanzada, como ventilación mecánica y hemodiálisis, para sostener las funciones vitales. Sin embargo, la prolongación de la vida en situaciones críticas plantea dilemas éticos, especialmente en casos de pacientes terminales o con muerte encefálica. La implementación de medidas desproporcionadas puede impedir un fallecimiento digno, desviando la muerte natural. En este contexto, se debatió el derecho a una muerte digna, regulado en países como Argentina por la Ley N° 26742, que protege la autonomía del paciente en la etapa final de su vida.
Desarrollo: Estudios analizaron la aplicación de normativas sobre muerte digna y cuidados paliativos en distintos contextos. Los resultados indicaron que muchos profesionales desconocieron aspectos clave de las legislaciones, aunque respetaron principios éticos básicos. En tanto, los protocolos para diagnosticar muerte encefálica se basaron en criterios clínicos rigurosos y técnicas confirmatorias como el electroencefalograma. Sin embargo, las barreras para garantizar una muerte digna incluyeron la falta de formación en aspectos éticos y culturales, la ausencia de protocolos actualizados y dificultades en la comunicación con los familiares. Estos factores limitaron la implementación efectiva de directivas anticipadas y el consentimiento informado.
Conclusiones: La atención en las UCI y el manejo al final de la vida exigieron una combinación de conocimientos técnicos y sensibilidad ética. La educación continua del personal sanitario, el desarrollo de protocolos claros y la promoción de un enfoque humanizado fueron esenciales para respetar la dignidad y autonomía del paciente, brindando cuidados paliativos adecuados y permitiendo decisiones informadas en situaciones terminales.

Palabras clave: Muerte digna; pacientes críticos; cuidados paliativos; ética médica; autonomía del paciente.

INTRODUCTION

Intensive care units (ICUs) are services intended for hospitalized critical patients who require continuous specialized professional care, the frequent use of certain specific materials, and some technologies necessary for diagnosis and treatment. These units are staffed by a highly specialized health team, which provides precise, continuous, and immediate care to patients suffering from conditions such as heart, kidney, and/or respiratory failure, surgical pathologies (major surgeries with or without associated complications, transplants), polytrauma, neuro-intensive care, shock, among others. The length of stay of these patients depends on their condition and/or severity. A critical patient is considered to be any individual whose one or more main physiological systems are compromised, with a loss of self-control, which may be reversible.

In today's complex world, we will inevitably face ethical questions in all aspects of life, but more specifically in the field of health. Here, we try to understand some moral issues that influence people, such as certain advances in technology and genetics and less health care and financial resources. Today, sophisticated technologies (for example, in resuscitation, mechanical ventilation, hemodialysis, and nutritional therapy, among others) make it possible to prolong life well beyond the point at which death would have occurred in the past. Some expensive experimental procedures and drugs can be used in an attempt to prolong a person's life, even when the trial is likely to fail. Despite the advantages offered by these advances, the circumstances in which it is appropriate to apply them have been questioned, as many people receive a better quality of life. Still, others experience continuous suffering due to repeated attempts to prolong their lives.

There are patients considered "terminal" who, due to certain conditions, have a life expectancy of no more than six months. If disproportionate measures are applied to them, this would be a deviation from natural or expected death. They would not be able to enjoy the right to a good death. These are mechanisms related to protecting life, sustaining it, and avoiding anything threatening it. Therefore, the ethical problems associated with a dignified death must be studied in depth from an interdisciplinary perspective so that the final journey of the human being is as dignified as possible.

General objective

To analyze the ethical, clinical, and technological aspects related to the care of critical patients in intensive care units (ICUs), with emphasis on the implications of the use of advanced technologies and the application of disproportionate measures, as well as on the need to guarantee the right to a dignified death through an interdisciplinary approach that respects patient autonomy.

DEVELOPMENT

Background

- According to Quiñonez Pérez et al. (2014) in their research study called Knowledge and application of the law of "dignified death" among hospital emergency room professionals. This was a cross-sectional study using a closed questionnaire for all medical and nursing staff, which collected sociodemographic and qualitative variables that gathered Knowledge of Basic Law 41/2002 and Regional Law 2/2010 and essential aspects included in the latter (decision making, information, family support, spiritual assistance, pain control and the existence of a register of advance directives). The results concluded that most professionals are unaware of the content of both laws. However, the majority of professionals respect and apply the fundamental aspects of these.
- The research project entitled "Application of Law No. 26742 'Dignified Death' by nurses in the care of terminal patients at the Dr. Guillermo C. Paterson Hospital" was written by L., S Alemán and L. A. Gareca (2018) as a requirement to obtain a degree in Nursing. Its objective was to find out if nurses apply law no. 26742 "dignified death" in the care of terminal patients hospitalized in the months of March-July 2019, with a quantitative, descriptive and transversal methodology. It was carried out by observing all the nursing staff on the three shifts, considering three dimensions of the variable to be worked on, which were assigned a value. These are respected for the autonomy of will, compliance with advance directives, and a specific score criterion that had to be met to consider the third dimension of a dignified death. This work is justified by the observed reality of these types of patients without accompaniment, the absence of up-to-date protocols, the non-compliance with advance directives, and the lack of research in the country. The contribution of the results would enrich Knowledge with the increase of theoretical content relevant to the discipline, making it possible to recognize shortcomings in applying the law.
- The study entitled "Knowledge of the law and preparation of healthcare personnel in the process of caring for the dying," written by Torres-Mesa, Schmidt-Riovalle, and Garcia-Garcia (2012), aimed to ascertain healthcare professionals' perception of their preparation in caring for the terminally ill and to determine their Knowledge of palliative care legislation. A descriptive cross-sectional study in a trauma hospital in Granada (Spain) in April using a questionnaire with questions on variables of sex, age, professional category, year of graduation, work unit, and type of contract, as well as questions based on preparation and Knowledge of palliative care legislation. The results indicate that most professionals have worked with patients at the end of their lives, but only half consider themselves prepared. Some are unaware of current palliative care legislation, and while the majority would consider the withdrawal of life-sustaining therapies, they are unaware of the mechanism for reporting compliance with living wills.

The qualitative study called The Right to die with DignityDignity in an Acute Hospital, written by Sepulveda-Sanchez et al. (2014), aimed to explore the perceptions, beliefs, barriers, and facilitators encountered by healthcare professionals who provide care to terminal cancer and non-cancer patients

about the right to die with DignityDignity in an acute hospital and the applicability of the provisions of Law 2/2010. The results showed that there are different obstacles to guaranteeing patients' rights in the process of dying and to the fulfillment of the duties of healthcare professionals and institutions and that these obstacles depend on the characteristics of the patient and the family, the characteristics of the professional, the organization of care and cultural factors. The study highlights the need to improve the process of communication with the patient and their family and to encourage decision-making, establish clear measures for palliative sedation and the limitation of therapeutic effort, in addition to promoting the application of the law on dignified death, and advance directives in specialized non-oncological areas. Providing more training in the ethical, spiritual, and anthropological aspects of care is also necessary.

Patients with irreversible cessation of brain functions

The issue of brain death under neurological criteria emerged in medicine in the second half of the 20th century, following the development of modern Intensive Care Units and their procedures for supporting the so-called vital functions of respiration (mechanical ventilation) and the heart (inotropic drugs), enabling doctors to artificially maintain the functioning of the organs of the human body, after the complete and irreversible destruction of the encephalic structures (brain and brainstem) (Ministry of Public Health of Ecuador, 2015)

Dr. Uriarte-Méndez (2006, p.59) defines brain death (BD) as "a devastating and widespread injury to the brain, which clinically translates as a coma or irreversible vegetative state with cardiorespiratory functions maintained by mechanical ventilation, oxygen, and glucose. BD involves the cessation of the three brain functions: respiratory, motor reflex, and vigilance or consciousness, without administering drugs that depress the central nervous system (CNS) or muscle relaxants and without induced hypothermia. It is the result of an ischemic cascade initiated by brain damage, almost always severe cranioencephalic trauma or an anoxic, metabolic, or infectious lesion of the brain".

For their part, Abaroa and Garreto (2013) define brain death as "a condition determined by the complete and irreversible cessation of the functions of the cerebral hemispheres and the brainstem. The most frequent causes in adults are intracerebral hemorrhages, traumatic brain injuries, and hypoxic-ischemic injuries secondary to cardiorespiratory arrest. Whatever the cause, BD occurs when intracranial pressure exceeds the patient's systolic blood pressure, leading to cerebral circulatory arrest".

So much so that these injuries lead to death because vital centers are located in these structures, without which it is impossible to live. Among others, the centers that regulate and enable breathing, cardiocirculatory regulation, or more complex functions such as awakening or the connection with both external and internal stimuli, whose function is indispensable for life. (Álvarez, 2014, p. 4)

A brain-dead person is entirely unresponsive to external stimuli; that is, the person loses their connection with their environment and is therefore unable to perceive pain and is also in an unresponsive state about their cranial reflexes. The patient will be unable to breathe independently, will have to be kept breathing by a mechanical ventilator, and will not have gag reflexes. Some osteotendinous spinal reflexes may be present, which are performed with the withdrawal of the hammer, giving voluntary reflexes that do not involve the brain. (López-Romo et al. 2022)

- Clinical diagnosis of brain death

The clinical diagnosis of BD requires absolute certainty, which is why a systematic, strict, and rigorous protocol must be followed. The three diagnostic pillars are: a) to know the cause of the brain injury, b) to rule out disorders that could simulate brain death (current or relatively recent hemodynamic, metabolic, pharmacological, and toxic conditions), and c) to carry out a regulated neurological examination. (Castro et al. 2008)

1. Structural coma, of known origin and irreversible damage
2. General clinical conditions during neurological examination:

a) Cardiocirculatory stability
b) Adequate oxygenation and ventilation

c) Absence of severe hypothermia
d) Absence of significant metabolic diseases
e) Absence of toxic substances or drugs that depress the central nervous system
3. Neurological clinical examination
a) Cerebral neurological examination:
Coma or arousal
b) Brain stem neurological examination
Absence of photomotor reflex
Absence of corneal reflex
Absence of oculocephalic reflex
Absence of oculovestibular reflex
Absence of gag reflex
Absence of spontaneous breathing
Absence of response to atropine test
4. Spinal motor activity may exist, both reflex and spontaneous
5. Observation period
6 hours, modifiable at medical discretion according to type and severity of injury
6. In infratentorial injuries
Clinical examination + electroencephalogram or an instrumental diagnostic method that confirms the absence of function of the cerebral hemispheres

- Techniques to confirm brain death

Confirmatory techniques are artificial techniques that evaluate certain aspects of the function of the central nervous system or intracranial arterial circulation. They provide additional or indicative data. As their name suggests, they are confirmatory, a concept that implies the prior and, without exception, completion of the neurological examination protocol for the patient. They can be classified into two groups: a) those that evaluate the electrical activity of the nervous system, such as electroencephalogram and evoked potentials, and b) those that evaluate cranial arterial circulation, such as arteriography of the four cerebral, vertebral, and internal carotid vessels, hexamethyl-propylene amine-p-phenylene isophorone (HMPAO) brain scintigraphy and transcranial Doppler (TCD) (Castro et al. 2008)

1) Electrophysiological
a. Electroencephalogram
b. Multimodal evoked potentials
2) Which evaluate cerebral blood flow
a. Transcranial Doppler sonography
b. Four-vessel cerebral arteriography
c. Digital subtraction cerebral angiography (arterial or venous)
d. Spiral CT angiography
e. Cerebral scintigraphy with 99mTc-HMPAO or other diffusible radiopharmaceuticals.

Dignified death

Human life ends with death; it is an inexorable and unavoidable fact. All living beings will die at some point in their history; that is the "law of life." But we do not always die as we want or as we should. (Álvarez, 2014, p.2).

The term dignity (dignitas in Latin) refers to a person's subjective concept of themselves: how they conceive their life, achievements, and place in the world. (Pfeiffer, 2012)

Death is not a topic of conversation when there are things to talk about, and although it is a fact of life that we must also die, nobody plans how they would prefer to do so. What these authors are pointing out is that although it may seem somewhat "raw and cold," it is true that the life of a human being ends with their death on earth at some point in history, and how the individual perceives their passage through

life has a lot to do with it, whether they have found, built and maintained sufficiently solid and lasting bonds to find meaning in it, indicating that they have deserved a good life.

The debates and references to "dignified death" and "good dying," which can be traced back a long way, acquired new meaning and relevance from the process of medicalization and technification of the end of life in the West, involving professionalization and advances in the medical field, as well as cultural, demographic and epidemiological changes. (Alonso, Villarejo & Brague, 2017, p. 1032).

Issues such as changes in lifestyle and increased life expectancy, as well as technological advances in medicine, such as mechanical ventilation, dialysis machines, and artificial feeding, to mention a few, are among the great discoveries that have made it possible to continue life conventionally and to demonstrate what we mean when we talk about dying with dignity.

According to Ousteda (2016), in current thinking, dignified death "refers to the quality of existence in the final part of life, respecting the will of the patient, without pain and being contained and accompanied by their loved ones."

For Álvarez (2014), it is death that, desired by a person, occurs with the assistance of all appropriate medical palliative care, relief, and all possible human comforts.

In more general terms, it would be the right to die with dignity, assisted with all the appropriate medical relief when it is inevitable that medical science can no longer cure an illness, avoiding the prolongation of agony or unnecessary suffering. (Villareal González, 2013, p. 12)

Law No. 26742 Dignified Death

In the last years of our lives, an externality alien to us settles on us inconsiderately and forces us to reflect on this. Are we human beings the holders of rights? If this is the case, do I have the right to choose how I want to die? Concerning my individuality and human dignity, can others decide for me? (Álvarez, 2014, p. 2)

Law No. 26742 was passed on May 9, 2012. It was adopted in Argentina as part of social demands and after long ideological discussions to strengthen the autonomy of the patient's will and legitimately objectively take a step forward in the field of human rights, protecting rights and guarantees of human dignity both during life and at death.

National law no. 26529, the "law on the rights of patients in their relationship with healthcare professionals and institutions" in our country since 2009, comprehensively regulates patients' rights, medical records, and informed consent. With a general scope, this public policy was modified by law 26742 in 2012 to emphasize the human person's rights regarding a good death. It is expressly incorporated into our legal system by amending articles 2°, 5°, 6°, 10° and 11° of the law on patients' rights (no. 26529) and adding an article to the same law, 11 bis, and a subsection to article 7. (Villareal González, 2013, p. 18)

Precisely in our country, the current law (26742) and its regulatory decree on death 1089/12 aims to protect the dignity of the person and respect for their will, granting the terminally ill the possibility of "accepting or rejecting surgical procedures, hydration, feeding, and artificial resuscitation, when they are extraordinary or disproportionate to the prospects of improvement and produce excessive pain and suffering." Consequently, the law grants, through a specific right, the possibility of choosing whether or not to continue artificially with life when there are no real prospects of improvement. (Villareal González, 2013, p. 18).

The law on dignified death is based on some main concepts that are detailed below (excerpted verbatim from Law No. 26742):

- Freedom of will: the patient has the right to accept or reject specific medical or biological therapies or procedures, with or without giving a reason, and to revoke their declaration of will subsequently.

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- Informed consent: this is the declaration of sufficient will made by the patient or by their legal representatives, if applicable, issued after receiving, from the intervening professional, clear, precise, and adequate information concerning:

a) their state of health
b) the proposed procedure specifying the objectives pursued
c) the expected benefits of the procedure
d) the foreseeable risks, discomforts, and adverse effects
e) the specifications of alternative procedures and their risks, benefits, and harms to the proposed procedure
f) the foreseeable consequences of not carrying out the proposed procedure or the specific alternatives
g) the right to refuse surgical procedures, hydration, nutrition, artificial resuscitation, or the withdrawal of life support measures that are extraordinary or disproportionate about the prospects of improvement or that have the sole effect of prolonging the time of an irreversible and incurable terminal stage of the disease, if the person suffers from an irreversible or incurable illness, or is in a similar situation
h) the right to receive comprehensive palliative care for their illness or condition.

- Advance directives: any capable person of legal age can have advance directives regarding their health, being able to consent to or refuse specific medical, preventive, or palliative treatments and decisions relating to their health. The directives must be accepted by the doctor in charge, except for those that involve the development of euthanasia practices, which will be considered non-existent. The declaration of will must be formalized in writing before a notary public or court of first instance, for which the presence of two (2) witnesses will be required. This declaration may be revoked at any time by the person who made it.

CONCLUSIONS

The review addressed the complex ethical and clinical context of intensive care unit (ICU) care, particularly about the right to a dignified death and the processes associated with brain death. Care in these units is characterized by the high level of specialization of the healthcare team and the intensive use of advanced technologies, which, although they have made it possible to prolong life in critical situations, have also raised serious ethical dilemmas regarding the proportionality of the treatments applied and their impact on the quality of life of patients.

Advances in medicine and technology have increased life expectancy, but they have also highlighted the need to establish ethical limits in end-of-life care. This challenge is reflected in legislation, such as Law No. 26742 in Argentina, which recognizes the right of the patient to decide on the treatments they receive in terminal situations. However, the studies analyzed revealed that, despite the existence of regulations, a significant proportion of health professionals are unaware of key aspects of the legislation on dignified death and palliative care. This lack of knowledge limits the guarantee of respectful care focused on patient autonomy.

The diagnosis and management of brain death are also critical areas within ICUs. Although clinical protocols provide precise tools for identifying this condition, their correct application requires technical skills, multidisciplinary evaluation, and confirmatory technologies. These practices must also be complemented by effective communication with the patient's relatives, respecting the process's medical and ethical aspects.

In the context of end-of-life care, it was observed that the barriers to ensuring a dignified death include organizational, cultural, and professional factors. Healthcare institutions and teams face challenges related to a lack of training in ethical and legal aspects, insufficient updated protocols, and difficulties in making shared decisions with the patient and their family. These limitations highlight the

need to promote continuous education covering technical knowledge and care's ethical, spiritual, and cultural elements.

The right to a dignified death implies respecting the patient's autonomy and providing comprehensive palliative care to alleviate pain and suffering in the final stage of life. Implementing advance directives, informed consent and family support are fundamental tools to guarantee a respectful and humanized process.

In conclusion, guaranteeing adequate care in ICUs and at the end of life requires a balanced integration of technical knowledge, professional ethics, and human sensitivity. Continuous training of healthcare teams, the development of clear protocols, and the promotion of interdisciplinary dialogue are essential strategies for facing current and future challenges in the care of critical patients, ensuring respect for their dignity and autonomy at all times.

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FINANCING

None.

CONFLICT OF INTEREST

None.

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