

The Philosophy of Edmund Pellegrino and the bioethical dilemmas related to assisted suicide

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Abstract

Despite the growing emphasis given to autonomy on the decision-making process, mere autonomous decision does not always reflect the patient's welfare. In this article it is sustained from Edmund Pellegrino's Philosophy of Medicine, that the patient's welfare is composed of four elements, one delimiting the other, to ensure a balance between welfare as assessed by the doctor and the welfare as understood by the patient. The teleological approach to medicine, i.e., an approach based on *telos* (end) of medicine, defines the degree to which the patient's decisions are consistent with his or her own welfare. It follows that the patient's requests for procedures such as physician-assisted suicide are not in accordance with this end, so, it would be the role of health professionals to make their best to provide alternatives to prevent and relieve the suffering of patients, and in this point it's inserted the topic of palliative care.

Key words: Ethics. Bioethical issues. Bioethics. Assisted suicide. Palliative care.

Resumo

A filosofia da medicina de Edmund Pellegrino e os dilemas bioéticos relacionados ao suicídio assistido

Apesar da crescente ênfase dada à autonomia no processo de tomada de decisões, a mera decisão autônoma nem sempre reflete o bem do paciente. Este artigo sustentará, a partir da filosofia da medicina de Edmund Pellegrino, que o bem do paciente é composto por quatro elementos, um delimitando o outro, com vistas a assegurar maior equilíbrio entre o bem como avaliado pelo médico e o bem como compreendido pelo paciente. A abordagem teleológica da medicina, ou seja, uma abordagem baseada no *telos* (fim) da medicina, delinea até que ponto as decisões do paciente são condizentes com o seu bem. Segue-se que os pedidos de pacientes por procedimentos como o suicídio assistido não estão acordes com esse fim, e que caberia aos profissionais de saúde fornecer alternativas para prevenir e aliviar o sofrimento dos pacientes, no que se insere a temática dos cuidados paliativos.

Palavras-chave: Ética. Temas bioéticos. Bioética. Suicídio assistido. Cuidado paliativo.

Resumen

La filosofía de Edmund Pellegrino de la medicina y los dilemas bioéticos relacionados con el suicidio asistido

Pese al creciente énfasis en la autonomía en el proceso de toma de decisiones, la mera decisión autónoma no siempre refleja el bien del paciente. Se mantendrá en este artículo desde la Filosofía de la Medicina de Edmund Pellegrino que el bien del paciente se compone de cuatro elementos, un elemento delimita el otro, con el fin de garantizar mayor equilibrio entre el bien evaluado por el médico y el bien comprendido por el paciente. El enfoque teleológico de la medicina, es decir, un enfoque basado en el *telos* (final) de la medicina, define la medida en que las decisiones son consistentes con el bien del propio paciente. Se entiende que las solicitudes de los pacientes para procedimientos como el suicidio asistido no están de acuerdo con este fin, y que correspondería a los profesionales de la salud ofrecen alternativas para prevenir y aliviar el sufrimiento de los pacientes, donde se introduce el tema de los cuidados paliativos.

Palabras-clave: Ética. Discusiones bioéticas. Bioética. Suicidio asistido. Atención paliativa.

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Based on what can we talk about beneficence in medical practices? How can we defend universal values in a pluralist society? Pellegrino, physician and professor of the Kennedy Institute of Ethics (Georgetown University) suggests that, in the case of medical practices, what governs the doctor-patient relationship is the medicine's end, specifically, offering the cure, or when it is not possible, all the feasible palliative care, focusing on the patient's best interests. The philosophy of medicine, as it was structured by Pellegrino and Thomasma in *For the patient's good*¹, is based on the *telos* or the medicine's end – and according to this focus, we could understand which practices/actions would be morally correct in order to achieve this end.

Using this approach, this article intends to show that, despite the growing emphasis given to the autonomy in the decision making process derived from liberal societies, the mere autonomous decision does not always reflect the patient's welfare, because autonomy is only one of the elements that compose this welfare. We shall present, then, the patient's welfare as being made up of four elements, one delimitating the other, to ensure a balance between what is considered welfare for the physician and the welfare as understood by the patient, because, in our opinion, neither one nor the other can, all by itself, define the complexity of the patient's welfare.

The teleological approach of the biomedical ethics that will be presented provided sufficient and coherent answers to a lot of bioethical dilemmas, because it involves the clarification of what is the end of medicine, the search for the patient's best interests, besides clarifying the concept of futility and the affirmation of the importance of trust in the doctor-patient relationship – because only through this trust the doctor may achieve the end (*telos*) of their activity. It is worth pointing out that by trust Pellegrino does not refer to the doctor's power over the patient, which would be considered patronizing, but in the patient's trust that the doctor will act accordingly to the patient's best interests, since they have the knowledge and the skills to do so.

Our discussion regards the acceptance of the fundamentals offered to this philosophy of medicine, that is, why should we accept as the bioethics basis a teleological approach of medicine instead of the social construction of these practices? Why should we allow an essentialism in medicine instead of accepting that each people and culture may have different expectations towards a health professional (as in the case of patients who wish

to perform an abortion, or go under a physician-assisted suicide)?

Bioethics and the issue of substantiation

Bioethics, originated in an interdisciplinary speech, has been facing several difficulties concerning the loss of its normative character and substantiation. The ideas that have prevailed are the ones of social construction, discourse ethics and dialogue, which emphasize this interdisciplinary character, but take for granted the aspect of ethical substantiation and its normativity. Epistemologically, *bioethics* means the systematic study of moral issues concerning the application of biological knowledge in human relations, such as agriculture and ecology, and medicine and public policies. By this definition, it is understood that bioethics would involve the search for a moral truth and certain normativity that follows this truth.

The Enlightenment (*Aufklärung*) helped reinforcing the idea of ethics free from a religious basis and from any metaphysics, basing the moral truth on human reason. However, nowadays the post-modernists even question our capacity of reaching a moral knowledge through reason, that is, there is a disbelief in being able to access moral truth through reason, which makes negotiation the only resource for an ethical conflict, since rationality itself lost its credibility.

As Pellegrino highlights, in the article *Bioethics at the century's turn*², ethics applied nowadays is regarded in terms of conciliation of *values* or finding what could be a *comfortable* decision. But feelings and values are not norms and do not carry the moral weight of a norm. They reflect subjective beliefs and we cannot argue about feelings. In parallel to this, the norms have a certain degree of subjectivity and are based on some conception of truth, of what is good, correct or wrong. But they are not self-justifiable, that is, it is possible to argue about norms. Thus, for the author, *reducing the moral conflict to a conflict of values is turning ethics into an exchange of opinions*.

As a result of this plurality of values, the only acceptable norm would be respecting other people's values, simply because they are their values. In the case of conflict of values, the impasse might be solved, at best, with a decision; and at worst, with a violent confrontation. For this reason, the bioethics normative basis cannot be taken for granted, because the clinical decisions cannot be based only

on people's values and beliefs, whether they are physicians or patients, since every belief is subject to moral evaluation. The societies and the biological knowledge will continue to expand and the decisions in the bioethical field cannot be left to conflicts of values and parameters such as social construction, reflective balance or dialogue.

Abandoning norms in favor of conceptions of what works or is *useful* is considered the erosion of the ethical component in bioethics and entails individual, and also public and international risks. Nowadays, one of the challenges for bioethics is recovering and preserving the ethical credibility and its normative content, with universal acceptance and application, in a way that it coexists with its multidisciplinary character without being absorbed by these disciplines.

Bioethics arose at the same time in two different environments and distinct approaches. At Georgetown University, it appeared as an approach of normative ethics applied to the medical practice. At the University of Wisconsin, it was conceived as a wider and more interdisciplinary scientific search, with its roots in biology, from ecology and populations to molecular biology. In many universities the teaching of bioethics contemplates elements of both approaches, reinforcing its interdisciplinary character, even though it may cause a loss of its identity as bioethics loses its normative character – as highlighted by Pellegrino.

Bioethics, when guided by values instead of norms, becomes a subjective enterprise that cannot be argued. Thus, bioethics nowadays needs to retake and reinforce its normative character, in order to develop certain universality, because, even considering cultural differences among different peoples, beliefs and religions, the ethics in the doctor-patient relationships is subjected to some degree of objectivity, without which the profession is emptied of its meaning and *telos*.

The danger in the substitution of norms, principles and precepts for *values* is that the latter are subjective, which makes bioethics lose its identity concerning the ethical normativity. Thus, what the author highlights is that, even though the humanities and social and physical sciences contribute to understanding the moral dimension of human life and are the substance for descriptive ethics, the facts, observations, histories and perceptions are not norms. And, without norms of action, ethics does not exist. Ethics involves reflection about what must be done, in a way that it analyzes if human conduct is good or bad, right or wrong.

Even though the role of practices has been highlighted, those without deep substantiation lose credibility among different notions of right and wrong. As a result, the ethical speech is reduced to a consensus regarding the information, confusing one of the political practice's virtues with substantiation for moral choice. When we talk about substantiation in ethics, we mean principles that work as action guides, from which it will be defined if an action may be considered good or bad. If we take ethical substantiation for granted, bioethics starts meeting the interests of different groups that offer facilities, services and medication, or even the interests of leaders or powerful groups. The patient's welfare becomes a secondary aspect.

Bioethics' teleological approach versus social construction

The end of medicine, or *telos*, as Pellegrino highlights, cannot be a fruit of mere social construction, meeting the economic, social and state interests or the interests of institutions and researchers involved in the patient's treatment. For this reason, the author highlights the importance of considering the cultural aspects in this doctor-patient relationship, not as a basis for this relationship, but related to respecting the patient's autonomous choices concerning their treatment and discontinuity.

When we consider the model presented by Pellegrino – *beneficence-in-confidence* –, we notice that it encompasses both clinical and personal aspects, since the patient's welfare can only be achieved when it is in compliance with their best interests (which involve personal choices, culture, religion, etc.). Consequently, basing the medical practices in the idea of *telos* instead of social construction is a way of protecting the patient's interests from others that may generate actions that do not necessarily have their best interests at sight.

Besides, an approach of bioethics based on the medicine's *telos* guarantees that ethics is not only part of the bioethics name, but also part of its practices, preventing economic approaches and contract relationships from weakening the doctor-patient relationship bases – that must be built on trust. When emphasizing the economic contracts and aspects, these approaches empty bioethics' philosophical and critical character, leaving only rules and procedures that are convenient to health care plan companies, hospital institutions, pharmaceutical industries and transplant organ collection.

Thus, basing medical practices on something other than the medicine's *telos* generates the risk of having several interests at sight, leaving the patient in an even more vulnerable situation than their own disease. But, if we accept the idea that the medical practices should be regulated by the medicine's *telos*, is it worth questioning what this *telos* is? What is the end of medicine? Or, going further, what is medicine?

Discussion about *telos* and the ethical principles

For Pellegrino, reviewing the basic concepts in medicine is indispensable, especially when the latest great changes in the area are considered, particularly from the biotechnological advancement, that makes us reevaluate the concepts of health and sickness. As the author highlights, *concepts are the currency of the philosophical speech*³, and when concepts are seriously modified we are subjected to intellectual and moral disorientation. And when concepts such as health and sickness are not clear, the concept of medicine itself becomes dull, since, when we define what medicine is, all of the other basic concepts, such as futility, the medicine's end, the patient's welfare and autonomy are molded.

The huge expansion of scientific knowledge increased the expectations regarding the medicine's power of improving human life's quality and duration and, even creating the illusion of immortality through technological progress. With such progress, the concept of sickness starts being questioned, because even the simplest of human limitations are no longer tolerated, since they can be subjected to clinical treatment. For example, can being overweight, having low life expectancy, having a below average IQ (*Intelligence Quotient*) or having a short stature be considered diseases? In the same way, we could think about menopause, adolescence, hyperactivity in children and infertility. Could all these conditions be considered diseases, defined by the availability of treatment?

For Pellegrino, when we answer the question 'what is medicine?', we answer all of these questions, and we are also able to see clearly which practices are morally correct and which should not be tolerated. With the definition of these concepts, we can certainly have an overview of what clinical bioethics is nowadays, its main problems and even proposed solutions.

According to what the author highlights, the beneficence is the first principle in medical ethics,

since this profession's *telos* is the patient and their interests. That is why, when we talk about rationalization of resources, we are referring to the restriction of futile, unnecessary treatments, and not to the limitation of resources to necessary treatments, because that would be morally problematic. Likewise, it is pointed out that *doing everything possible* is not a synonym for medical good practices. After all, everything that is medically recommended and that is in compliance with the patient's interests should be done, considering the concept of medical futility according to the criteria defended by the author: *efficacy, benefit and duties* of a treatment.

The conception of medicine defended by Pellegrino, which states that health professionals must act accordingly to the *patient's best interests*, implies, above all, in not acting only according to the doctor's welfare, but also to the patient's perception of their own welfare, their preferences, values, goals and aspirations. This means that, even though the medical practices should not be *merely* guided by the patient's preferences, they must be fulfilled when such preferences are not harmful to themselves, because they are part of the patient's own conception of welfare and, consequently, part of their autonomy.

In order for the doctor-patient relationship to occur appropriately, trust is necessary. By trust, the author does not consider trust in the doctor's infallibility, but belief in their profession and in their proposal, which would be acting in compliance with the patient's best interests. That is, in this relationship, the doctor's economic or personal interests must be left out, because they might go against the patient's best interests.

However, what medical laws and associations have been supporting is the fact that the health professionals may choose who they would like to treat, not being forced to treat those who cannot afford their services. Yet, a big number of doctors with character feel it is their duty to treat these people, even though they are not obliged by law. The difference between law and morale is clear, because law does not oblige doctors to do good, but requires no cause of damage, in a way that the moral language places the principle of beneficence in a higher value than the mere non-maleficence.

In the article Allocation of resources at the bedside⁴ Pellegrino reminds of the fact that physicians receive their training and knowledge, and develop their abilities as a result of an agreement with society. The physicians are allowed to dissect corpses, carry out researches in human beings, per-

form physical examinations, autopsies, assist the patient's care, define practical procedures and, even, seek knowledge about the patient's emotional and private lives, resources which are only allowed for the sake of their profession.

Society allows inexperienced people to gain skills and practice this way, because it needs physicians and the only way to promote their capacities safely is through experience. Physicians, on the other hand, receive benefits for the use of their acquired skills. Actually, there is an implied agreement when students start studying medicine. As a result, they obtain medical knowledge as guardians or managers of this knowledge for the patients.

The doctors are not absolute masters of their knowledge. As a way of returning what they were allowed to learn, they must take care of those who need their abilities⁴. Pellegrino calls this duty the physician has of having to take care of the sick: *fiduciary duty*, that is, a duty that comes from the trust invested by society and from all the knowledge and experience provided.

As for the economic issues that might be involved in the clinical practices, Pellegrino highlights that differences in assistance are allowed when they refer to luxurious hospital rooms, sophisticated food and other aspects which are not necessarily part of the medical care, and regard the medical care facilities. These may be provided to those who can afford, i.e., two levels of treatment are allowed, but only regarding the facilities and not regarding the treatment's medical quality.

The experience of sickness

Pellegrino shows how some concepts of phenomenology may assist a better understanding of the doctor-patient relationship, because he believes that the ethics based on the clinical meeting reports the concrete experiences of doctors and patients, more than the application of preexisting ethical theories. Thus, a phenomenological approach, in a broad sense, starts with the reflection about the experience shared by the doctor and the patient.

This heuristic approach would start from the concepts of *epoché* and *reduction*, as well as the concepts of *lifeworld* and *intersubjectivity*. With the former, we would have the stage of world abstraction, in which we aim at interpreting an experience not using the interpretation that would be naturally given to the case, trying to achieve a type of *essence* that does not come from the world. It is way

of changing focus from frivolity and particularity to the essential and universal qualities.

In parallel to that, when we talk about lifeworld and intersubjectivity, we are focusing on our natural attitudes towards a situation, the common way people act, this common reality we share, because the lifeworld is not private, since others exist, have similar consciousness and share kind of the same reality⁵.

In this context, the physicians' and the patients' lifeworld may be understood inside this concept of intersubjectivity, since they shared the experience of sickness, cure, being cured and giving hopes of being cured, and, along with the concept of *epoché*, they would allow a total construction of the social reality of this doctor-patient encounter.

Thus, the phenomenological ethics must be based on experience, not being, therefore, an ethics which is only based on practice. The physician's and the patient's lifeworld is the reality of the clinical encounter, in a way that only they know the meaning of this encounter and how ethics is incorporated to this context. That is, the meaning is not raw data, but our human perception of this data, its meaning in the lifeworld.

Pellegrino aims at showing through these phenomenological concepts that the lifeworld of physicians and patients interpenetrates itself. In the moment of the clinical encounter, the relationship is conditioned by intersubjectivity: from a person who is suffering from a disease and is looking for treatment, and from another human being that has the necessary knowledge and capacity to take care of this sick person. In this relationship, the intersubjective apprehension of what is care and what is damage for this specific patient is crucial: *The telos of medicine is the cure, and the medicine, as medicine, is a group of human activities that have an end and a purpose – for both physicians and patients –, the act of curing, of 'becoming whole again'. In the clinical encounter, the telos is the correct and appropriate way of treating this patient.*

Thus, we may notice that there is not *one* correct way of acting in the doctor-patient relationship in general, but there is the correct way of acting in the particular relationship, and this will be understood by the physician and the patient in that intersubjective relationship. In order for this *telos* to be achieved, once again we highlight the importance of the trust the patient has in the doctor, since the latter will have access to the patient's lifeworld and, due to this privileged access, they must commit to

the intellectual honesty, trust, courage and suppression of their own interests, in order to be able to act appropriately in the curing process.

The patient's welfare

The end of medicine, as we have defended in this article, is seeking the patient's welfare, since its *telos* is the cure or, when it is not feasible, all the possible palliative care, understood as relief from suffering, not only physical suffering, but also psychosocial and spiritual suffering, according to the definition of the WHO (World Health Organization), reviewed in 2002 ⁶.

It is necessary, then, to clarify what this welfare would be. The patient's welfare, according to Pellegrino, must not be seen only in clinical terms, because the treatments and possibilities made available by medicine nowadays are not always interesting to the patient, because they may go against their beliefs and values of what they consider a good life. Having effective awareness of the complexity of factors involved when the patient's welfare is approached, Pellegrino defends that the patient's welfare is defined to contemplate at least four of these components, hierarchically ordered:

The smallest of them is the medical welfare, that is, the good functioning of the human organism as an organism. This includes both the physical and the psychosocial functioning. In this field, the physician has their biggest ability. The subsequent level is the patient's own evaluation of their welfare, the definition of their preferences, objectives and the lifestyle the patient wishes to have. In this context, the patient or their representative is the point of reference. The next level is the patient's welfare as a human being, an evaluation in terms of the comprehension of natural laws and what is proper to the life of human beings as humans – this level of the patient's welfare is not defined by the doctor or by the patient. It is built based on what it is to be a human being. This point of reference is the natural law. Finally, the highest form of welfare is the spiritual welfare, the one derived from the fact that humans are created and designed by a personal God for a life that goes beyond this world, together with Him (...). This is not defined by the patient or by the doctor. This level is completely denied or ignored by ancient bioethics, despite the fact that all of the patients, physicians or representative are committed to some faith, or even to the rejection of some faith ⁷.

The end of medicine is duly achieved when the clinical practice aims at the patient's best interests. However, it is worth pointing out that by 'best interests' we do not understand the mere subjective interest, because not always what the patient needs is in accordance with their welfare, because the experience of sickness, as it has been seen, may alter their capacity of making decisions that really reflect their best interests and that they would certainly make in normal conditions. We defend, therefore, that many of our decisions are based on mistaken beliefs or in the lack of enough information or knowledge to which certain decisions can lead us. Thereby, many of the patients' decisions should not be taken seriously by the physicians, because they represent a hazard to the patients themselves, instead of supporting their best interests.

According to the parameters mentioned above, the patient must be seen as a human being in a society, with individual characteristics, values and beliefs that must be taken into consideration by the doctor, in order to realize, with the patient, what clinical procedures meet their expectations. Even though values and beliefs may be present in all of the medical practices and, consequently, also in the choices/refusals of treatments by patients, the fact that certain values or beliefs are defended by someone that does not make them true and free from moral analysis. Thus, the patient's preferences are part of their welfare, but they are not unquestionable, and they may, therefore, be unconsidered when they configure decisions against their own welfare and against the *telos* of medicine: curing and relieving from suffering. In other words: the patient's decisions do not always reflect their welfare, as in the cases where the patient wishes their own death, because they consider themselves to be a burden to their relatives.

Philosophy and Medicine

As it has been said initially, the teleological approach of bioethics provided satisfactory and coherent answers to the dilemmas in clinical bioethics, because defining the medicine's end as seeking for the patient's best interests also clarifies what are the patient's welfare and concepts such as futility, by which it is possible to clarify common bioethical dilemmas, such as euthanasia and physician-assisted suicide.

For Pellegrino, speaking of *beneficent death*, using the argument of compassion, relief from pain,

or even not causing damage to the patient that is in unbearable pain, is a big mistake. In their understanding, it is not possible to relate the act of killing a patient to the status of a beneficent action, even if it is based on autonomy arguments, relief from pain, etc. According to the author, what is frequently diagnosed as untreatable pain is, actually, pain that is being treated inappropriately and that could be eased without leaving the patient unconscious. That is, with the optimized and insightful use of the means available, there practically would be no patient whose pain cannot be relieved.

And, of course, it is necessary to understand that pain and suffering manifest a lot of times as different things. It is a responsibility of the professional who provides palliative care not only the efficient relief of physical pain, but also caring for the psychological aspects. For this reason, the teams of comprehensive palliative care are usually made up of professionals from different areas, such as physicians and psychologists, besides family members and spiritual mentors, because many times the patient's discomfort with the terminal disease goes way beyond physical discomfort.

According to Pellegrino, using the argument of unbearable suffering to support the legalization of euthanasia or physician-assisted suicide is, besides being a mistake according to clinical aspects, a fallacy of composition, because when there are rare cases where the patient's pain cannot be treated, it is not accepted that one must morally or legally approve euthanasia or physician-assisted suicide procedures. Besides being a logical and practical mistake, this train of thought, somehow, removes the health professionals' responsibility of providing the appropriate palliative care for the patients' pain and suffering relief, besides the possible use of these practices as a means of social control⁸. Arguing in favor of euthanasia or the physician-assisted suicide may imply in exposing the patients that, in their vulnerable situation, may see these practices as the only way out of their suffering.

It is a mistake to generalize few particular cases, motivating actions that support the legalization of euthanasia and physician-assisted suicide, because even in the most extreme cases of intense pain in terminal patients, the use of high doses of opioids may be considered, although it is known that the possibility of these medications abbreviating the patient's life, because, in this case, the principle of twofold effect is applied (since the objective is relieving the pain and not anticipating the patient's death). Besides, it is worth highlighting that

suffering is not a synonym for pain. Pellegrino defines suffering as *the conscious response of a person to the meaning and implications of pain and to the unique situation in life in which pain or other forms of alteration occur*⁸.

Thus, before anything else, the causes of suffering must be identified. When pain accompanies suffering, it must be relieved through the most effective means available. However, in order to relieve suffering, a lot more than that is required. The skillful use of antidepressants and anti-anxiety medications is suggested, as well as emotional support and the company of other people beside the patient who is suffering. In this way, Pellegrino describes the comprehensive palliative care with an integrated approach which aims at not only relieving pain, but also the patient's suffering.

With this approach, several aspects of the disease are examined, since – as the author highlights in his writings and lectures – the sickness phenomenon modifies the person, putting them in a situation of anxiety, fragility and vulnerability. Hence, it is pivotal to examine the sickness phenomenon itself in order to understand the reasons that make a patient wish for their own death. Understanding these reasons, we may offer better palliative care, which makes discussions about euthanasia and physician-assisted suicide unnecessary:

*Patients affected by a fatal disease that are still not in their terminal stage suffer from the anticipation of pain. Terminal patients or patients who are dying suffer from fear of death and fear of the process of dying. They also suffer from a feeling of guilt because they are sick, because they feel like a burden to others, in physical, financial and emotional terms, or for making their relatives suffer for them (...) Patients also suffer from pity, fear or aversion to what they feel from healthy people that come to visit. Physicians, nurses, visitors, relatives and friends may, unintentionally, induce feelings of invalidity, rejection and alienation by the way they react in the presence of the sick person who is dying*⁸.

All of these facts help understanding the need for comprehensive palliative care that sees the patient in their condition and helps them overcoming their physical and emotional suffering, due to the complexity of the experience of being sick, above all when they are in terminal stage. In this stage, the patient has to deal with all these feelings that are added to the fear of death and pain that is caused by the disease even more intensely.

Pellegrino interprets these pleas for euthanasia or physician-assisted suicide as cries for help from patients to their caregivers for coping with their suffering and pain. The death wish might be a desperate action to draw the attention to their experience of disease or suffering. It may also be an expression of disappointment with the lack of compassion from the family or the caregiver, that is, an attitude that might be originated from the lack of comprehension of those who surround them regarding their needs – or the response to the physical and emotional fatigue that the patient notices in their family, doctor or nurse.

As Pellegrino affirms, *it is unfair to offer physician-assisted suicide or euthanasia as options to these patients, while so many other possibilities may be provided, regarding sophisticated treatments*⁸. The heart of the matter is that it seems easier to offer physician-assisted suicide than offering a quality palliative care, because the latter requires a lot of commitment from the professionals and the whole medical teams and relatives.

Patients who are treated with comprehensive and intensive palliative care rarely ask for the anticipation of their deaths; and if they do, they end up changing their minds, because the reasons that lead them towards this decision are identified and all the necessary – physical, psychological and spiritual – support is provided. With this, Pellegrino is not considering a bad work of the caregivers, but recognizing the emotional demands and the reality of exhaustion and frustration involved in taking care of terminal patients. Bearing this in mind, even the people who defend the patient's autonomy the most in order to demand processes of life shortening must recognize this reality that surrounds the experience of being sick, and the way this experience is able to alter our own view of care, if euthanasia or physician-assisted suicide become a moral and legal option.

It is worth pointing out that, when we talk about comprehensive and intensive palliative care, we do not mean *improving* the treatment in terms of technology; by the way, the exaggeration in the treatments applied may bring more damage than benefits to the patient. Doing *everything that is possible* does not necessarily mean improving the care of terminal patients, since certain treatments are unnecessary and shallow. Besides, a fact that is pointed out as a reason for supporting physician-assisted suicide, even by people that would usually be against this practice, is the fear of being kept alive by tubes, wires and machines when their lives are coming to an end because of old age or sickness. That

is, many people are concerned about inappropriate and invasive treatments, which do not represent a real benefit to the patients, but, instead, cause fear and the feeling of incapability.

This problem may be solved by respecting the patient's autonomy concerning the right to refuse treatments, even though this right might have been mistaken by some patients with the right to demand treatments, even those that are considered shallow, according to doctors, or ethically inappropriate. The fact that physicians do not have an appropriate control of terminal diseases does not guarantee the approval of actions such as euthanasia or physician-assisted suicide of their patients. The doctors are expected to pay more attention to the patients and their interests, in order not to have excessive or insufficient treatment, since these are the reasons why patients wish to end their lives, for fear of excessive suffering or lack of appropriate treatment.

The patient chooses death when they consider to have lost control of the situation, when they feel unappreciated, dependent or incapable. When they feel pain and suffer for several different reasons that might not only be physical, but also psychological, spiritual, and so on. As it has been mentioned, Pellegrino believes that, if pain and depression were appropriately treated, the majority of patients would abandon their death wish. Another argument that is as strongly used as autonomy is compassion. Compassion is a feeling of empathy that may lead to beneficent actions, but can also cause damage, because, as the author highlights, having compassion does not mean doing everything a person wants:

*True compassion requires living in the other person's shoes, entering the unique experience of the person who is suffering and being able to share from this experience as a whole. This means giving yourself up, not pitying the person who is suffering. Being there even when there is no easy solution at hand may be hard, but it is essential for the patient to have a good death, and not for relieving or satisfying the observer*⁹.

Thus, for Pellegrino, considering or suggesting the anticipation of a person's death is much more an act of abandonment than the attitude of someone who wants to be together and give support, since compassion, according to its etymological definition, means *suffering with the other* and not eliminating the person who suffers, pitying them or disliking the person and their situation. The terminal patient wants to feel accepted, not rejected – this type of attitude is what triggers the death wish on a patient.

Finally, considering the most diverse aspects involved in the end of life, Pellegrino concluded that euthanasia and physician-assisted suicide are acts of maleficence, not beneficence, as some defenders of these practices suggest, because instead of acting according to the patient's best interests, relieving their suffering and helping them live their last moments well, death is offered, which for the author can never be considered a patient's interest. And those who wish it are not fully using their mental capabilities, or are suffering from depression, anxiety, angst and even physical pain, factors that may be reversed with comprehensive and intensive palliative care.

Final remarks

With this article, we aimed at showing how, in the philosophy of medicine of Edmund Pellegrino, beneficence is justified as a principle that could be a guide to biomedical practices, based on the idea of the medicine's end, which is assisting the patient's welfare, that is defined by four elements: the patient's welfare, their welfare regarding the species, their welfare seen from the patient's perspective, and the biomedical welfare. Bearing the consideration of this end in mind, issues related to patients with chronic or terminal diseases were discussed,

especially the author's perspective on the importance of intensive and comprehensive palliative care. We believe that the subject was clarified with the analysis of what the patient's welfare would be and in what levels this care must be considered.

Finally, the considerations about palliative care that back up this approach may be interpreted as an attempt to answer the dilemmas and discussions about euthanasia, physician-assisted suicide, abortion, and so on, as well as the protection of the person that is (or at least should be) the medical practice's focus. Thus, the position defended in this article affirms the patient's primacy in building the medicine's sense. The patient's needs are what justify the doctor-patient relationship, and not the health institutions, government's interests, health care plans or even the pharmaceutical industries and health professionals involved.

We could also see that the patient's welfare is not always represented by their choices, since a lot of these decisions are harmful to the patient, instead of supporting their best interests, which may occur due to lack of information or to decisions based on mistaken beliefs. Therefore, morally desirable practices in medicine must have the patient's welfare as a focus, according to the four elements presented here, which may be achieved, if not by cure, through palliative care that prevents or relieves the patients' suffering with chronic or terminal-stage diseases.

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