

DIGNIFIED DEATH IN BRAZIL

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1 INTRODUCTION

All social spheres and stages of the life cycle have been impacted by the changes happened in the modernity. The increase of new techno-scientific instruments and apparatus reverberated in Medicine and definitely hit the health of people and the relationship between health professionals and patients, emerging in this march, the zeal to improve the quality of life and longevity.

Axiologically impregnated concepts such as human dignity, the notions of autonomy, freedom and property, used to ensure the dominant political and economic interests were adopted. The understanding about life and death, as well as other vital phenomena, also was altered to the extent that man has to put himself in the center of the universe.

In the mid-twentieth century, the possibilities of a die with dignity was openly discussed in face of the increasing number of patients terminally ill, due to various illnesses, bringing up arguments that could enhance the autonomy of patients changing the borderline between life and death. It was in this scenario that the instrument of the Advance Directives Will was coined, as a tool that could facilitate the choice of treatments and medical therapies for people in the end of life.

In this study, it is intended to bring to the discussion the history of death; the philosophical understanding of this phenomenon; to verify whether euthanasia and assisted suicide would be probable motivators of a slippery slope; whether orthothanasia would be a dignified way to die; to assess the actual validity of the constitutional right to dignified death in the Brazilian legal system and examine palliative care in the Brazilian reality, and respond, from that study, how the death of terminal patients has occurred in Brazil.

This short writing does not intend to deepen the notions of human dignity or explore the understanding of Advance Directives Will. The construction of this writing will be made by applying the deductive method of qualitative approach in national and foreign references, starting from general notions about death, end-of-life and palliative care, to then investigate the Brazilian reality.

2 HISTORY OF DEATH

Foucault (1984, p. 79-80) did not understand the modern scientific medicine, which emerged in the late eighteenth century and early nineteenth century, by pathological anatomy, as individualist. His position was that modern medicine is a social medicine. Modern medicine values the doctor-patient relationship. In the Middle Ages, medicine was individualist with rare collective manifestations of medical action. Capitalism did not contribute to the transit of public medicine to private, but, against that, socialized latter, in other words, socialized body as productive and labour force. Capitalist society employed in biological and somatic body as a “bio-political reali-

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ty”, so that the medicine is a biopolitical resource. For the Philosopher, in medical terms, body and health only took a prominent position in the second half of the nineteenth century.

The appearance of hospitals occurred in the second half of the seventeenth century with a view to a political and medical quarantine process, within the urbanization, especially French, of sanitizer objective within the urban medicine, in order to avoid crowds and endemic and epidemic events. At that time, individual coffin and family graves were created (FOUCAULT, 1984, p. 89).

The concern about the bodies at this stage was political-sanitary and the respect was for the living beings, imbued with a medical design and non-Christian religious. The scope of urban medicine was to maintain good circulation of water and air. The medicalization of urban medicine was supported by chemical activity. The transition to scientific medicine came from the social medicine, collective and urban, and not for private medicine, individualized, focused on the subject. Urban medicine passed to be moved thinking on the living conditions and salubrity (FOUCAULT, 1984, p. 90-93)

In his study of Foucault (1979), Menezes (2003, p. 104) notes that the author focused on the passage of care for the sick by family and religious to doctors and institutions. At the end of the eighteenth century, general hospitals were created, while the anatomical rationality and consistent practice were the basis of modern western medicine. Before that, however, the poor were grouped to die in care institutions. Since this new anatomical-clinical scientific discourse, medicine was transformed into the individual science, flourishing a new perspective of integration of death.

Foucault’s (1984, p. 93) thesis is that the English medicine of poor aimed at the control of body health of the poorest aiming to make them more able to work task and less threatening to the well-off classes. This model resulted in three parameters: a) medical care to the poor; b) administrative medicine focused on vaccination and control of epidemics; c) private medicine for those who could pay for it.

The medicine of the seventeenth and eighteenth centuries was individualized, so that the doctors did not know how to deal with the hospital realities. The medical intervention was on the patient and disease in crisis situations when needed to observe and monitor the evolution of the signs. Hospital medicalization began with maritime and military hospitals because of their economic disorder where goods and spices circulated emanating from the colonies. Hospitals became from institutions managed by religious and lay people to the hands of doctors (FOUCAULT, 1984, p. 102-103)

In the twentieth century, to death was attributed a new definition predominantly using machines, tools and practices that changed the borderline between life and death. It was introduced the “modern death, medicalized, connected to appliances, producer of functional bodies.” (KIND, 2009, p. 14). In this century, medicine, in combination with practice, machines and knowledge, provided better living conditions for people always incorporating new instruments. It was created, for example, the artificial respirator that attended the polio affected people in the United States equipping intensive care units that were extremely important for the care of wounded soldiers in World War II, with new techniques of resuscitation³ (KIND, 2009). This new scenario has allowed the opening of a moral problem: “bodies with life,” as only alive because linked to

³ The author makes some references to Hilberman’s works (1975) and Bendixen and Kinney’s studies (1977).

artificial devices thus remained bound by the need to maintain life, postponing death (KIND, 2009, p 14-15).

In 1957, the Society of Anaesthesiology sent to Pope Pius XII some issues around death, answered by the Pope (PIUS XII, 1957, p. 1031) through “The Prolongation of Life”. To the questioning about resuscitation, including in the cases of patients with no survival prospects, and on the compulsory withdrawal of devices in patients with deep unconsciousness and cardiac arrest by doctors, the Pope said that, in the absence of consciousness and without any hope of recovery, doctor should abide by the request of the family, when existing. In case of respiratory arrest, the appliances should be switched off by doctors. At that time, the criterion for death due to cardiac arrest was in force. But it was necessary to redefine death considering the cases of unconsciousness (KIND, 2009, p. 15-18).

In the 1960s, heated debates arose around the redefinition of death. In particular, the report “Definition of Irreversible Coma”, published by the Ad Hoc Committee in August 1968, that proposed the establishment of irreversible coma as a new criterion of death, or brain death. The criticism that followed the publication were many, but Jonas’s unfavourable position was relevant for believing that it legitimized the supply of organ transplant practice which were insufficient for the demands (KIND, 2009, p. 18-20).

Jonas (1997, p. 145-150) explains that the diagnosis of the Committee in relation to brain death (irreversible coma) was defined as long as brain activity, by verifying electro-encephalogram and brain physical activity resulted of the brain as the actions reflex and spontaneous breathing, was not found. The Committee understood that brain death was equal to bodily death, which meant that they would not investigate functional artificial resources, for example, respirators and other instruments for maintaining life, but making room for the practice of transplants organs.⁴ According to Jonas (1997), in “Against the Stream”,⁵ this new definition would only be valid if it made sense for the patient, who had no improvement expectations but the mere extension of his state. Jonas (1997) understands that the new definition can bring relief to the patient, to their relatives and medical resources, due to the prolonged coma of the patient. However, to say that the death definition is important in order to free organ transplants leads to inferences that do not relate to the patient and that merely vegetative existence has no meaning, in fact, would be

⁴ The Medicine Federal Council, in the Opinion n. 1.243/00, differentiated irreversible coma brain from brain death. In the latter, the patient has no brain function, working, however, some organs spontaneously or by the aid of drugs and devices. Brain death is defined in the Resolution n. 1.480/1997 of the same institution since the diagnosis: the cause of comatose syndrome must be known; absent reversible cause, such as poisoning or hypothermia, for example; lack of response to stimuli and the brain stem functions; apnea and unresponsive apnea test; presence of alterations in brain supplementary examination; variable observation period with two clinical trials, with time interval of six hours between the first and the second, the realization of an additional choice exam and, with twelve hours if not performed further examination. With brain death, the body is maintained with the help of apparatus. In the case of irreversible coma (PVS), the brainstem works at some extent with severe and diffuse lesions in the cerebral hemispheres compromising the reaction to stimuli and the cycle of sleep and wakefulness. Precisely because of the vital existence in irreversible coma is that exist some discussions whether it is better for the patient to keep him alive in these conditions. Both the Brazilian legislation and the Code of Medical Ethics do not allow the physician to facilitate actively the patient’s death. The latter enhances that doctors must not make use of extraordinary life-sustaining methods (CONSELHO REGIONAL DE MEDICINA DO PARANÁ, 2000). Organ Transplants Act, n. 9.434 / 97 on the disposal of bodies, states that only is permitted donation of organs if it is found brain death (BRASIL, 1997).

⁵ “Contra la Corriente” was published in the work *Philosophical Essays: From Ancient Creed to Technological Man* by Hans Jonas in 1974. The publication did not please the doctors of the time.

“donor cadavers”. It does not define death as a last end, but only creates a criterion that does not obstruct, for example, the removal of the artificial respirator (JONAS, 1997 p. 150).

Jonas (1997, p. 149-153) was invited by the University of California Medical Center in San Francisco to detail his position where he remained for a week discussing the criterion of organic spontaneity. There, he concluded that, in a situation of irreversible coma, the respirator and other devices keep the body except the brain. The philosopher drew a response that will be covered in detail over the next topic.

Death, as a philosophical object of discussion, gained major space among philosophers in the first half of the twentieth century, because of their own experiences with the phenomenon of death. Thus, Heidegger’s phenomenological existentialism served as a source for Levinas’s ethical critique of otherness, and more specifically in the context of medicine, for Jonas’s philosophy.

3 PHILOSOPHICAL UNDERSTANDINGS OF DEATH

Heidegger (2005a, p. 11-12), in *Being and Time*, developed the existential-phenomenological method, investigating the being-toward-death and ways of being of Dasein, being-there, from the ontical-ontological perspective of being in the world. The philosopher analyzed being between birth and death, claiming to be the end of being in the world to death, the end of power-be in existence.

Man is a being-in-world that feels anguished, said Heidegger (2005b, p. 17-20), he is a temporal being, a being-toward-death. When he claimed that the “pre-sence completed its course,” he meant that there is no way to avoid death that is a normal and time course. Being has the power to anticipate things and how he is with the death of others, he is aware of it, has experience on it. Reaching death is reaching its entirety. Death is no-longer-being-present, no-longer-being in the world, but it is like a body simply given. However, playing that way is to lose the phenomenal basis, that is, a dead body can be used for the pathologic anatomy, with the idea of life. In this case, it is a being without life. There is an ontological relationship with the dead person in funeral ceremonies. Those who are with him are in homage, so it is more than a simply given. This is the being-with the dead. The feeling of loss is of whom stays alive and not of the dead person, so the being-with-him. The dying is a phenomenon (not a given) that is comprised of existential way.

Man is an unfinished being-in-the-world and finds his entirety in the death of each presence that is irreplaceable. He is like a fruit that is directed to the maturation. The ending, however, does not always mean completeness, which is being-toward-the-end or not yet, that is not mature. “Death is a phenomenon of life” and “should be understood life as a way of being.” The ontic finding allows access data on the duration of the life of plants, animals and men, get data on multiplication and ways to die (HEIDEGGER, 2005b, p. 23-28).

Heidegger criticized the not metaphysical preoccupation with the finiteness of life, to the extent that vision sets inflexible bases of thinking. In this sense too, the difference between health and disease, and the medicalization as the traditional metaphysical paradigm should be replaced by existential concepts. Health begins to compose an “existential project” and instead of

metaphysical “person”, there is the “existing” (Dasein),⁶ a being that is in the world. Man makes himself constantly in time and history, and he does not have an essence whether moral whether rational. Dasein is finite, but indefinite. In Modernity, technique took a dominant position which did not stimulate thought, creation and revelation of being. The Heideggerian texts indicate that disease, since it would be an existential phenomenon could not be produced causally, because the modern medicalization may precede diseases and produce Daseins. Technical technologies have reduced their application to principlism as a way to solve conflicts (CABRERA; SALAMANO, 2014, p 119-122).

Lévinas (2000, p. 10-11), in *God, Death and Time*, points out that the “annihilation” of death is a “negative” attribute given to her, carved in anger and in order to take life of another person. Lévinas (2000) stands contrary to Heidegger’s assumption in thinking that death is something already certain, *a priori*, and that has an annihilating sense, therefore, for Lévinas (2000), death is not only that, it is also an emotional and intellectual relationship that includes knowledge about the death of others.

The behavioral expressiveness covers the biological being (same) and reveals him overcoming his own nakedness so that it is made a face from the being through which this being is expressed, but not indifferently. The other is different and touches the same (being). “Someone who dies: a face becomes a mask” by disappearing the expressiveness. It is an experience of the death of the other, therefore, not mine, but that maintain a relationship that goes beyond the biological, since it is someone (LÉVINAS, 2000, p. 11-12).

Lévinas (2000, p. 12) focus on face. In this section of the book, he describes the face in a phenomenological way. The face is not materialized and expresses the soul materialized as a structured thing, as a vague idea of someone. The soul manifests itself by the face. The question raised comes before the “to be or not be”. Death is not an empirical fact and it is not limited in what presents itself. The naked expression of the other, the face of this one, calls for the same, placing under the responsibility of the same - then, the same responds to the signals of the other. Regardless of debt to the other, this one is delivered to that one, in order the same takes care of the other. Same’s identity is affected by the death of the other, attributing to that one guilty.

Anxiety about death has to do with the notion of nothing assigned to it. The length of time requires mortality (LÉVINAS, 2000, p. 15-18). Being is not limited by time because he is related with infinite, with different. Death is not an annihilating time, but needed to infinity that will be produced. Dealing with death is a question of relationship (LÉVINAS, 2000, p. 19-20).

Death as an end demands the nontransferable responsibility for the other to such an extent that the same includes himself in the other’s death and takes it as the first death of the same. So, it goes beyond the idea of nothing (death) defended by Heidegger because of the honour to the other’s death. On the basis of the relationship with the infinite is the time (LÉVINAS, 2000, p. 43).

Valuable are Jonas’s contributions (1997, p. 149-153) about the definition of brain death. While on his mission at the Medical Center of the University of California in San Francisco, reported in the previous topic, he asked, “did the patient die?”; “what will happen to what remains

⁶ The proposal to use the Heideggerian term “existing” instead of “person” from the traditional metaphysics was made by Julio Cabrera in Montevideo, in 2004, at a meeting of Bioethics. The semantic value of “person” was linked to a “cartesian-baconian” from the perspective of human rationality (CABRERA; SALAMANO, 2014, p 119-120).

being a patient?”. Through these questions, Jonas (1997) did not intend to define death, but life and the concept of human being. His understanding was that the body cannot be treated as a mere thing, then, the life of a body without brain cannot be extended. Doctors should interrupt the connection of patients to devices. This is an axiological decision. It is not the clinical fact of brain death that determines it, but the mandatory analysis made by doctors in order to extend patients’ life at all costs. From the definition one might conclude for a patient or a cadaver. Was it a way of simulate life or enhance body parts?

The boundary between life and death is not certainly known. So it is not a simple definition that will take the place of knowledge, even because it is uncertain if the comatose state may be a remnant of life in this way, life is a presumed fact. On the side of philosophy, this definition reflects the dual body and brain, analogically equivalent to the old transnatural dualism that considered brain the base of the human person and the rest of the body just a useful tool. On the other hand, it is argued that in the present of a complete and irreversible brain failure, death should occur naturally. Individual’s identity covers the whole body (JONAS, 1997, p. 154-155).

The decision making about death is motivated by moral values. The modern secular society is afraid of talking about death conceiving it as an absolute harm. In fact, the routine life replaced evaluative responsibility of the decision. The redefinition of death would have the power of supplanting the principles underlying the process of untying the person from de respirator. Death, moreover, has its proper dignity and it is a human right to leave its normal course (JONAS, 1997, p. 155-156).

It sounds strange speaking in right to die, since the reigning discourse has always been the right to live, because all granted or denied rights, in practice, are offshoots of the right to live that is of vital interest. Not because of a right that life exists. Being alive is a fact and life is a natural result of an innate capacity for self-preservation. The fact of being alive, in human relations, demands the mutual recognition of the right to life (JONAS, 1997, p. 159).

How is it possible to dedicate to a right of dying that is seen as an inevitable harm, if people seek the right to satisfy a good? This paradox leads to question whether living is a right or an obligation. This leads to another conclusion: starting from the premise that it is an obligation to live, others have an obligation to contribute to this (obligation to live) so that from this obligation would result an impediment to die before, even if it is preferred. From this analysis it is extracted the need to examine and discuss the dignity of death, which is one of the most private events. Morally and religiously speaking, in practice of suicide is that it is seen the best representation of choice. However, it is noted that the right to die should not be confused with suicide. That one is related to that patient condition that is in mortal and vulnerable state to modern medicine materialized in death delaying techniques. There are differences between reject death and suicide, as well as between letting die and cause death (JONAS, 1997, p. 160).

Thus, if modern medicine cannot improve patient’s condition so that his body does not respond anymore to treatments whose work in the body is reduced to keep it only, it would be postponing the event of death, a suffering without improving expectations or cure that can put the patient in imprisonment and suffering situation. From this situation it is needed to make some considerations: the specter of death by stopping treatment felt by the doctor and the institution; by the side of the patient who has to demand the end of treatment knowing that his choice will result in his death; and the feeling of guilt of others involved with compassion (JONAS, 1997, p. 160-161).

In free societies, in legal terms, except minors and mentally ill people, everyone has the right to submit to or abandon treatment, with the exception of public interest cases such as that of the patient, by prior arrangement with the doctor, has already been operated and is under care for a new surgery in the postoperative interval continuing the treatment; in the case of contagious disease that could endanger the life and health of others; in cases of mental disorders that require isolation and treatment; needing preventative measures, such as vaccination. Excluding these circumstances, health and disease relate only to the patient and are part of his privacy. Any decision within this sphere depends on free contracting of medical services (JONAS, 1997, p. 16).

There is difference between what was said and the obligation of a person without any hope of recovering or improving his quality of life to continue living under treatments and therapies that offer only maintenance. No one is obliged to do so and no one has the right / obligation to submit the other to “prolonged denial of self-determination.” Fact similar to the dialysis machine as life-saving therapy is the administration of insulin on diabetics. In such cases, the patient has the capacity both operative as acting. There are situations where the patient is dying, the so-called “prisoner” in terminally ill who needs to be conducted by others to perform withdrawal treatments that may take him to death (JONAS, 1997, p. 162).

To conscious and incurably patients in state of terminal illness, remains reveal clearly the disease as well as respect the autonomy of those regarding the rejection of therapies and treatments. These are patients’ rights on their death which include human dignity within the plane of being and not of doing. The option for non-therapeutic extension declared by the patient after being presented by the medical team, reflected on another problem: avoid suffering (which was also planned before), whether by mitigation of suffering, or by ending of suffering, needing the patient’s stay in hospital because of the impossibility of treatment at home. In view of this, the patient is placed in a public space becoming dependent on hospital rules and guidelines. Finally the pain and suffering may mean acceleration of death. It is unthinkable to force doctors to act positively in this regard or any health professional. Giving death must not be imposed on doctors (JONAS, 1997, p. 165-167).

Patients in an irreversible coma depict an artificially sustained remaining life and are unable to declare their desire which can be made by a representative. In this case, there is not a strict right to die since there is not a claimant, that is, a right owner to demand it, resting the doubt about which right must be preserved, of the former, of that previous person, or of what is left of the current one. Of course that prevail, albeit posthumous, the previous wishes of the previous person, with great moral and legal strength, an anticipated declaration of will writing despite the medical precept always to stand for life (JONAS, 1997, p. 169). In this sense, euthanasia and assisted suicide may be interpreted as a slippery slope since they are practices that can lead to irreversible situations of human degradation as it will be shown in the next topic.

4 EUTHANASIA AND ASSISTED SUICIDE: A SLIPPERY SLOPE

According to the historian Young (1994, p. 657), traditional cultures like India, China, Japan, Greece and Rome, at some point in their histories, came to legitimize the self-willed death, but for certain motivations. As for the spontaneous suicide, however, by anger, passion, fear or despair, it was seen as unfortunate and should be discouraged by the community for its

illegitimacy. It can be said that there has been invested trying to regulate the practice of self-willed death,⁷ but the evidence shows that they were unsuccessful due to some factors, among others, the unstable social conditions emerging from a desire for control; the legitimacy associated with religious, philosophical and societal values; the devaluation of the body; and cultural contact. There is, according to the author, some evidence that may have contributed to the continuity of physician assisted suicide practice in Rome and Greece, typifying a ‘slippery slope’ of Bioethics.⁸ In classical antiquity, the Greeks and the Romans accepted the practice of euthanasia, albeit with different nature and practice of today. Still, there were authors contrary to it, as a group of doctors headed by Hippocrates that was not favorable to the use of deadly drugs. The Stoics endorsed euthanasia when the life of an individual was no longer according to their own needs and self-development. Socrates and Plato defended it as Aristotle considered as the act of extreme cowardice.

Nowadays, it is possible the development of a slippery slope if the legitimacy of assisted suicide or self-willed death due to the presence of certain social conditions, such as large population aging, the legitimacy associated with core corporate values such as autonomy and freedom, and rapid social change. Moreover, future circumstances may happen that contribute to these slopes, what does not legitimize these practices, even substantiated by compassion for these individuals and by recognition of their autonomy (YOUNG, 1994, p. 657).

In ancient times, the originally Greek expressions of “good death” or “easy death” meant “euthanasia” and referred to natural death happening with peace and without pain in the proximity and comfort of their families. This archaic use changed and passed to refer to the conduct of one ends with another person’s life and suffering. The very euthanasia became subdivided into categories: a) voluntary euthanasia when the patient request to be killed; b) Involuntary euthanasia, when the death of an incapable person is involved, as a child or demented elderly person held at the request of a caregiver or family member; c) passive euthanasia, unwanted death occurred after the withdrawal or discontinuation of treatment that sustains life, actually, it is a misnomer because the person dies not because of the withdrawal or discontinuation of treatment, but of course the underlying disease or injury⁹ (SMITH, 2002, p. 1).

Assisted suicide is very close to euthanasia and happens when a person is instructed by other who provides instructions, means and ability, with the objective to provoke her own death. The difference between suicide and assisted suicide is that, in the first situation, the very person alone ends her life, while in the second one, the person commits suicide by joining others who provide assistance. Both assisted suicide and euthanasia are prohibited practices by the Hippocra-

⁷ It is important to note that this type of Buddhist provocation of death is equated with western euthanasia as stated Neogi (2013, p. 1211).

⁸ The slippery slope is a term used in Bioethics which means that a single act can generate future harm progressive events, or make small concessions that may mean controversial results. This is a term created by Dr. Leo Alexander, assistant prosecutor of Nazi doctors at Nuremberg, 1946-1947, to explain the events in the concentration camps and the eugenic behavior performed (GOLDIM, 2004).

⁹ In the Netherlands, between 1990 and 2001, euthanasia was tolerated being legalized after 2001. In that country, patients over 12 years, afflicted with incurable disease who presented unbearable pain that do not respond to treatments and medical assistance, might request euthanasia. Then, Belgium and Luxembourg have allowed voluntary euthanasia only for people over 18 years. The Uruguayan Penal Code (1937) admits murder of compassion, which is equivalent to voluntary euthanasia. In Australia, the Northern Territory of Australia, no longer allows performing euthanasia remained in force only for the period from July 1996 to March 1997. A study in the Netherlands found that following the request for euthanasia, the estimated survival of patients mostly was four weeks. The World Medical Association sees voluntary euthanasia as a risk of enlargement of conduct of Slippery Slope, meaning that, once slope started down, it is hardly able to return to the starting point (GOLDIM, 2014, p. 27-28).

tic Oath (SMITH, 2002, p. 1). Knowing that these actions are rejected by the Medical Ethics Code and the Brazilian laws, is with the practice of orthothanasia conceiving it as the only one able to answer what is expected of a dignified death, in medical terms.

The process of facing death for patients in the end-stage of life leads to a new concept of death, the “good death” incorporating palliative care and the hospice movement. The hospice philosophy seeks to offer more dignity in the act of dying, inside a desirable aesthetic and ethical care environment (FLORIANI, 2013, p. 402). Starting from a proposal for a more humane medicine, palliative care (know how) have been employed in local hospices¹⁰. Originally from England, in 1967, they receive patients that are treated by a multidisciplinary team, with actions intending to prevent and relieve pain and suffering from a holistic perspective contemplating emotional, physical, spiritual and social aspects (FLORIANI, 2009, p. 9-11).

Dignified death¹¹ has been centered on two axes which are integrated: patient autonomy and the duties of care to be provided by health professionals. The problem is when there is hypertrophy of patient autonomy, which may result in a “defensive medicine.” This occurs when, laudably, it is tried to enhance patient dignity and freedom and abolish the medical paternalism through rules governing patient autonomy requiring the practice of informed consent and the transmission of clarification and information to the patient. Another important aspect is the trust that must exist between doctor and patient since it is characterized by the intimacy and personal basis of physical, psychological and spiritual suffering and the need to properly diagnose and provide the right treatment and offer well-being for the patient. But when the relationship is strictly professional, the mistrust relation of the defensive medicine reigns, emerging conflicts. Altruism, empathy, integrity, honor and truth are essentials for a full confidence. In the context of health relations, this paradigm shift has occurred because of the complexity of health system, technological development and the fact that medical practice is more impersonal and dehumanized (OTERO, 2012, p. 152).

Moreover, the way a society behaves or interprets death show its “collective identity”, since this interaction with death is how this community is organized culturally (GIACOIA JÚNIOR, 2005, p. 14-15). The way to deal with these circumstances were interpreted differently throughout the history of mankind showing that death has a cultural character according to the historical moment reaching social, religious, philosophical, scientific and biological areas (ALBUQUERQUE; DUNNINGHAM, 2013, p. 7).

There has been a transformation in the way we interpret the “good death” or “dying well”. In fact, it relates to the “dying wishes” as the choice of burial place and with the fear of death. For a long time, the idea of good death was linked to the fact of not dying suddenly. The attitude towards death has changed and has appeared the concepts of “dignified death” and “good death” and related. Orthothanasia, that is defended in this article, etymologically means correct death (ortho - correct; thanatos - death) by no artificial prolongation of the dying process providing opportunities for the natural process of death. This practice is also known as the “good death” or “desirable death” and it is opposed to dysthanasia that consists in the purpose to extend life at

¹⁰ In the 1970s, the “palliative care” term was coined by the Canadian Balfour Mount, incorporating the English hospice ideology (FLORIANI, 2009, p. 39).

¹¹ “dignified death” here is understood as “good death” or “good death”.

any cost not caring about patient suffering. This is a highly questionable practice since prolong the patient's agony unable to cure (JUNGES et al., 2010, p. 278-279).

There has been a change from the concept of "good death" to "dignified death" occurred concomitantly to the outstanding of euthanasia in the twentieth century. The idea of "dignified death" or "dying with dignity", within the field of medicine, offers the patient better chances to improve his quality of life and dignity while alive.

5 DIGNIFIED DEATH IN BRAZILIAN LAW AND HOSPICE CARE IN BRAZILIAN REALITY

Death, as the end of life, requires the application of the bioethical and juridical assumptions, since concepts and ethical, biological and philosophical considerations are essential to the development of substantiating standards for doctrinal and jurisprudential opinion, which will form the basis for the solution of ethical and moral conflicts of great complexity.

The Brazilian legal system does not refer to the process of dying with dignity, even though the national doctrine and the Federal Council of Medicine address the mechanisms that advocate the idea of a dignified death, represented by palliative care, orthothanasia¹² and Advance Directives of Will¹³ of terminal patients.

In constitutional terms, dignity comes as a foundation in paragraph III of article 1 of the Federal Constitution of 1988. Then, in theory, it is the basis for all fundamental rights. The Charter did not define the term, perhaps because of the multiculturalism that is a characteristic of Brazilian reality. Contrarily to the provisions in the Charter related to the inherent dignity to the human being, it is believed that the dignity is only a value, which has a particular meaning of an individual, a group of people, a cultural tradition, in short, a symbolic conventionalism mutually recognized by a group of interests even, for example, professional and that, in the western society, it is a condition of inherence of human beings.

In terms of the medical Bioethics, in principle, life is defended. However, no one may be subjected to torture or to inhuman or degrading treatment (art. 5, III, CF) in the name of life. If death is the finitude of life, it is part of this one. If Bioethics takes care of life, as a consequence, it cares for death too. When talking about end-of-life, dignity can be understood through the appreciation of certain factors such as the mitigation of pain and suffering, comfort, respect for patient, to decide on the location where he prefers to spend his last days, information about the disease and risks of procedures, access to treatment and drugs that can ease his pain, resignation, withdrawal or suspension of treatments and therapies that does not desire, do not abandon the patient, respect his religious convictions, do not carry out referrals for therapies and reject unnecessary surgeries and always show affection for whom is in despair.

Moreover, the ambiguous article 15 of the Brazilian Civil Code conveys the idea that, in the presence of life-threatening to patient, he cannot be forced to perform surgical intervention,

¹² Physicians are prohibited to shorten patient's life, even at his request or his legal representative. In cases of incurable and terminal illness, physician should offer all palliative care available without undertaking diagnostic actions or useless or obstinate therapy, always taking into account patient wishes, and in their absence, legal representative (CONSELHO FEDERAL DE MEDICINA, 2009, Art. 41).

¹³ Set advance directives of will as set of desires, previously and expressly manifested by the patient on care and treatment that he wants or not to receive when he is unable to express freely and autonomously his will (CONSELHO FEDERAL DE MEDICINA, 2012, Art. 1º).

and that, in the absence of risk he may be required to submit to intervention. It is clear that the intention of the legislator was not to force anyone to perform undesirable procedures even they do not provoke risk of life or health risk. It seems that the intention of the legislature by drafting such a standard was to enhance the patient autonomy, embodied in the informed consent, although this has not been regulated legally, remaining until then only in the ethical domain (CONSELHO FEDERAL DE MEDICINA, 2009, Art. 22).

In practice, in Brazil, three ideal death modalities coexist: traditional, modern and contemporary. The first one is still lived in country towns where someone's death affects the entire community and the person's identity intertwined with the group to which he belongs. Modern death persists in large urban centers with the loss of one's identity over the finishing process of life due to the progressive reduction of autonomy in decision-making. Contemporary death experienced in palliative care units allows the establishment of new identities from the relations with palliative caregivers following the "natural" course of death. This contemporary model, however, must be applied observing some limits, especially regarding the terminal patient's autonomy. The model adopted in the Brazilian case follows the English parameters in which the terminally ill should remain at home. The problem is related to inequalities of care received by terminal patient because of social diversity, so that there are patients who live in shacks crowding around ten people in a single environment, and those who live in unhealthy slums and unhygienic. There are sick people who have no families and need nursing homes shelter maintained by church services (MENEZES, 2003, p. 113).

At last, Foucault (1984) is right that there has been the socialization and institutionalization of medicine with emphasis to the relationship between doctors and patients, but also Menezes (2003) is also correct regarding loss of identity in the face of the modern paradigm dying. Die is a phenomenon (not a given) that is comprised of existential way, said Heidegger (2005b). The human being is temporal, so the ways of seeing death change according to the flavour of the moment. The types of death brought by Menezes (2003) demonstrate Brazilian social stratification and the insurmountable difficulty of access to dignified death for everybody. That is one more reason to defend a secular and respectful Bioethics.

It is sensible Lévinas's contribution (2000) about death. Death cannot be seen as something annihilator, but an emotional and intellectual relationship that includes knowledge about the death of others. Nobody can say death is nothing, but a passage into the unknown. From this point, although the author has not expressly referred to, he would not agree with euthanasia and assisted suicide practices.

Jonas (1997) is right when said that decision-making involves moral values. Society needs to lose the fear of talking about death. There is dignity in dying embodied in the human right to permit its normal course. Patients' rights are in the field of being and not of doing. In this sense, some factors such as respect for patient's autonomy regarding the rejection of therapies and treatments are important. If dignity is a constitutional foundation contemplating life, it is in relation to death. This is a constitutional support for Advance Directives of Will.

6 FINAL CONSIDERATIONS

The objective of this paper aimed to approach death history; some philosophical understandings of this phenomenon; euthanasia and assisted suicide as causes for slippery slope; dignified death through the lens of orthoethanasia; dignified death in the Brazilian legal system and palliative care in the Brazilian reality, and demonstrate Brazilian situation in dealing with the death of terminally ill patients.

It was found that the best solution to solve these existential conflicts is through orthoethanasia whose philosophy asserts respect for the natural course of life and its purpose. This practice aims to offer patients the means of mitigating suffering by rejecting interventions and treatments that only prolong life, and unsuccessful in the search for cure. It was demonstrated that palliative care and hospice care movement help relieve patient's suffering respecting him in his holistic totality involving physical, psychosocial, emotional, spiritual and religious preferences. It is also suggested that dignity, in the field of medical Bioethics, is interpreted as a value recognized as relief and mitigation of pain and suffering, comfort, respect for patient's autonomy to decide on the place where he prefers to spend his last days, information about the disease and risks of procedures, access to treatment and drugs that can ease their martyrdom, resignation or interventions suspension, do not abandon the patient, respect his religious and moral convictions, defending the secular Bioethics, unprejudiced and not aiming at universalization of morals and values.

REFERENCES

ALBUQUERQUE, D. R.; DUNNINGHAM, W. A. Distanásia: uma reflexão sobre o papel psicossocial da morte. *Revista Brasileira de Neurologia e Psiquiatria*, Salvador, v. 17, n. 1, p. 5-24, Apr. 2013.

BRASIL. Lei n. 9.434, de 4 de fevereiro de 1997. Regula a remoção de órgãos, tecidos e partes do corpo humano para fins de transplante e tratamento. *Diário Oficial da União*, Brasília, DF, 04 fev. 1997. Available from: <http://www.planalto.gov.br/ccivil_03/leis/l9434.htm>. Access on: May 5 2015.

BRASIL. *Código Civil*: Lei 10.406, de 10 de janeiro de 2002. São Paulo: Revista dos Tribunais, 2002.

BRASIL. Constituição. *República Federativa do Brasil*. 35. ed. São Paulo: Saraiva, 2012.

CABRERA, J.; SALAMANO, M. C. Heidegger para a Bioética. *Revista Latinoamericana de Bioética*, v. 14, n. 2, p. 118-127, 2014.

CONSELHO FEDERAL DE MEDICINA. *Novo Código de Ética Médica*. Curitiba: CFM, 2009.

CONSELHO FEDERAL DE MEDICINA. *Resolução n. 1.995/2012*. Available from: <http://www.portal-medico.org.br/resolucoes/CFM/2012/1995_2012.pdf>. Access on: Jul. 6 2015.

CONSELHO REGIONAL DE MEDICINA DO PARANÁ. *Parecer n. 1.243/2000*. Protocolo n. 2.516/2000. Morte cerebral encefálica/coma. Available from: <http://www.portalmedico.org.br/pareceres/CRMPR/pareceres/2000/1243_2000.htm>. Access on: Nov. 16 2015.

FLORIANI, C. A. *Moderno movimento hospice: fundamentos, crenças e contradições na busca da boa morte*. 2009. Thesis (Doutorado em Ciências na Área da Saúde Pública)-Fundação Oswaldo Cruz, Rio de Janeiro, 2009.

- FLORIANI, C. A. *Moderno movimento hospice: kalotanásia e o revivalismo estético da boa morte*. *Revista Bioética*, Rio de Janeiro, v. 21, n. 3, p. 397-404, 2013.
- FOUCAULT, M. *A microfísica do poder*. Organização e tradução Roberto Machado. 4. ed. Rio de Janeiro: Edições Graal, 1984.
- GIACOIA JÚNIOR, O. A visão da morte ao longo do tempo. *Medicina*, Ribeirão Preto, v. 38, n. 1, p. 13-9, 2005.
- GOLDIM, J. R. Refletindo sobre a morte: aborto, infanticídio e eutanásia. In: GOLDIM, J. R. *Breve introdução ao pensamento de Peter Singer*. Porto Alegre: Ed. UniRitter, 2014.
- GOLDIM, J. R. *Slippery Slope*. 22 ago. 2004. Available from: <<http://www.ufrgs.br/bioetica/slippery.htm>>. Access on: Sept. 10 2015.
- HEIDEGGER, M. *Ser e tempo*. Translated by Márcia Sá Cavalcante Schuback. 15. ed. São Paulo: Vozes, 2005a. (Coleção Pensamento Humano; Parte 1).
- HEIDEGGER, M. *Ser e tempo*. Translated by Márcia Sá Cavalcante Schuback. 15. ed. São Paulo: Vozes, 2005b. (Coleção Pensamento Humano; Parte 2).
- JONAS, H. *Técnica, medicina y ética: sobre la práctica del principio de responsabilidad*. Barcelona: Buenos Aires: México: Editorial Paidós, 1997.
- JUNGES, J. R. et al. Legal and ethical reflections on end-of-life: a discussion on orthothanasia. *Revista Bioética*, v. 18, i. 2, p. 275-88, 2010.
- KIND, L. Máquinas e argumentos: das tecnologias de suporte da vida à definição de morte cerebral. *História, Ciências, Saúde - Manguinhos*, Rio de Janeiro, v. 16, n. 1, p. 13-34, Jan./Mar. 2009.
- LÉVINAS, E. *God, death and time*. Translated by Bettina Bergo. California: Stanford University Press, 2000.
- MENEZES, R. A. Um modelo para morrer: última etapa na construção social contemporânea da pessoa? *Campos*, v. 3, p. 103-16, 2003.
- NEOGI, S. Self-willed death: an aspect of euthanasia in Buddhism. Department of philosophy, Burdwan University, W.B, India. *International Journal of Current Research*, v. 5, i. 7, p. 2010-2011, Jul. 2013.
- OTERO, J. M. M. Autonomía e información de los pacientes: del reconocimiento de derechos a la perdida de confianza. Reflexiones con motivo de la aparición de nuevas normas sobre los derechos de los pacientes al final de la vida. *Cuad. Bioét.*, Universidad CEU Cardenal Herrera - Valencia (España), v. 23, p. 153-67, 2012.
- SMITH, W. J. Euthanasia and assisted suicide. *Encyclopedia of Crime and Justice*, 2002. Sept. 2015. Available from: <<http://www.encyclopedia.com/doc/1G2-3403000109.html>>. Access on: Jun. 18 2015.
- YOUNG, K. K. A cross-cultural historical case against planned self-willed death and assisted suicide. *McGill Law Journal*, p. 657, 1994.

