

# Reflections on care for critical patients at the end of life

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## Abstract

The influence of technological pragmatism in health care offered to critically ill patients, especially to those who are in the end of life, makes most of them end their days in an intensive care unit. This article defends more humanized care for these people and proposes bioethical reflection on the subject. The text is divided into three parts. Initially, the study presents the reality of intensive care units in Brazil, based on Resolução 2.156/2016 [Resolution 2,156/2016] of the Brazilian Federal Council of Medicine, which disciplines medical use and procedures in these sectors. Subsequently, the discussion on some end-of-life issues is contextualized considering international research carried out in four countries, namely: the United States, Japan, Italy and Brazil. The last part is dedicated to the analysis of euthanasia and assisted suicide, considering technical and moral arguments presented by the American physician and bioethicist Ezekiel Emanuel.

**Keywords:** Bioethics. Intensive care units. Palliative care. Euthanasia. Suicide, assisted.

## Resumo

### Reflexões sobre cuidados a pacientes críticos em final de vida

A influência do pragmatismo tecnológico nos cuidados de saúde oferecidos a pacientes criticamente enfermos, sobretudo àqueles na terminalidade da vida, faz a maioria deles terminar seus dias em unidade de terapia intensiva. Este artigo defende atendimento mais humanizado para essas pessoas e propõe reflexão bioética sobre a temática. O texto é dividido em três partes. Inicialmente apresenta-se a realidade das unidades de terapia intensiva no Brasil, baseando-se na Resolução 2.156/2016 do Conselho Federal de Medicina, que disciplina o uso e os procedimentos médicos nestes setores. Em seguida, contextualiza-se a discussão sobre algumas questões relativas ao final da vida, a partir de pesquisa internacional realizada em quatro países: Estados Unidos, Japão, Itália e Brasil. A última parte é dedicada à análise da eutanásia e do suicídio assistido, considerando argumentos técnicos e morais apresentados pelo médico e bioeticista norte-americano Ezekiel Emanuel.

**Palavras-chave:** Bioética. Unidades de terapia intensiva. Cuidados paliativos. Eutanásia. Suicídio assistido.

## Resumen

### Reflexiones sobre los cuidados brindados a pacientes críticos en el final de la vida

La influencia del pragmatismo tecnológico en los cuidados de salud que se ofrecen a los pacientes críticamente enfermos, especialmente a aquellos que se encuentran en la terminalidad de la vida, hace que la mayoría de ellos terminen sus días en una unidad de cuidados intensivos. Este artículo defiende una atención más humanizada para estas personas y propone la reflexión bioética sobre el tema. El texto se divide en tres partes. Inicialmente, se presenta la realidad de las unidades de cuidados intensivos en Brasil, de acuerdo con la Resolución 2.156/2016 del Consejo Federal de Medicina, que regula el uso y los procedimientos médicos en estos sectores. Seguidamente, se contextualiza la discusión sobre algunas cuestiones relativas al final de la vida, a partir de la investigación internacional llevada a cabo en cuatro países: Estados Unidos, Japón, Italia y Brasil. La última parte está dedicada al análisis de la eutanasia y el suicidio asistido, considerando los argumentos técnicos y morales presentados por el médico y bioeticista norteamericano Ezekiel Emanuel.

**Palabras clave:** Bioética. Unidades de cuidados intensivos. Cuidados paliativos. Eutanasia. Suicidio asistido.

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Declararam não haver conflito de interesse.

The ethical and critical issues about the care offered to terminally ill patients generate heated academic and legal debates in the field of bioethics since its emergence in the United States in the early 1970s. This field of knowledge is a valuable tool for proposing changes in the Western culture, which persists in considering death as a taboo subject, denying the reality of the finitude of life.

The importance of this discussion is evident in the examples of medical professionals *who elegantly embrace their finitude*<sup>1</sup>, as well as in many scientific events and health courses that aim to give more humanistic training to professionals in underestimating the necessary technical qualification. In addition, the literature on these issues has increased significantly<sup>2-4</sup>.

The World Medical Association (WMA)<sup>4-6</sup> promoted several conferences around the world in 2017, with the objective of organizing and reviewing its policy regarding euthanasia and assisted suicide. Over the past few years, the WMA has released several documents that warn doctors about disproportionate procedures in the terminus of life.

Considering this reality, this essay was organized in three parts. Initially, a critical evaluation of the reality of Brazilian intensive care units (ICUs) is made, based on Resolution 2,156/2016<sup>7</sup> of the Conselho Federal de Medicina - CFM (Federal Council of Medicine), which established criteria for admission and discharge of critically ill patients in the ICU.

In the same line of reasoning, the metaphor that classifies the Brazilian ICUs as *modern cathedrals of pain*<sup>8</sup> is rescued, and the results of a survey carried out by the Kaiser Family Foundation<sup>9</sup> and published in *The Economist*, about how people wish be treated at the end of life. The study took into account four countries, Japan, USA, Italy and Brazil, and addresses the expectations and needs of patients in this critical phase of existence.

Finally, it is brought to light the instigative provocation of American oncologist Ezekiel Emanuel<sup>10</sup> regarding the unsatisfactory approach to euthanasia and assisted suicide. The way the international media routinely addresses these issues underestimates the necessary biopsychosocial and spiritual breadth of care for this type of patient.

### Criteria for admission and discharge in Brazilian ICUs

One of the most prestigious medical publications, the *New England Journal of Medicine*,

in the end of 2016 published a courageous testimony of Flávia Machado, a Brazilian intensivist doctor, in which she denounces the prevailing chaos in the health area and, at the same time, expresses her commitment and optimism regarding the solutions to these problems<sup>11</sup>. It also describes her dramatic day-to-day care for patients in critical situations in a public hospital in the city of São Paulo.

The physician is responsible for the intensive care sector of the discipline of anesthesiology at the Escola Paulista de Medicina of the Federal University of São Paulo (Unifesp), and coordinator of the Latin American Sepsis Institute (Instituto Latino-Americano de Sepse, IlaS).

The article published online had great repercussion and attracted the attention of health professionals from all over the world. In Brazil, the repercussion was timid, recorded in two articles by Claudia Colucci, published on the newspaper *Folha de S.Paulo* on March 30 and May 7, 2017<sup>12,13</sup>. At the beginning of the text, Flávia reports a moment of her daily life:

*Another work day starts at 7:00 in the morning, and once again we need to decide who will get a bed in the ICU (...) A 55-year-old grandmother with colon cancer? An elderly man with liver metastases? A young woman who suffers from pain and who needs an arthrodesis [spinal surgery] to continue working so she can feed her family? Should we choose or deny care to cancer patients? Should we choose based on age? About the patients' previous quality of life? Or about social impact, for example, if a patient has four children to raise? Should we admit a patient we've had to refuse once? Or maybe we should just stop playing God and give it to those who ask first?*<sup>14</sup>.

This dramatic scenario of the work of the intensivist physician reveals the suffering not only of those who need care but also of the health professionals themselves. In this context, CFM Resolution 2,156/2016<sup>7</sup> seeks to optimize the flow of care in the face of the chronic shortage of intensive care beds in Brazilian hospitals. This standard will be of great value to these physicians when making decisions regarding the admission or discharge of patients in the ICU. For the lay public, far from these medical dilemmas, it is necessary to facilitate the understanding of the CFM guidelines.

### Intensive Care Unit

The ICU is the highly complex medical care sector where human and material resources capable

of introducing advanced life support procedures are found. It aims to benefit critically ill patients, stabilizing essential clinical and hemodynamic variables. Intensive therapies welcome critically ill people with a possibility of recovery<sup>15</sup>.

Patients considered for ICU admission are those who present instability of one or more organic functions with the potential to lead to death. This requires the physician to adopt procedures such as mechanical ventilation (ventilatory assistance), hemodialysis and circulatory support, provided by equipment available only in emergency or intensive care units.

The critical patient demands immediate interventions, since their condition evolves with multiple organ failure and a time-dependent prognosis. In addition, the delay of four hours or more for ICU admission contributes to increasing the mortality of these individuals.

### Brazilian ICUs: fundamental concepts and everyday problems

A complicating factor in the definition of criteria to be admitted to the ICU is the hospitalization of patients who, although serious, have little possibility of recovery and yet receive conventional intensive care. This situation characterizes an unreasonable practice as it only prolongs the process of dying and invariably results in more suffering for patients and families. This is what we call therapeutic obstinacy or dysthanasia<sup>16,17</sup>.

Regarding discharge in these units, it is common for stable patients to remain hospitalized without justification, despite requiring only semi-intensive care. The CFM<sup>7</sup> directs the intensivist physician to consider not only the diagnosis but also the prognostic conditions of its recovery. In addition, it recommends conducts supported by scientific and ethical criteria to face the challenge of offering the best care to critically ill patients. Therefore, ICU admissions should be based on an accurate assessment of the chances of recovery, considering the best clinical practices.

Resolution 2,156/2016 prioritizes for ICU admission those patients who need: 1) life support interventions, with high probability of recovery and without limit of therapeutic procedure; 2) intensive monitoring due to the high risk of needing immediate intervention, without limit of therapeutic conduct; 3) life support procedures, with low probability of recovery or limited therapeutic use; 4) intensive monitoring due to the high risk of

needing immediate intervention, but with a limit of therapeutic conduct. Patients with terminal illness with no possibility of cure are admitted on an exceptional basis, and this decision depends on the evaluation of the intensivist physician.

Regarding these criteria, the coordinator of the Intensive Medicine Chamber of the CFM, Hermann Von Tiesenhausen, explained: *We created a five-step ladder. Each one translates into a more precise indication until it reaches the last step, type 5, which, in general, no longer has a formal indication [to remain] in an ICU*<sup>18</sup>. Therefore, patients should not occupy ICU beds outside established criteria by the Resolution, although the family members pressure the doctors.

The clamor of families is understandable, but submitting to it, there is the risk of occupying beds unfairly, depriving critical patients with real chances of recovery of this right. Obviously, these decisions should be preceded by respectful and enlightening dialogue with family members.

As for discharge from the ICU, the resolution directs that it be given to the patient whose vital parameters are completely stable. On the other hand, terminal patients should be transferred to the palliative care unit<sup>7</sup>.

Each institution must offer care based on the criteria set forth, and it will be up to the physicians to follow them with maximum professional commitment. Therefore, it is imperative to maintain objectivity in making ICU-related decisions. Moreover, it is imperative that undergraduate courses of health professionals address issues related to the termination of life and palliative care.

### Research on bioethical issues related to the end of life

Interestingly, *The Economist*, one of the most respected international economics publications, has in recent years been the most publicized information medium for end-of-life care. In 2010 it published a report commissioned by the Lien Foundation<sup>19</sup>, and in 2015 updated the quality of death index, considering the number of palliative care units in the world<sup>20</sup>.

In April 2017, in partnership with the Kaiser Family Foundation, the magazine published a new report<sup>9</sup>, which deserves the attention of all professionals working in critical care and end-of-life care, as it provided valuable information on the

subject. Due to the importance of the study, we will highlight some essential data below. Based on patients' opinions about how they would like to be assisted at the end of life, five more emblematic issues were elected:

***“When it comes to assistance and care, what do you consider most important at the end of your own life?”***

1) extend life as long as possible: Japan (9%), USA (19%), Italy (13%), Brazil (50%); 2) helping people to die without pain: Japan (82%), the United States (71%), Italy (68%), Brazil (42%). A striking fact observed in Brazil was that 50% of the interviewees defended the extension of life for the longest time possible. It is likely that this misperception is related to the inadequate use of beds in the ICU and to the fact that Brazil is still one of the few countries to believe that palliative care in the ICU is justifiable.

***“When thinking about your own death, what do you consider to be of the utmost importance?”***

1) not to leave the family in financial difficulties: Japan (59%) and USA (54%); 2) be in peace spiritually: Brazil (40%); and 3) have loved ones in the process of dying: Italy (34%). Here the second item that shows the vision of most of the Brazilians interviewed deserves attention.

***“On the extension of life for as long as possible”***

According to research data, 50% of Brazilians, when questioned about the end of life, emphatically expressed their desire to remain in the ICU, while in the USA, Italy and Japan rates were lower, between 9% and 19%, with prevalence of the choice for palliative care and death without pain and suffering.

Given this difference, it should be noted that data collected in Brazil considered different levels of schooling: 51% of those interviewed with elementary education favored prolonged life and stay in the ICU, while 53% of Brazilians with a secondary level had the same opinion, and only 35% of individuals with a higher education level agreed with the idea.

The majority response gives rise to several sociological considerations on quality of life, as well as on the religious and spiritual dimension of the Brazilians of these population strata. The data also allow us to understand that participants have more difficulty to understand that this is an irreversible situation. On the other hand, Brazilians with a higher educational level follow the decision criteria of foreign participants, favoring pain relief and

physical and emotional comfort to the detriment of artificially prolonged life.

***“Dying with less pain, discomfort and suffering”***

Considering all the other countries studied, the care to reduce pain and allow the company of relatives at the end of life were approved by 41% of people with elementary education; 40% of respondents with secondary education; and 58% of university-level individuals. In summary, when it comes to serious and incurable diseases, most interviewees in Japan, Italy, and the US favored this measure rather than the artificial prolongation of life.

***“On who should decide on medical treatment to be adopted in patients at the end of life”***

In the general average of the countries, 57% of the interviewees considered this decision to be exclusive competence of patients and relatives, while 40% defended physician-defined behaviors, and 3% did not know how to respond.

**Expectations and needs of end-of-life patients**

Another data identified by the research was the prevalence of religiosity among Brazilians since 40% of respondents considered it extremely important to be in peace spiritually at the end of their lives. Eight out of ten Brazilians participating in the study (83%) attributed importance to religious and spiritual convictions, and this stands out especially when these people declare the treatment they wish to receive at the end of life.

In the survey, 54% of Brazilian adults identified themselves as Catholics, and three out of ten declared themselves evangelicals. According to the 2010 Census of the Brazilian Institute of Geography and Statistics (IBGE)<sup>21</sup>, Brazil continues to be a Catholic majority country, but it is moving toward religious pluralism, with significant growth in other beliefs. Data that gave a dimension of the faith of Brazilians are aggregated by different faiths: Catholics (64%), Evangelicals (22%), Spiritists (2%), Umbandists and Candomblers (0.3%) and other religions (3%). People without religion were 8% and 0.1% did not know or did not declare any option.

The figures reveal that the Brazilian people is fundamentally religious. This historical and cultural feature is closely related to what is considered important at the end of life. The question that arises in the face of the high number of Brazilians who are

concerned to be spiritually at peace in the face of the imminence of death is how this care is offered?<sup>9</sup>

In the US and Japan, where medical care costs are often very high, it is considered important to ensure the financial stability of the family after the death of the patient. In Italy the greatest concern was to be able to rely on loved ones at his side in the final moments, followed by the certainty that his personal wishes about medical procedures adopted at the end of life were respected.

A worrying finding revealed by research in the four countries was the quasi-systematic absence of dialogue with patients about the termination of life. In Japan, for example, only 31% of adult patients and 33% of those over 65 reported having had the opportunity to talk about it with a loved one. Only 7% treated the subject with the doctor, 6% stated that they had formally registered their anticipated will directives, and 64% did not elaborate them because they did not know about this alternative.

A dissertation presented to the master's program in bioethics at the Pontifícia Universidade Católica do Paraná - PUCPR (Pontifical Catholic University of Paraná) in 2016<sup>22</sup> evaluated the knowledge of 55 patients assisted by the Advance Directives of Will (ADW) program in a private home care service for patients with terminal illnesses in Florianópolis (SC). According to the study, only one patient had recorded their ADW, three expressed a desire to do so after talking to the researcher, and 51 said they did not have the opportunity to talk about it.

The formal ADW registration is still restricted and varies widely in each country. The results on the subject in the four countries studied were: 1) for the general population: 6% in Japan and Italy, 27% in the USA and 14% in Brazil; 2) only for the population over 65 years old: 12% in Japan, 5% in Italy, 51% in the USA and 13% in Brazil.

Also worthy of reflection is the fact that in the US approximately 1/3 of the people who die after the age of 65 were hospitalized in the ICU in the months before death, and 1/5 of them underwent a surgical procedure in the month prior to death. It is estimated that by 2020 at least 40% of the population of the United States will die without the company of family members, in their homes or in nursing homes for the elderly.

On the other hand, the serious situation of public health services in Brazil, with failures in communication between services of greater and lesser complexity (referral / counter-referral system), and insufficient resources and hospital

infrastructure, together with the insecurity and disinformation of people, can create the mistaken idea that orthothanasia, that is, die without enduring futile or disproportionate therapies when facing an incurable terminal disease, would amount to abandoning care or omitting medical help.

Brazil has 110 palliative care services registered at the Academia Nacional de Cuidados Paliativos - ANCP (National Academy of Palliative Care), while in the US this number reaches 1,700 units. Another major challenge is the almost total absence of an approach to the topic of termination of life and palliative care in undergraduate courses in health. A study published in *The Lancet* in December 2010 showed worrying results about the qualification of the graduates of 2,420 medical courses worldwide<sup>23</sup>.

The first pedagogical project used by medical schools in the early twentieth century, after the reforms proposed by the "Flexner Report"<sup>24</sup>, emphasized teaching in tertiary hospitals. The second model, known as problem based learning (PBL)<sup>25</sup> and conceived in the 1970s by the universities of Maastricht and McMaster, was widely accepted in health courses. The third, called Health Education Systems<sup>26</sup>, promised to train professionals with more social responsibility, in accordance with the principles of otherness ethics, but their implementation still lacks initiatives. This study, conceived by twenty educators from different countries with extensive experience in medical education and who were part of the Lancet Commissions<sup>23</sup>, had the goal of defining the most appropriate vocational training profile for practicing medicine in the 21<sup>st</sup> century. The new training model was intended to make graduates of medical education better prepared to make reasonable and prudent decisions in the face of frequent ethical conflicts in contemporary Western societies marked by moral plurality.

In this dilemma, vocational training oscillates between ideals and virtues defended by experienced educators, but does not respond to the interests of university institutions governed by market rules. These medical schools prefer to train professionals to serve as many patients as possible, regardless of the quality of the service provided. Unfortunately we are far from training physicians who recognize patients as biopsychosocial and spiritual beings, individuals with autonomy to participate actively in the procedures that will be performed in their own bodies.

But how to have a humanist background if we do not even get knowledge about life termination and palliative care at the undergraduate level? This is what a study carried out by Pinheiro<sup>27</sup>, who

interviewed students of the fifth and sixth year of medical courses in the city of São Paulo points out. According to the survey, 83% of the students did not receive information on care for patients with terminal illnesses, 63% did not have access to any topic on “how to give bad news” and 76% said they did not know clinical criteria to optimize pain treatment in cancer patients.

Brazilian universities have emphasized several disciplines, without establishing a logical connection that allows students to understand that, regardless of disease, it always involves the biopsychosocial universe of the patient. Most medical schools practice the “slicing” of the human body into organs and systems, preparing students, future physicians, to treat diseases rather than people. Edgar Morin is emphatic in stating that *disciplinary developments in science have not only brought the advantages of division of labor but also the drawbacks of over-specialization, confinement, and shredding of knowledge. Not only did they produce knowledge and elucidation, but also ignorance and blindness*<sup>28</sup>.

Although incipient, the multidisciplinary approach introduced in medical colleges is welcome, even though it is still insufficient to address the complex moral problems of end-of-life situations. In relation to human finiteness, it is essential that there be dialogue between different areas of knowledge, such as medicine, psychology, theology, nursing and many others, since only the interdisciplinary perspective can prepare the doctor to care for the terminal patient and to conduct in an appropriate manner decisions on palliative care<sup>8</sup>.

It is appropriate to recover the experience of the American neurosurgeon Paul Kalanithi, recorded in the book “When Breath Becomes Air”<sup>29</sup>, which reproduces his trajectory from the stage “In perfect health I begin (part I)” to “Do not stop until I die (Part II)”. In 167 pages the author exposes his way to meet death. The epilogue written by Lucy, Paul’s widow, has the following teaching: *Paul’s decision not to look away from death sums up a force we do not celebrate enough in our culture averse to the idea of mortality. Writing this book was an opportunity to teach us how to face death with integrity.*<sup>30</sup>

Taking up the research published by The Economist<sup>9</sup>, it is important to underline some data. Despite the sociodemographic and cultural differences between the four countries studied, certain convergences deserve to be highlighted, such as the fact that most of the interviewees, regardless of country, consider health care sponsored by government initiatives as unsatisfactory. For many of

them, the rulers are unprepared or unmotivated to establish adequate measures for the care of elderly people or people suffering from terminal illnesses.

Regarding essential health care at the end of life, most Japanese, Italians and Americans have prioritized therapies to reduce pain and relieve suffering caused by the disease. Similarly, faced with the question of the finitude of one’s life, the expressive consensus stood out: *“to live well, as far as possible, provided that the dignity of the person is always respected”*. As for the planning to face this phase of life, most interviewees said that death is still taboo, which is the biggest obstacle to talk about it, although there are other issues pertaining to the cultural differences of each people. With regard to ADW records, Americans were the most likely to sign the document.

### End-of-life care in the perception of Ezekiel Jonathan Emanuel

*The Medical Journal of Australia* published an article by American oncologist and bioethicist Ezekiel Emanuel<sup>31</sup> that aroused great public interest and heated debate in academic settings. In summary, the author argues that the focus on finitude of life must migrate from euthanasia and assisted suicide to the improvement of the palliative care to be provided to patients in the terminal phase. About the subject, Linda Emanuel published the book *“Regulating how we die”*<sup>32</sup> in 1998, by Harvard University Press, with collaborators like Marcia Angell and Edmund Pellegrino.

Pellegrino’s chapter, *“The false promise of beneficent killing,”* is assertive in its conclusions: *it is an injustice to offer these [end-of-life] patients assisted suicide or euthanasia as [valid] options, while so many other possibilities can be provided*<sup>33</sup>. In a recent article by Emanuel<sup>31</sup> it is easy to identify Pellegrino as his main inspiration. According to the author, there are arguments that rarely gain media attention and that are fundamental to offer ethical support to medical decisions in terminally ill patients.

Using data from countries where euthanasia and assisted suicide are legalized, he argues that the clamor to legalize euthanasia [E] and assisted suicide [SA] do not help improve end-of-life care. *E and SA do not resolve the management of symptoms or improve the practice of palliative care. These interventions are for 1% and not for 99% of patients who are dying. We also need to deal with the problem that the vast majority of terminal patients*

face, namely how to achieve symptom relief, and how to avoid hospitalization and stay home in the final weeks of life. Legalizing E and SA would be really secondary in the case of end-of-life care, a fact advocated by the few with the support of the media, but that does not aim to improve the care for most end-of-life patients, which will continue to suffer<sup>34</sup>.

According to the author, the public perception of the alleged need for euthanasia and assisted suicide overreacts pain. The word “suffering” is also used in an attempt to broaden [the scope] of the argument on “existential issues”. But existential sufferings, as well as pain, can well be controlled through medical care<sup>35</sup>. Therefore, pain is not the primary reason why patients seek these options, although many healthy people believe this.

According to Emanuel, patients who request and undergo euthanasia or assisted suicide rarely experience unbearable pain, and few of them desire such procedures. Research with patients suffering from cancer or AIDS demonstrated that those interested in these alternatives did not suffer unbearable pain. This fact has been confirmed countless times, in data from the State of Oregon, USA. The follow-up of patients who applied and submitted to assisted suicide showed that less than 33% experienced unsatisfactory pain control<sup>36</sup>.

If it is not the pain, then what motivates patients to request euthanasia or assisted suicide? In the author’s opinion, it could be depression, fatigue of life, loss of hope, control and dignity. The real reasons for the request would be psychological in nature and not primarily physical, so they could not be alleviated by increasing the dose of morphine, for example, but by a psychotherapeutic approach.

In the states of Oregon and Washington, where euthanasia is legalized, the reasons for assisted suicide were loss of autonomy (90% of patients) and personal dignity (70%)<sup>31</sup>. It is interesting to note that depression and hopelessness are not usually included as reasons to decide for assisted suicide. In the Netherlands, for example, the main legal requirement for the practice is extreme physical or mental suffering, which makes it difficult to recognize whether the determining reasons depend or not on the emotional state<sup>34</sup>.

Emanuel stresses the importance of careful consideration of psychological distress, an indicator that many requests for euthanasia and assisted suicide are less palliative and more similar to conventional suicide motives<sup>35</sup>. The main causes of conventional suicide are psychological

problems, theme not valued by doctors of states where these mentioned options are legalized. In Oregon and Washington, for example, less than 4% of patients who applied for assisted suicide received psychological counseling. Being psycho-existent the predominant reasons for this type of request, offering psychiatric follow-up to these patients would be the most prudent before making irreversible medical decisions.

Emanuel concludes his argument by arguing for the need to think differently about the reasons that underlie these choices. The image that most people have of patients writhing in unbearable pain is wrong<sup>31</sup>. The idea, widely publicized in the media, that bringing death to a lethal dose of a drug is a “dignified” way to die is also fallacious. For Emanuel, this conclusion results from a hasty assessment of reality.

He also warns that there is no risk-free medical act, as any procedure can have adverse effects. Emanuel justifies this assertion by mentioning a study done in the Netherlands in 2000, which showed that 5.5% of the cases of euthanasia and assisted suicide had technical errors that caused a certain degree of suffering to the patients. In 6.9% of these cases, it was also difficult to complete the procedure that would culminate in death. Technical problems, including difficulty in venous access for drug infusion, occurred in 4.5% of euthanasias and 9.8% of assisted deaths. These facts suggest that the commonly held view that these alternatives are quick and free from complications to induce a quiet end is misleading.

### Final considerations

Despite the taboo about death, one must look at it more naturally and spare patients from senseless and prolonged agony, respecting their personal values and beliefs so that they can complete life cycles with dignity. We agree with Ezekiel Emanuel when he states that in taking into account the evidence presented here, the legalization of E and SA appears as a much less attractive alternative<sup>36</sup>.

What, then, would be the main motivation to legalize interventions that would abbreviate the lives of a minority of depressed and frightened patients because they lost their autonomy? Although there is no consensual answer, we consider it imperative to conduct professional practice based on the most authentic purposes that for millennia have guided medical art, expressed in the aphorism *to heal at*

times, often to alleviate and always to comfort, attributed to Hippocrates although not included in his major work, the “*Corpus Hippocraticum*”<sup>37</sup>.

According to the author, we should shift the focus of the media frenzy on E and AS as if they were a panacea for improving end-of-life care. Rather, instead, we need to focus on improving

palliative care offered to the majority of dying patients who need optimal symptom control<sup>36</sup>. Here the palliative care philosophy underpinned by sound clinical practice emerges vigorously, with a solid and proven scientific base capable of providing humanized care to patients suffering from terminal illnesses<sup>38</sup>.

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#### Participation of the authors

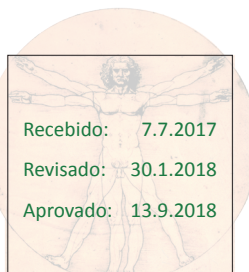
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