Bioethics and religious processes among terminally ill patients in Brazil

Alvaro Angelo Salles

Abstract

The techno scientific advances in the last decades have contributed to increase the number of terminally ill patients in the world. Given the millenary connection between life's terminal phase and spiritualist processes, this fact has gained peculiar shades in Brazil, a country where the number of religious/spiritualist-oriented segments has also multiplied in the last decades. This study seeks to demonstrate that the diversification of Brazilian terminally ill patients' needs regarding the spiritual wellbeing may bring about new bioethical dilemmas for health professionals who are not familiar with the tenets of the current main spiritualist followings in Brazil. Supporting the fact that this knowledge is an important tool for health professionals who seek to observe the principles of beneficence and patient's autonomy, this paper provides some basic orientations of the main Brazilian spiritualist tenets about the processes of death and dying.

Keywords: Bioethics. Autonomy. Living will. Life terminality. Religious beliefs. Terminal patient. Terminal illness.

Resumo

Bioética e processos de religiosidade entre os pacientes com doenças terminais no Brasil

Os avanços tecnocientíficos das últimas décadas contribuíram para o aumento do número de pacientes com doenças terminais no mundo. Em decorrência da milenar conexão entre a fase de terminalidade de vida e os processos espiritualistas, esse fato assumiu aspectos peculiares no Brasil, país em que o número de segmentos religiosos/espiritualistas multiplicou-se nas últimas décadas. Este trabalho procura mostrar que a diversificação das necessidades de pacientes brasileiros com referência ao bem-estar espiritual na fase final da vida pode gerar dilemas bioéticos novos para o profissional da saúde que não conheça os fundamentos das principais correntes espiritualistas do país. Defendendo que tal conhecimento é ferramenta útil para o profissional da saúde que quer observar os princípios da beneficência e do respeito à autonomia do paciente, o texto disponibiliza algumas orientações básicas das principais linhas espiritualistas brasileiras sobre os processos da morte e do morrer.

Palavras-chave: Bioética. Autonomia. Testamento vital. Terminalidade de vida. Crenças religiosas. Paciente terminal. Doença terminal.

Resumen

Bioética y procesos de religiosidad entre los pacientes con enfermedades terminales en Brasil

Los avances tecnocientíficos de las últimas décadas contribuyeron para aumentar la cantidad de pacientes con enfermedades terminales en el mundo. Por consecuencia de la milenaria conexión entre la fase de terminación de la vida y los procesos espiritualistas, este hecho adquirió aspectos peculiares en Brasil, país en que el número de segmentos religiosos/espiritualistas se multiplicó los últimos años. El presente trabajo busca mostrar que la diversificación de las necesidades de pacientes brasileños en relación al bienestar espiritual en la fase final de la vida puede generar nuevos dilemas bioéticos al profesional de salud que ignore los fundamentos de las principales corrientes espiritualistas del país. Defendiendo que este conocimiento se constituya en herramienta útil para el profesional de sanidad que desee observar los principios de beneficencia y respeto a la autonomía del paciente, el texto dispone las orientaciones básicas de las principales líneas espiritualistas brasileñas sobre los procesos de muerte y de morir.

Palabras-clave: Bioética. Autonomía. Testamento vital. Terminación de la vida. Creencias religiosas. Paciente terminal. Enfermedad terminal.

Mestre alvaroangelo7@yahoo.com – Escola de Medicina da Faculdade de Minas (Faminas), Belo Horizonte/MG, Brasil.

Correspondência
Rua Euclásio 231, apto. 504. Santa Efigênia CEP 30260-210. Belo Horizonte/MG, Brasil.

Declara não haver conflito de interesse.

Two facts, together, have contributed to the recent emergence of some dilemmas for the healthcare professional in Brazil: the scientific and technological advances that have led to the increased life average of the global population and, naturally the number of end-stage patients; and the multiplication of religions, sects and the spiritual nature of segments in Brazil, in parallel to the loss of hegemony of the Catholic Church in the country. Given the ancient connection between the end stage of life and spiritual processes, it began to grow the number of patient requests regarding posture or rites with which the Brazilian health professional might not be familiar to, generating dilemmas.

The principles of bioethics are presented here as a path to help solving the impasse, giving emphasis to the principles of respect for autonomy, beneficence and otherness. As a support for the practice of these principles, basic information about death and dying are presented and discussed, from the perspective of some of the major spiritualists religions, sects or chains currently existing in Brazil.

The technology and death

Thanks to the profound technological and scientific advances from the early twentieth century, it became possible to extend human life for periods never imagined. According to projections of Camarano 1, the number of elderly in the world in 2050 will correspond to almost a quarter of the population. In Brazil, in 1950, the percentage of people over 60 was 4.9%; in 2000, 7.8%; the projection for 2050 is 23.6%. At the same time, the limits of the period known as terminality of life have been directly affected by medical and technological possibilities of keeping a patient alive for extended periods.

Nunes 2 considers as a terminally ill the person who is in the final stage of life, being the determination of that period always casuistic. The author still believes that, in a general sense, this term applies to the patient whose disease does not respond to any known treatment, facing then a process that irreversibly leads to death. To these characteristics we add the observations of the Portuguese Palliative Care Association (APCP) 3, who understands as terminally ill the person who has, on average, three to six months of life, period estimated by criteria of prognostic objectification. As the patient may be unable to express their thoughts, it is understood, for the purposes of this discussion, that their wishes can be expressed by its legal representative or his family.

In the twentieth century, medicine was deeply affected by scientism and an accelerated technicisation process. These factors made the more abstract and subtle issues to gradually unconnect from medical practice. As the human factor did not accompanied pari passu the technical development, the hospital began to run serious risk of not being more faithful to its primary function, that is, hospitality. According to Salles 4, the challenge now became choosing between technology and human warmth, or integrate into technological development a humanistic character. That option was supported by Potter 5, which emphasized the need to gather biological knowledge with human values to achieve a new wisdom referent to nowadays. In the early 1970s, Hellegers 6 foresaw that the problems that would present to physicians in subsequent decades would increasingly have more the ethical aspect and less the technical-biological nature.

At the bottom of this discussion, the ethical dilemmas around the theme of death would evidently be of relevance and great complexity. After all, the taboo of death (for so is generally considered) reveals, in essence, as the intimacy. If we start looking at the phenomenon, we see that, by dealing with it, it is to the depth of ourselves that we are focusing attention. “Who am I? Where did I come? Where am I going? Is there a hereafter? Do I have autonomy over the procedures to be done in my body? And the decision of the moment of my death?” Doing this confrontation forces us to reflect about our own lives, our foundation as human beings, our deepest values. In today’s world, these questions are generally avoided, but in the case of health professionals dealing with terminal illnesses, there is no escaping from the scope of such reflections.

Dilemmas of spiritual nature in terminal life

During the course of illness, the patient already knows a process of loss, pain and anxiety. He faces social breakdowns and becomes vulnerable when taken out of his socio-family environment, having then to search for a consistent sense of life along with these new conditions. With the perspective of death, the complexity of these processes increases and consequently the ethical and existential questions about if, when and to what extent the health professional must intervene. It arises the need of establishing clear and precise criteria for good clinical practice by the professionals involved.

 http://dx.doi.org/10.1590/1983-80422014223021

In the pursuit of these criteria, it is easily observed that, lately, the involvement between medicine, bioethics and psychology was strengthened, since man can be considered, in its first instance, a biopsychosocial being, with diverse facets to be considered in care. Barnard and colleagues 7 defended the need for professionals to also have sociological and cultural knowledge of the death process, besides skills in communication and in the practice of self-knowledge and reflection. However, it is the spirituality facet that, almost inevitably, manifests itself significantly in the terminality of life.

There is almost always some type of religious expression present in the rites of death and dying, even if the person involved has adopted a position contrary to any religions or beliefs throughout life. Inevitably there is a relative, friend or someone interested in the tranquility of the patient or the deceased in a different level than physical. And this person brings objects that supposedly cure or cause well-being, or dedicates to the dead person a prayer during the funeral, or extend his consolation to those familiar with phrases dictated by fundaments of spirituality. The patient, in turn, is in a vulnerable situation, and thus his search for support or help may increase his desire of, in the occasion, adopting certain procedures linked to their spiritual area. However, the peculiarities of the spiritual nature of the patient's wishes may represent different procedures than what is standardized in hospitals.

When it takes place in a multicultural country like Brazil, where several races merge and numerous types of immigrants coexist, the issue is more complex considering the greater the number of religions, sects or doctrines followed. For centuries, the Catholic Church dictated to Brazilians the rituals related to death. For the 1872 census, 99.6% of Brazilians were Catholics. In the last three decades, the rate was already 64%. And there has been a continuous downward trend, with a decrease of 12% only in the last decade, according to the Brazilian Institute of Geography and Statistics (IBGE) 8. At the same time, it is seen a multiplication of religious segments in the country, which adopt different thoughts about death and dying.

It is not hard to observe the growing influence of a patient's spiritual guidance on the decisions of the health professional. One example is the decision on blood transfusion or body manipulation immediately after death. What happens, then, if the will of the dead patient and / or his family does not fit the usual procedures or the known religious rites of health professionals responsible for this patient? Until what extent the professional, who is unfamiliar with certain procedures (that may seem bizarre to him), should take into consideration the spiritual side of the patient? We believe that, for the solution of these and other similar dilemmas, the professional shall find benefits within bioethics.

The role of bioethics in religious processes of terminality

As much as medicine, psychology and other sciences have provided knowledge and guidance to help professionals to make decisions that would benefit the patient, bioethics guidelines for the terminal phase of life should be highlighted. The "distance" between the professional and the patient can be reduced or suppressed if certain principles are taken into account, such as the respect for the patient's autonomy, beneficence and, in particular, otherness.

For the South American bioethicists, in the principle of otherness are encompassed human values such as care, compassion and mercy. This is because, if defined succinctly - but enlightening -, the otherness translates into a movement through which the individual tries to put himself in the position of the other and feel or experience his needs, pain and limitations. For Hennezel and Leloup 9, not being afraid of the other's suffering and assuming it within himself would be true compassion. Although the principle of otherness is not often discussed in books of bioethics, it is of utmost importance. Ironically, this assertion is often found in situations where such principle is absent, for example, when we find a health professional that sticks only to the technique in his procedures.

The resolutions of the expert may be drastically modified if it is guided by the principle of otherness, putting himself in the place of the patient and seeing the issue "with the eyes of another." The difference between these decisions was verified by Asai, Fukuhara and Lo 10, comparing the conduct of Japanese doctors in a proposed case of an elderly patient in terminal phase and with disseminated cancer. Doctors initially opted for very aggressive and invasive procedures aimed at maintaining the patient's life. In a second step, the researchers asked the doctors to try to put themselves in the place of the patient and indicate which procedures would they apply to themselves. The intervention rate and invasive procedures fell drastically, blood transfusions decreased from 74% to 29%, total parenteral

nutrition has decreased from 67% to 33%, and the use of vasopressor drugs fell from 61% to 25%. It was then demonstrated that while the patient is seen as an object decisions tend to reproduce the technical perspective, which in the first instance is at the heart of a formal transmission of knowledge, but when the physician puts himself in place of the other, in a personification of an act of compassion, the procedures adopted are different.

Each being has various systems of values and beliefs, even the ethical and religious. These systems may not influence during youth or maturity, but usually gain power in the terminal period of life. Our attitude towards death is always a heritage of our culture and religion, to whose representations we use to correspond to. The image we have about death and suffering is internalized, but almost never analyzed. Therefore, the death issu may be seen from different perspectives and in accordance with the cultural environment. And the professional may not always know these different perspectives.

Applying the principles of autonomy and otherness

The care, compassion and mercy, values from the heart of the bioethical principle of otherness, will require reflection and study of the health professional who treats a terminally ill patient, as well as the principle of respect for the patient's autonomy. When the patient's needs come from a spiritual belief, it will be easier for the professional to interpret them, understand them and possibly accommodate them to the hospital environment if he has any knowledge about such belief. The data offered here may represent an opportunity for reflecting on the respect for the beliefs of others, which would represent a bioethical process (and thus "human") of attention, to counterbalance the technicisation surrounding the patient. Hence the need to debate not only the professional relationship with the patient in the terminality of life, but also to highlight aspects of the dying process, for example, the manipulation of the body and how that body will be disposed.

Perspectives on death and dying

Buddhism

Buddhism is not structured as a homogeneous block of doctrines, as in various religions. It has several schools and philosophical principles, sometimes divergent. In here we focus its common features with respect to death and dying.

Are among the basic concepts of Buddhism (1) everything in the universe is impermanent and all beings that are born are doomed to die and that (2) suffering is a constant in the universe and all beings suffer, grow old, get sick and die. These precepts are part of the so-called Four Noble Truths 11.

Integrating the Buddhist teachings is the constant training of the mind to remain calm and observant, especially when near death. This preparation for death is present in almost all Buddhist practices, among which stands out the practice to conscious death, named P'owa 12. The most famous text of Buddhism over death is the "Tibetan Book of the Dead" (Bardo Thodol), which describes in detail the passage from this world to the other.

In Buddhism there is the notion of reincarnation after the physical death of the body. Thus, in Buddhist thought the cries and lamentations of family and friends moments before or shortly after the death of the person are useless and counterproductive. Long periods of silence are considered very important for the diseased to make his meditations and rituals undisturbed.

Before the patient breaths for the last time, the companion must gently give, with the tip of the right index finger, a succession of little touches in the exact center of the top of the head of the recently deceased, to attract his focus of attention to the so-called coronary chakra, where it is located and from where it is believed that the spirit leaves the body 13. It can be also used some specific substances that are placed on top of the head in order to attract awareness for the coronary chakra 14, but any other part in the body should be touched at that time, meaning a disrespect to the beliefs of the deceased (and therefore to his autonomy). There would also be a breach of the bioethical principle of non-maleficence, because, for the Buddhist view, it would be causing harm to the patient and impairing him in the preparation for a later reincarnation.

Buddhists believe that a person's spirit may delay to leave the body, which should, wherever possible, be in the right lateral decumbency 15. The average period of departure is three days, but they believe that the process may take up to seven days. Thus, Buddhists have great concern about the manipulations made in the body after death, that should be avoided to the maximum. If in an absolute need for manipulating the body, one must touch be-

 http://dx.doi.org/10.1590/1983-80422014223021

fore in the head 15. The confirmation of the departure of the spirit is confirmed by some physical signs that the body presents and that are declared by a more experienced monk, group leader accompanying the body 13. From the moment the spirit is set free, the body is no longer important to Buddhism, unlike what happens in other religions.

A common practice of Buddhism at the time of death is the recitation of hymns and mantras or the reading of specific texts. It's called the liberation by listening, once it is believed that the spirit may be guided by the words spoken by the accompanying personal 14. It is the personal current recommendation of Dalai Lama, the Vajrayana branch of Buddhism, that friends take turns to speak softly into the patient's ear by passing spiritual teachings, until the breath ceases 16.

Another concern is to bring the patient's altar of prayer into the room, which should be constantly in view, representing thus an act of respect to his belief autonomy. But the procedure may often cause nuisance to the administrative part of the hospital, which keeps track of the entry and permanence of objects in the hospital area. It would then be desirable that administrators could consider the bioethical principle of beneficence, as the acceptance of certain objects connected to the patient's worship will result in greater peace of mind for the person in his final moments 17.

There is no support for assisted suicide in the Buddhist practices. It is also not accepted the use of drugs that prolong life and at the same time, put the patient unconscious, once it is very important for the Buddhist to make the transition to another level as conscious and calmly as possible 18. There is also the implementation of Tonglen, a respiratory practice that can be performed by the moribund's companion, known as " serenity transfusion" or "transmission of serenity". The companion perfoms the practice to calm himself and to transmit to the moribund the serenity reached by him 19. As for the funeral, cremation is almost always chosen 17.

Spiritism

It is a religion (or, as some prefer, a doctrine) that was encoded by Alan Kardec in the nineteenth century. His most famous texts are "The Book of Spirits" and "The Gospel according to spiritism." The latter is based on the Christian gospels, but receives interpretations of the so-called medium mentors. Spiritualism has many points in common with Christianism, as the figure of Jesus Christ with the disciples and, as already mentioned, the biblical gospels.

A key point of difference between the two religions relates to issues about reincarnation and the contact with the so-called disembodied spirits. In common with Buddhism, has the notions of chakras as body strength centers and the reincarnation theory. However, by accepting a new incarnation only in another human body, different from Buddhism, which admits the possibility of reincarnation in animal body.

Spiritisim sees the human being in constant process of improvement, through the lessons of his countless lives. Considers to be responsible for everything that happens to you, thus sharing with the Buddhists notion of karma (law of action with its consequent reaction). Following this principle, that spiritism values life until its last breath, as this is considered a form of learning, and does not allow euthanasia and, in some cases, not even orthothanasia 20.

Its funeral rite is the burial. However, if preferred, cremation is allowed, but only after three days after the medical confirmation, once it is believed that an earlier cremation would represent a painful process to the spirit of the dead, which still maintains energy ties with the physical body, and also for being the cremation seen as a too fast process of separation between spirit and body. It should be added that, for the spiritualist, the crematory process should only be used by very advanced people in ethical and spiritual senses 21.

There is a difference between the ideas of death (the death of the physical body, the irreversibility of the vital process) and disembodiment (when the subtle part of the person is able to rupture the energy ties that bound to the physical body and completely releases). But in spiritism, the word "disembodiment" may be used in both directions.

In spiritism, there are no strongly opposing beliefs to the use of organs for transplantation, although it takes into consideration the type of death (if violent or not) and the emotional and psychological state of the person at the time of death, as well as previous manifestations of the person's will to whether or not be organs donor 22. A confrontation between the principle of beneficence (if family members wish that the deceased's organs are used for transplantation) and the non-maleficence (the leader of the spiritualist group which the deceased made part considers him in no spiritual condition to make donation) may arise. For Teixeira 23, in the

spiritualist belief, an involuntary and not prepared donor may, in the subtle plane, desiderate the organ and thus suffer for being still emotionally attached to his physical body, which could also energetically contribute for installing a rejection process in the receiver body.

There are no provisions contrary to the manipulation of the corpse. There is also no greater concern about the moribund's state of awareness (unlike Buddhism) and the medications that would give him some level of unconsciousness, once spiritualists believe that in the other plan there will always be figures known as helpers, that will help the deceased to make the transition, waiting for him on the other side 22. While acknowledging the advantage of a more conscious transition, some think it would depend on the person's level of spiritual progress and his merits in this life and in previous lives.

Spiritism understands death as a natural part of life, and the fear of death, as an instinctive reaction of self-preservation phenomenon. The types of death and disease will always be linked to a karmic inheritance. Spiritualists note also that the disembodiment process may be accompanied by psychics and paranormals phenomena, resulting from the energy cuts between the physical and subtle bodies at that time 21.

The spiritual doctrine is quite popular in Brazil, and several people who profess the Catholic religion profess together the spiritism.

African-based religions (Candomblé, Umbanda and Quimbanda)

These are called African-Brazilian religions, once they keep connection with the arrival of African slaves in Brazil. According to Trindade 24, they are quite popular in several Brazilian states, especially among the black population. In general, these religions adopt ceremonies in which some people - named "horses" - go into a trance and "receive" spiritual entities, which will "occupy" their bodies, in where "will ride" 25.

These religions are very connected to nature and its phenomena and, in that sense, may even be considered religions of nature or ecological. Its followers consider important the energy of rivers, wind, thunder and the forest, elements seen as points of consciousness or energetic beings, being all linked to humans. Thus, the main learning is how to invoke and manipulate the energies that are found in nature, including animals.

Ferreira 26 instructs that, among the rites of African based religions found in Brazil, there is the one which allows the sacrifice or offering of an animal to improve the health of a patient, even if in terminal phase. This sacrifice is considered valid even if the patient does not know that it was intended to him. This belief bases itself on the notion that the blood would be a powerful source of energy, a true agent of transformation, healing or magnetization. When criticized by those who say that are defending the animals of sacrifice, practitioners often argue that if everyone uses animals for all, why could they not use it in help rituals?

In general, we are zealous of our culture and beliefs. A visitor who barefooted enters enters in certain temples in India can be expeled from the premises in a physically aggressive and loudly manner, while in Brazil it would be fully accepted in churches or temples. Also in India, in some regions, a tourist could even be lynched by the population if he killed of a cow, while in Brazil, many people make various celebrations around animals cooked meat. These ponctual examples demonstrate how it can be difficult to overcome the limits of one's world view.

Just as in the examples above, in Brazil there are almost insurmountable difficulties for the sacrifice of animals in the hospital area. Therefore, the most common action with respect to patients from these religions is their removal from the hospital for them to make the transition in their own homes, with appropriate rituals. Therefore, as in the case of animal sacrifice, it is important that professionals always try to discern when facing various dilemmas encountered in terminality, if their rejection is generated by compassion to the other - the animal -, or because their ingrained way of thinking and their culture are being questioned.

The supporters of the African based religions believe that the spirit of the deceased keeps hovering the body, but accept medical decisions of brain death, have no restrictions to organ transplantation and, unlike the Buddhists, do not believe that the manipulation of the body may disrupt or influence the spirit in the post mortem period. Some groups also accept the idea of orthothanasia if a spiritual leader (known as "pai de santo" or "babalorixá", who is the head of the yard ("terreiro") or the house where the religion is practiced) says that the spirit is no longer in the body, even if the body is being kept alive by machines.

Adherents of these religions understand that death is part of nature's cycle and that the de-

 http://dx.doi.org/10.1590/1983-80422014223021

ceased's relatives should not get carried away by strong emotions, because they can make them vulnerable and fragile. If it happens, think the Umbanda practioners, the disembodied spirits stay among who is alive in acts such as eating, drinking or having sex, feeding off the energy emanated by these physiological phenomena 27.

They believe in reincarnation, but find that it always within the same clan, that is, the spirit is reincarnated in the same family line and in between members who had a special bond in a previous life. In this respect, it differs from spiritualism, whereby reincarnation happens to pay debts (karma) and can happen in any family, in any region of the planet.

In African-based religions, there is also the belief that all human beings possess mediumship in a greater or lesser extent 24. Unlike Spiritism and Buddhism, they have no dogmatic texts, its tradition is oral and the rites are quite varied, however always with a connection to the energies of nature.

Catholicism

Regarding the corpse, the Catholic Church makes no objection to the fact that it is touched or handled and accepts the donation of organs and the condition of brain death. Disagrees, however, with the shortening of life, not approving, therefore, euthanasia, even if some leaders accept orthothanasia. Catholicism does not believe in reincarnation, although there is the belief of resurrection, which is the return of all the dead, in the flesh, in the Judgment Day.

For the terminality of life period, the Church advises prayers for relieving physical and mental suffering, and the use of the so-called health blessings. At the time of death or shortly after, there is the ritual of the sacrament of anointing of the sick, given by priests. In more conservative Catholic groups, the tradition of prayers being made by family members and friends present at the time of death is maintained, but this tradition is slowly disappearing. There are, in some regions of Brazil, other rituals for the time of death, for example, put a candle in hand of the moribund or dead; put four candles, one in each corner of the bed or room; give a crucifix to the moribund to hold in his chest with both hands; and wash the deceased body after the death. As for the end-stage adult who does not profess Catholicism, whenever possible, the Church seeks permission to baptize him.

Catholics have two outstanding concerns about death: the first is with the sudden death because they believe in a particular judgment that happens after death and for which the person may be unprepared to die suddenly; and the second is with those who commit suicide. There has been a reduction in restrictions and prejudices about suicide, but in some locations, discrimination continues to guide how suicidals are treated. A conduct that exists, most commonly in very small communities, is to bury the dead body outside of the cemetery, where the Church still "manages". With that, the family, already discriminated by the suicidal act, is even more marginalized, which is a violation of the bioethical principle of justice.

The Living Will

Nowadays, one cannot debate on dilemmas of the health professional during the terminality stage of a patient without mentioning the Living Will. It consists of advance directives of will, understood as instructions the person gives in advance regarding treatments he wants or refuses to receive at the end of life, in case he becomes unable to express his will or make decisions to and for himself 28.

This Will therefore aligns itself in importance to the wishes of the patient able to make himself understood during the terminal phase. Just as the wills verbalized by the patient, the health professional may notice that on the basis of wills registered in advance by the patient, it is generally detected religious / spiritual roots. Therefore, the professional relationship with the patient regarding the issues covered by the living will may also be facilitated by the knowledge that the professional has on the patient's spiritual conceptions. Likewise, the dilemmas related to the compliance with the will of the patient may be softened - and therefore regarding the autonomy of the other.

Understanding the spiritual reasons that underlie the expression of will of a patient, the health professional can comprehend, at a deeper level, the importance of their desires. Consequently, the attitude of the professional and the decisions he makes in relation to the living will have better foundation. At the same time, the professional find it easier to let himself be guided in their actions by bioethical principles, such as respect for autonomy, beneficence and otherness.

Accepting as true that, to act with greater serenity, the professional needs the knowledge about his patient's spirituality, one can also say that the patient's family is often a more accessible source of

information. The decision on when to put in place the wishes expressed in his living will (for example, the time to turn off the life support machines) should also include the participation of the family if the patient is unable to speak. It is for the family, therefore, that the health care provider passes the information about the extreme conditions of the patient.

Nunes transcribes the rules that compose the Proposal on suspension and failure to treatment in terminally ill patients, among which we highlight: when the patient is incompetent and therefore unable to decide freely, the clinically relevant information should be shared with the family, comprehending as family those who are in greater proximity to the patient, regardless of existing parental relationship 2.

In the work of Nunes and Melo 28 enough aspects of the living will issue are exposed to the reader - patient or healthcare provider – to make his own decisions, choosing whether or not to adopt the Advance Directives.

In Brazil, this issue has started with the Resolution 1.995/2012, of the Federal Council of Medicine 29, which specifies the conditions under which orthothanasia may occur. In the experience of the terminality dilemmas, it has been found the crucial importance of implementing in Brazil the practice of the living will to be written by the own hand of the patient and registered, in which he expresses his will both in relation to end of life as well as regarding his willingness to be an organ donor.

We understand that, if considering Brazil, the living will have one more peculiarity to be considered and that attention to this specific detail would directly link with the principle of otherness. As discussed in this text, the manifestations of religious or spiritual nature have significantly diversified in the country. Therefore, it is possible that the instructions previously given by the person on the treatment he desires for the terminal phase have to be read from a "code" generated by the spiritual line he follows.

Take a very simple and common example. A person instructed, in his living will, that wants the doctors to "turn off the machines" in the event of a specific condition. However, being that person faithful to the dictates of the Roman Catholic Church, in that desire could be implied another wish, that is for him a fundamental prerequisite: receiving the sacrament of anointing of the sick before the final medical measures. There is no guarantee that the family will remember it to the doctor.

In addition, each Brazilian hospital can be held to a different religious line. So, the attention of making a quick inquiry to the family may be in the hands of the health professional. To ensure your patient to complete his spiritual cycle on Earth according to the rituals of his belief reflects the practice of the principles of respect for autonomy, beneficence and otherness in a context of deep compassion. In the example of the sacrament of anointing of the sick, the professional would be respecting his patient even though he did not consciously realize that the sacrament was administered to him. Ultimately, and as we learn from Alves and Selli 30, to respect the religiousness of the patient may be considered also a respect for their cultural rights, which are part of their human rights.

Final Considerations

Regardless of the patient's code of ethics, or how many the opinions on the issue of terminalityof life are, the attitude of not abandoning the patient is essential in the final period of his life. According Quill, Lo and Brock 31, the act of not abandoning is the central ethical obligation of health professionals, reflecting his commitment to the patient and their code of ethics. And for that, it is necessary that the health professional is able to understand - and then comprehend - a bit of his needs in the spiritual field.

Knowledge, even if brief, of how the phenomenon of death is seen by certain religions, doctrines and beliefs allows some reflection that we consider important for dealing with this situation, particularly the bioethicist. The respect for autonomy to follow different beliefs must always remain, even if they are strange and scape our standards. This exercise is fundamental to the quality of the patient's terminality period and, at the stage where he is still conscious, for a better relationship with the professionals who give provide healthcare.

We must reflect that, ultimately, patients have beliefs in the same way that we have, or could have, and he would like to see them respected as much as we would like to see ours respected. For being beliefs, they only represent "possible truths" considerably particular for each group, not "universal truths" or facts that could or should be proven. Therefore, the professional care for the patient to find space for his spiritual manifestations is a bioethics attitude

 http://dx.doi.org/10.1590/1983-80422014223021

that will bring benefits, while its supression will result in conflicts. This perspective is also adopted by Alves and Selli, authors who point that, among the benefits of bioethics, the resignification of the spiritual dimension as a cultural need and, therefore, as an inherent part of human dignity 30.

We believe that by adopting an attitude of comprehension regarding the beliefs of the patient, the physician reveals his human and spiritual interest in who receives healthcare. And this concern with the other is the translation in acts of the bioethical principles of otherness and of the respect to autonomy of the patient. The time of death will be a little less complex for both parties - patient and health professional - from that attitude of tolerance, respect and compassion, human support elements that should not be missed or could not be replaced by technological support, as recommended by Potter 5. The health professional works for life, but perhaps this human support helps him and patients to understand that, as Hegel instructs 32, life and death are deeply intertwined once there is no life without death - in a plant, the death of the button allows the flower to bloom, the death of the flower gives life to the fruit, which will allow us to realize the true meaning of the tree.

Referências

1. Camarano AA. Envelhecimento da população brasileira: uma contribuição demográfica. 3ª ed. In: Freitas EV, Py L, editores. Tratado de geriatria e gerontologia. Rio de Janeiro: Guanabara Koogan; 2011. p. 58-71.
2. Nunes R. Proposta sobre suspensão e abstenção de tratamento em doentes terminais. Bioética. 2009;17(1):29-39.
3. Associação Portuguesa de Cuidados Paliativos. Comentários referentes à proposta de "guidelines" sobre suspensão e abstenção de tratamento em doentes terminais. [Internet]. [acesso 14 set 2014]. Disponível: http://www.apbioetica.org/fotos/gca/12802541901211800343guidelines_p_11_apb_08.pdf
4. Salles AA. Transformações na relação médico-paciente na era da informatização. Rev. bioét. (Impr.). 2010;18(1):49-60.
5. Potter VR. Bioethics: bridge to the future. Englewood Cliffs: Prentice Hall; 1971.
6. Hellegers AE. La Bioéthique. Paris: Les Presses de l'Université; 1979. (Cahiers de Bioétique; vol 1).
7. Barnard D, Quill T, Hafferty FW, Arnold R, Plumb J, Bulger R *et al*. Preparing the ground: contributions of the preclinical years to medical education for care near the end of life. Acad Med. 1999;74:499-505.
8. Instituto Brasileiro de Geografia e Estatística. Censo 2010: número de católicos cai e aumenta o de evangélicos, espíritas e sem religião. [Internet]. [acesso 14 set 2014]. Disponível: http://www.ibge.gov.br/home/pesquisa/pesquisa_google.shtm?cx=009791019813784313549%3Aonz63jzsr68&cof=FORID%3A9&ie=ISO-8859-1&q=cat%F3licos&sa=Pesquisar&siteurl=www.ibge.gov.br%2F&ref=&ss=1384j227194j10
9. Hennezel M, Leloup JY. A arte de morrer: tradições religiosas e espiritualidade humanista diante da morte na atualidade. Petrópolis: Vozes; 2005.
10. Asai A, Fukuhara S, Lo B. Attitude of Japanese and Japanese-American physicians towards life-sustaining treatment. Lancet. 1995;346:356-9.
11. Mizuno K. Essentials of Buddhism: basic terminology and concepts of Buddhist philosophy and practice. Tóquio: Kosei Publishing; 1996.
12. Chagdud K. Comentários sobre P'owa. Três Coroas: Rigdzin; 2000.
13. Rinpoche S. O livro tibetano do viver e do morrer. São Paulo: Talento; 1999.
14. Rinpoche B. Morte e arte de morrer no budismo tibetano. Brasília: ShiSil; 1997.
15. Grupo de Trabalho Religiões e Saúde, editor. Manual da assistência espiritual e religiosa hospitalar. Porto: Comissão Ecumênica do Porto; 2010.
16. Dalai Lama. Advice on dying: and living a better life. Londres: Rider; 2004.
17. Smith-Stoner M. End of life preferences for practitioners of Tibetan Buddhism. J Hospice and Palliative Nurs. 2005 jul-ago:228-33.
18. Thondup T. Peaceful death joyful rebirth: a Tibetan-Buddhist guidebook. Boston: Shambala Publications; 2006.
19. Hennezel M. A arte de morrer. Petrópolis: Vozes; 1999.
20. Xavier FC. Ação e reação. Rio de Janeiro: Federação Espírita Brasileira; 2004.
21. Kardec A. O livro dos espíritos. Rio de Janeiro: Federação Espírita Brasileira; 2004.
22. Xavier FC. O consolador. Rio de Janeiro: Federação Espírita Brasileira; 2003.
23. Teixeira CM. Anatomia do desencarne. Porto Alegre: Quarup; 1977.
24. Trindade DF. Umbanda e sua história. São Paulo: Ícone; 2003.
25. Meneghetti D. O Rio Grande do Sul revelado em cultos africanos. Fotografe Melhor. 2011 jul:45.

26. Ferreira CP. Kardecismo e umbanda. São Paulo: Pioneira; 1961.
27. Silva WG. Candomblé e umbanda. São Paulo: Summus; 2005.
28. Nunes R, Melo HP. Testamento vital. Coimbra: Almedina; 2011. p.96.
29. Brasil. Resolução CFM nº 1.995, de 9 de agosto de 2012. Diretivas antecipadas de vontade dos pacientes. Diário Oficial da União. Brasília, p. 269-70, 31 ago 2012. Seção I:269-70.
30. Alves JS, Selli L. Cuidado espiritual ao paciente terminal: uma abordagem a partir da bioética. Revista Bras. Bioética. 2007;3(1):65-85.
31. Quill TE, Lo B, Brock DW. Palliative options of last resort: a comparison of voluntarily stopping eating and drinking, terminal sedation, physician-assisted suicide, and voluntary active euthanasia. Jama. 1997;278:2.099-104.
32. Hegel GF. Fenomenologia do espírito. São Paulo: Nova Cultural; 1999. (Os Pensadores; vol. 16).

Recebido: 8.10.2014
Revisado: 21.10.2014
Aprovado: 3.11.2014

 http://dx.doi.org/10.1590/1983-80422014223021