



Research Article

Ethics for Clinicians and Surgeons: End of Life Issues and The Brazilian Penal Law

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Imagine a situation posed by Hester [1] to illustrate a conflict that arises when we think of acting on behalf of a patient. He said: “We will consider you to be a good person, raised appropriately with ‘good’ values. Furthermore, we will recognize that, as a medical professional, you must act in the best interests of your patients, and as a citizen, you have been told that you should not kill another person. However, one day, one of your 65-year-old cancer patients, after unsuccessfully going through the third round of chemotherapy, asks you to speed up your death. He tells you that his life is unbearable and that dying while still having some dignity is the most important thing for him at that moment. Taking into account that you are a ‘good’ person and that you recognize your professional obligations, how can these two characteristics of yours help to solve this problem?”

It is a question of arguing the legal and moral justifications of euthanasia. Being a “good person,” with “good values” (moral justification) and, at the same time, respecting the legal norms (legal justification) - that is, a clear situation of inner conflict that can generate some chances of action, which, regardless of legal and moral justification, are possible to be taken.

The first is that you, moved by compassion, decide to shorten your patient’s life by injecting him with a lethal substance. This action is called active consent euthanasia because your patient requested it. However, suppose your patient was unconscious, and you still decided to apply the lethal substance to him. In this case, we will call such an act of nonconsenting active euthanasia because your unconscious patient did not request it. However, another situation may be possible. Due to the last round of chemotherapy, imagine that the patient entered a respiratory failure and coma picture, characterizing a terminal view. At this point, you can choose not to take any therapeutic measures, knowing that there is nothing left to do for him in terms of prognosis. Some authors

refer to this type of act as passive euthanasia. And yet, on the other hand, suppose that you decide to intubate the patient, keeping him under ventilatory assistance, with the use of vasoactive drugs, in an intensive care environment. For many, this type of action, in which the life of a terminal patient is prolonged, subjecting it to useless treatment and suffering, is called Dysthanasia.

Suppose further that the patient’s clinical condition deteriorates rapidly due to a state of pneumonia that is complicated by consequent septicemia, perceptual and recreational coma, with no electrical and metabolic activity in the brain (i.e., brain death) and you decide not to take a more therapeutic attitude, letting the disease run its course until the inevitable end, maintaining only clinical support of palliative care to avoid further suffering to the patient. We can call this act orthothanasia. Initially, it is necessary to take into account, from a purely legal point of view, that our Penal Code, in Article 121, prohibits “killing someone” (penalty of 6 to 20 years of imprisonment), even though, in the case of euthanasia, it may be alleged what the first paragraph of that same article prescribes: “if the agent commits the crime impelled because of relevant social or moral value”. Even in this case, the crime persists, and only the sentence can be reduced from 1/6 to 1/3 by the judge. In other words, euthanasia is a crime of homicide in our country. However, it can often be called “pious homicide.” As França [2], recalls, “our Code does not accept compassionate death as criminal exclusion: it just gave the judge the power to reduce the sentence.” Lippmann [3], on the other hand, affirms that euthanasia “is defined as the accomplishment of death, required by the patient and, in Brazil, it is vetoed by law and medical ethics.” Dysthanasia, on the other hand, is “the postponement of death, albeit at the cost of suffering” for the patient, and orthothanasia is “the possibility of a dignified death, letting nature take its course, according to the patient’s wishes and with family awareness. With orthothanasia - already regulated by Resolution No. 1,805 / 2006 of the CFM (Brazilian Council of Medicine) - it is not intended

to cause death. It is about not fighting death with excessive and disproportionate technology nor hastening it by intentional external action. The procedures are called palliative care, which seeks to bring comfort, relieve pain, respiratory distress, depression, and other symptoms that cause suffering. The decrease in lifetime is a predictable effect, without being desired, since the primary objective is to offer the maximum possible comfort to the patient, with no intention of causing the death event.” [3].

However, some do not see things clearly and put considerations that, in our opinion, are always useful in such controversial issues. France [2], for example, ponders that “in these ideas, one must distinguish what ordinary and extraordinary procedures mean”, or, in Lippmann’s terms [3], “excessive and disproportionate technology.” In this way, says França [2], “if a patient with intractable cancer needs a tracheostomy and the family refuses treatment because it considers it unnecessary and causes prolonged suffering, the doctor should not accept such a request, as this takes care of ordinary and necessary, including keeping the patient in a more comfortable situation. Suppose the same patient needed a series of renal dialysis. In that case, this procedure could be considered extraordinary, and the fact should be discussed with family members, evaluated under the principle of justice since the patient is subjected to uncomfortable conditions and the use of means that could favor salvable patients.”

Finally, it is necessary to consider from the legal point of view that what is conventionally called “assisted suicide” is also a crime. Thus, Article 122 of the Penal Code says: “Inducing or instigating someone to commit suicide or assisting them to do so. Penalty - imprisonment for two to six years, if the suicide is consummated or imprisonment for one to three years, if the attempted suicide results in a serious bodily injury”.

Kill and Let It Die

Although the Brazilian Penal Law is quite clear on the subject, from a moral point of view, the controversy is immediate. Genival Veloso de França [2], for example, is emphatic and peremptory: “Even if the patient is irremediably condemned to near death and in prolonged suffering, euthanasia is always, in any case, a homicide.” And he adds: “Euthanasia can be discussed in emotional or economic terms, but it will never find justification in man’s natural law and science. The legal and medical reasons are worth more in this respect”. It is a personal vision founded on the law and the interpretation of the Hippocratic principles of beneficence and non-maleficence. In “How We Die - Reflections on Life’s Final Chapter,” Sherwin Nuland [4], wrote: “I saw many people die in suffering, many families tormented by the sight of death without being able to do anything to help, to believe that my clinical observation was just a misinterpretation of reality.” Faced with a terminal patient, afflicted by atrocious suffering, how should we unmistakably interpret this reality? For Gillon [5], a

relevant question that the doctor must ask himself is: “What, if any, is the moral importance of the distinction between killing and letting die?” In other words, if we try to alleviate suffering by causing the patient’s death, or if we let life (death) take its course, are we breaking any existing rules of morality? One can argue that actions that result in undesirable consequences are always “morally worse” than omissions or failures of action that have the same unpleasant effects - an argument that Gillon himself called “doctrine of action and omission.” Returning to the issue of euthanasia, it is worth emphasizing here the importance of the voluntariness of the patient and his family.

Azevedo [6], states that those who “accept active euthanasia as a moral possibility accept it only due to a voluntary decision by the one who will die. Non-voluntary euthanasia, active or not, would represent a different situation. In this case, the question as to what is the will or decision of the one who suffers simply does not exist. However, some argue that in these cases, what is justified is the omission and not the action”. The problem is complex, depends on many variables, and can also be assessed from beneficence and non-maleficence. Imagine the same patient, who has metastatic cancer, and under which rests the order given by the head of the ward to “not resuscitate” in case of cardiopulmonary arrest - because, the doctor believes, that resuscitation would not bring any benefit to the patient and much it would probably bring you more damage and suffering. Suddenly, the patient suffers an acute infarction in front of the doctor, who deliberately does not resurrect him and, as a result, the patient dies. This is the typical case of omission - of “letting die” - in which the doctor justifiably believes that, generically, the patient will have no benefit from resuscitation.

Now consider the same patient, except that the infarction occurs during the night and the hospital on duty performs resuscitation maneuvers successfully. The patient is intubated, with assisted ventilation, and taken to the intensive care unit. The next day, when examining the patient, the ICU doctor diagnoses additional brain damage in the patient (without brain death), resulting in the brain being deprived of oxygen during the stop and deciding to disconnect it from the ventilation devices the patient dies. The detail here is that the ICU doctor was in a hurry to perform other tasks at the hospital and needed to leave work earlier.

In the first hypothesis, it is assumed that the doctor acted for good reasons for the patient’s benefit. In the second hypothesis, the intention to benefit the patient was left out. In other words, the omission in the first case, many would agree, was morally correct and justified, while in the second case, the action taken does not find an adequate justification. But, notice, at no time was there talk about whether or not the patient agreed with the order of non-resuscitation - because this is what happens in many hospital situations. Thus, if, as Azevedo [6], wishes (correctly),

active euthanasia can be accepted as a moral possibility only if it is voluntary, how could we explain and justify the omission of the first hypothesis? Frankly, it is challenging.

França [2], has a particular view of the “order not to revive.” For him, under these conditions, “the team will assess on a case-by-case basis. If you disagree because you understand that the patient has conditions for survival, you are correct in proceeding to resuscitation. Otherwise, if it is the family that insists on resuscitation maneuvers, and the team considers them to be unnecessary, inconvenient, and embarrassing, even so, the team must continue treating or delegating to the other team, as it is the patient and family’s decision to use the medical measures extraordinary and not those who assist the patient, even though it is the physician’s responsibility to define the moment of death.”

The living will

According to Lippmann [3], “a living will is a statement by a citizen showing - in cases where the terminality of life is reached, in chronic illnesses or serious accidents with no possibility of recovery - what are the treatments he wants to receive when death approaches, and, in particular, if you want to use palliative treatments (that bring

comfort) or aggressive and interventionist treatments. And also, what life support measures does he understand to be appropriate under these conditions, and which should be followed, even when he is unconscious and is no longer able to communicate with the doctor.” Any individual can sign the document over the age of 18, thoroughly enjoying his mental faculties, and therefore, can exercise his autonomy. “What is requested in the living will,” continues Lippmann [3], “prevails over the family’s wishes, and it is up to the doctor, by an ethical imperative expressed in Resolution No.995 of the CFM, to comply with the provisions of the anticipated directive of wills. The doctor must request that the document be incorporated into the medical record, and the desire expressed in it must be respected even when the patient is unconscious”. It is never too much to remember that the living will or advance will guidelines refer to orthothanasia, including palliative care, or the adoption of extreme measures – never concerning euthanasia or assisted suicide, which are crimes as we have already seen predicted in our Penal Code.

Final considerations

In our view, euthanasia, assisted suicide, and Dysthanasia is outside the basic principle of medicine: caring for the patient. Promoting death, helping it, or causing more suffering to the patient is not the doctor’s job (not to mention the fact that it is a crime provided for in our laws). Although this is the patient’s will. We respect the opinions to the contrary and the arguments used by those who defend euthanasia. Still, we can also argue, as Genival Veloso de França [2], that “in addition to its ethical, moral and legal implications, there could be an abuse of practice, misdiagnosis and wear on the doctor-patient relationship.” Medical arrogance must be combated in its two extremes: be it in which some are held in possession of all power against death, practicing Dysthanasia and causing more suffering to the patient, or in which some are held in possession of the power of death. We repeat, it is up to the doctor to take care and, at certain moments in the trajectory of a patient, all that remains: care and compassion. As the Catholic Church itself did, in the Declaration of May 5, 1980, of the Sacred Congregation for the Doctrine of the Faith, “one cannot impose on anyone the obligation to resort to a technique that, although already in use, is not yet in use free from dangers or is too costly. In the imminence of inevitable death, despite the means used, it is lawful to consciously decide to renounce the treatment that would give a precarious and painful extension to life, without, however, interrupting the normal care due to the patient in similar cases”.

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