Revista Bioética
Print version ISSN 1983-8042 | On-line version ISSN 1983-8034

Rev. Bioét. vol.31 Brasília 2023

Brazilian literature on bioethics and suicide: a systematic review

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Abstract

This systematic literature review mapped Brazilian academic production with bioethical approaches to suicide, aiming to contribute to the debate on the ethical conflicts involved in this phenomenon and to collaborate in its prevention. Bibliographical search was conducted on the SciELO and Google Scholar databases, as well as institutional databases of graduate programs in bioethics, using the descriptors "suicídio," "suicídio e bioética" and "suicídio e ética." Twenty publications met the inclusion criteria and were grouped and analyzed in three axes: general reflections on suicide stigmatization; moral dilemmas regarding suicide and bioethical principles; and ethical-political analysis of the phenomenon. The little research found on the subject is surprising given its relevance for public health and moral reflection on end-of-life.

Keywords: Suicide. Bioethics. Systematic review.

Resumo

Produções bioéticas brasileiras acerca do suicídio: revisão sistemática

Esta revisão sistemática da literatura mapeou produções brasileiras com abordagens bioéticas do suicídio, a fim de contribuir para o debate sobre os conflitos éticos envolvidos no fenômeno do suicídio e colaborar para sua prevenção. Consultaram-se as bases de dados SciELO e Google Acadêmico e repositórios institucionais de programas de pós-graduação em bioética, acionando os descritores "suicídio", "suicídio e bioética" e "suicídio e ética". As vinte publicações que cumpriam os critérios de inclusão foram agrupadas e analisadas em três eixos: reflexões gerais em torno da estigmatização do ato suicida; dilemas morais acerca do suicídio e os princípios bioéticos; e análise ético-política do fenômeno do suicídio. Conclui-se que a produção que aborda essa temática é escassa, com poucas pessoas concentrando a maioria das pesquisas, o que surpreende, tendo em vista a relevância do fenômeno para a saúde pública e reflexões morais sobre o fim da vida.

Palavras-chave: Suicídio. Bioética. Revisão sistemática.

Resumen

Producciones bioéticas brasileñas sobre el suicidio: revisión sistemática

Esta revisión sistemática de la literatura rastreó las producciones brasileñas con enfoques bioéticos sobre el suicidio, para tejer contribuciones al debate sobre los conflictos éticos involucrados en el fenómeno del suicidio y contribuir a su prevención. Se realizaron búsquedas en las bases de datos SciELO y Google Scholar, y en repositorios institucionales de programas de posgrado en bioética, utilizando los descriptores "suicidio", "suicidio y bioética" y "suicidio y ética". Veinte publicaciones cumplieron con los criterios de inclusión y se agruparon para análisis en tres ejes: reflexiones generales sobre el estigma del acto suicida; dilemas morales sobre el suicidio y los principios bioéticos; y análisis ético-políticos del fenómeno suicida. Se concluye que la producción sobre este tema es escasa, con pocas personas en la mayor parte de los estudios, lo cual es sorprendente dada la relevancia del fenómeno para la salud pública y las reflexiones morales sobre el final de la vida.

Palabras clave: Suicidio. Bioética. Revisión sistemática.

Research

The authors declare no conflict of interest.

Besides classic questions related to what is understood as the right to take one's own life, suicide is a bioethical issue due to the different ontological, political and public health impasses, conflicts and strains involved, and can be identified as a persistent and/or emergent situation. In Brazil, however, it is addressed in a particular manner, especially when compared to other end-of-life topics and other ways of dying, in which different theoretical and practical approaches are adopted in coping with the phenomenon. To begin with, there is a (con)fusion between the bioethical subjects of end of life, especially euthanasia, assisted suicide and suicide, and it is the aim of this review to differentiate such events.

Euthanasia comes from the Greek words *eu* (good) and *thánatos* (death), that is, it means "good death," quick and painless death. It is a procedure performed by someone else and thus refers to the act of taking someone's life to end their suffering.

Assisted suicide, in turn, derives from a request, wish or act of hastening death in a situation of terminal or incurable illness. In this procedure, it is the actual individual who, in addition to making the decision, puts an end to their life through the ingestion of lethal drugs. Usually, it is undertaken with the help of another person, whether actively, through an act, or passively, through encouragement.

Although the debate on euthanasia and assisted suicide revolves around on minimizing suffering, as in the case of dignity and quality of life and death, the interpretation of human rights and bioethical principles, such as dignity, the right to life or respect for autonomy, is not uniform. Thus, global legislation varies significantly regarding conditions, professional behavior, protocols and laws.

In many countries where assisted suicide is legal, the patient's extreme suffering and level of consciousness to make this decision are key conditions. Furthermore, it is known that medical, religious, moral and legal powers are decisive in supporting or disapproving the legalization of medical assistance to hasten death [1]. In Brazil, such practice is illegal according to the Penal Code [2] and therefore considered a crime.

Suicide, a frequent topic in bioethical debates about the end of life and the main subject of this article, differs conceptually, ethically and epistemologically from the referred phenomena. First, euthanasia and assisted suicide are historically linked to a situation that is terminal and incurable and/or with a fatal prognosis, grounded in a medical report and subject to legal criteria. Suicide, in turn, despite also having different legal understandings and being considered a crime in some parts of the world, in addition to transgressing medical, religious, social orders, etc., occurs regardless of the state and without assistance from other people [3,4].

Second, the debate about euthanasia and assisted suicide seems to be gaining momentum, at least in the field of Brazilian bioethics, as a response to medical technologies, whose side effect is therapeutic obstinacy. Suicide, which pervades history and reveals, above all, the condition of a suffering individual, is today recognized as a serious public health problem worldwide, especially due to the high rates [4,5].

The term suicide comes from the Latin words *sui* (of oneself) and *-cidium* (act of killing) and means the act of killing oneself. The perceptions about this voluntary and intentional act gave rise to the historical stigma surrounding suicide, linked to crime, sin and madness [3,6]. Thus, marked by an age-old religious, philosophical, moral, cultural and medical tradition, and especially by the influence of Christianity on the laws of the modern Western constitutional state, suicide was circumscribed in the idea that life belongs to God and thus viewed as a demonic, reprehensible and criminal act.

Studies such as those by Guillon and Le Bonniec [5] and Barbagli [7] demonstrate the process of dehumanization of individuals who attempted to commit or committed suicide in several European countries in the 17th and 18th centuries, with emphasis on trials, punishments, torture, decapitation, public humiliation, confiscation of property and even the death penalty. In the 18th and 19th centuries, especially in Europe but also in Brazil, medicine strived to classify suicide, detect signs and medicalize potential attempters, associating them with madness and mental disorders [8], a correlation defended until today by the hegemonic suicidology.

About 800,000 people commit suicide every year worldwide. Growth numbers are significant in young people and it is currently considered the second cause of death among individuals aged 15 to 29.

Although the numbers differ between countries, low- and middle-income countries account for the highest rate of this cause of death, estimated at 79%. Between 2010 and 2016, the global rate of occurrences fell 9.8%, except for the Americas, which experienced a 6% increase [5].

Compared to global suicide rates, mortality in Brazil is one of the lowest. However, in absolute numbers, Brazil ranks eighth worldwide and fourth in Latin American, with the sharpest growth between 2000 and 2012 [4].

The literature, whose only consensus is multiple factors, denies single causes or justifications, highlighting the importance of risk factors and feelings such as hopelessness, despair, helplessness, etc. One must consider the complexity of suicide, the context of inequalities and various vulnerabilities, and the public health issue, in particular the current fragility of mental health policies in Brazil, as well as the taboo that hinders information, education and training to deal with the subject. Given the above, the goal of this paper was to reflect on Brazilian bioethical studies on the subject and contribute to the debate on ethical conflicts related to suicide and its prevention.

Method

Literature reviews are important to chart the development of a given subject or field of research, in addition to avoiding unnecessary repetition or duplication of investigations and identifying flaws and limitations of previous studies. This article consists of a systematic review of the literature, a kind of work that makes it possible to use protocols that demonstrate the organization and logic of a field of debate, demonstrating its functioning in a given context. Thus, it allows the research to be checked and reproduced by other researchers and indicates the databases consulted and the strategies used [9].

The descriptors in Portuguese used for the search were: "suicídio" (suicide), "suicídio e bioética" (suicide and bioethics) and "suicídio e ética" (suicide and ethics). The online search was done in the SciELO and Google Scholar databases, as well as in the repositories of Brazilian graduate programs in bioethics: Unesco Chair of Bioethics (Universidade de Brasília), School of Life Sciences: Bioethics (Pontifícia Universidade Católica do Paraná), Bioethics, Applied Ethics and Collective Health (Fundação Oswaldo Cruz, Universidade Federal do Rio de Janeiro, Universidade do Estado do Rio de Janeiro e Universidade Federal Fluminense). Books, book chapters and reports were searched on Google Scholar with the same descriptors, besides being accessed through indications and/or prior knowledge.

A total of 58 publications were found and 20 studies that were relevant to the investigated subject were selected according to the following inclusion criteria: Brazilian bioethics studies on the subject of suicide available in full and published between 2000 and 2021. Publications that did not meet those criteria were removed from the sample. Duplicate works and those that, despite having the selected descriptors, did not directly address the proposed subject were also excluded.

Chart 1 presents summarized information on the works published in journals. Chart 2 shows that in the repositories of the three graduate programs in bioethics in the country, only one thesis was found, in the Universidade de Brasília one. Chart 3 shows books, book chapters and/or reports.

Chart 1. Summary of articles searched

Authorship; year	Title	Publication	Keywords
Kovács; 2003 [10]	"Bioética nas questões da vida e da morte"	*Psicologia USP*	Bioethics; death; euthanasia; palliative care
Heck; 2005 [11]	"O suicídio como violação de um dever de virtude"	*Filosofia Unisinos*	Kant; practical reason; suicide; doctrine of virtue; Kantian theory of duties

continues...

Chart 1. Continuation

Authorship; year	Title	Publication	Keywords
Daolio; 2012 [12]	"Suicídio: tema de reflexão bioética"	*Revista Bioética*	Suicide; bioethics; death; behavior; health
Schramm; 2012 [13]	"Acerca da moralidade do suicídio"	*Revista Lugar Comum*	–
Kovács; 2013 [14]	"Revisão crítica sobre conflitos éticos envolvidos na situação de suicídio"	*Psicologia: Teoria e Prática*	Suicide; prevention; ethics; health professionals; death
Silva, Sougey, Silva; 2015 [15]	"Estigma social no comportamento suicida: reflexões bioéticas"	*Revista Bioética*	Suicide; attempted; social stigma; bioethics; shame
Wünsch and collaborators; 2016 [16]	"Bioética, teologia e saúde mental: diretrizes de cuidado e prevenção do suicídio"	*Revista Iberoamericana de Bioética*	Bioethics; theology; mental health; suicide; prevention
Barreira; 2017 [17]	"Suicídio como autodeterminação da cidadania perante o Estado"	*Revista Bioética*	Suicide; personal autonomy; ethics; policy
Fukumitsu; 2018 [18]	"Suicídio: do desalojamento do ser ao desertor de si mesmo"	*Revista USP*	–
Albuquerque and collaborators; 2019 [19]	"Os direitos humanos de pacientes em risco de suicídio no Brasil"	*Cadernos Ibero-Americanos de Direitos Sanitários*	Human rights; suicide; patients; bioethics
Rocha , Araújo Filho, Ávila; 2020 [20]	"Atitudes de médicos e estudantes de medicina com pacientes com ideação suicida"	*Revista Bioética*	Suicide; ethics; malpractice; education-medicine
Dadalto, Santos, Pereira; 2020 [21]	"Suicídio racional: uma nova perspectiva acerca do direito de morrer"	*Revista Portuguesa de Direito da Saúde*	Rational suicide; dignified death; autonomy
Lima, Flor do Nascimento; 2020 [22]	"Del suicidio: entre éticas de la vida y políticas de muerte Reflexiones desde el Brasil"	*Red Latinoamericana y del Caribe de Bioética/ Unesco*	Suicide; biopolitics; necropolitics; public health; prevention
Lima, Weber; 2021 [23]	"Autonomia e dignidade em Kant: o suicídio como violação do 'dever pelo dever' e suas novas interpretações no campo da bioética"	*Quaestio Iuris*	Bioethics; autonomy; human dignity; moral action; right to die

Chart 2. Repositories of the three graduate programs in bioethics in Brazil

Authorship; year	Title	Advisor	Graduate program	Type of production
Lima; 2018 [24]	*Moralidades correntes sobre suicídio em unidades de saúde e seu impacto na assistência: uma análise na perspectiva da Bioética de Proteção*	Wanderson Flor do Nascimento	Cátedra Unesco Bioética (Universidade de Brasília)	Thesis

Chart 3. Books, book chapters and/or reports identified

Authorship; year	Title	Publisher	Type of production
Cabrera; 2011 [25]	*A ética e suas negações: não nascer, suicídio e pequenos assassinatos*	Rocco	Book
Observatório de Bioética e Direitos Humanos dos Pacientes; 2017 [26]	*Relatório sobre direitos humanos dos pacientes em risco de suicídio no Brasil*	–	Report

continues...

Chart 3. Continuation

Authorship; year	Title	Publisher	Type of production
Fukumitsu, Kovács; 2018 [27]	"De quem é a vida afinal? A bioética na prevenção e posvenção"	Editora Unifesp	Book chapter
Lima; 2020 [28]	*Deverei velar pelo outro? Suicídio, estigma e economia dos cuidados*	Dialética	Book

Results and discussion

The selected studies included 14 articles, a dissertation, two books, a report and a book chapter, totaling 20 sources. The articles were mainly published in bioethics, psychology, philosophy and health law journals.

Using the period 2000-2021 as a time frame, it was observed that, in several years, no works on suicide from the perspective of bioethics were produced in Brazil. Among the records, there was one publication each in 2003, 2005, 2008 and 2011; two in 2012; and one each also in 2013, 2015 and 2016. The following years had at least one publication: two in 2017; three in 2018; one in 2019; four in 2020; and one in 2021. One notes a continuous and greater production of works on the subject from 2015 onwards.

In total, 32 authors were identified, with six researchers authoring 15 of the 20 publications (75%). This fact seems to show, on the one hand, a deeper interest in the subject by a group of (women) researchers and, on the other, a reduced number of people studying suicide from the perspective of bioethics.

According to the sources of the last twenty years, the results were grouped by theoretical and epistemological approximation into three main pillars: 1) general reflections around the stigmatization of suicidal behavior and its repercussions on health; 2) moral dilemmas about suicide and bioethics principles; and 3) ethical-political analysis of the phenomenon of suicide.

Stigmatization of suicidal behavior

The studies involved in this category address the bioethical conflict linked to the field of health, especially in the biomedical dimension. Despite differences in methodology and time frame, all studies emphasize the need for destigmatization—a key aspect in the communication and interaction between healthcare providers and attempters—due to the huge harmful impacts, especially on individuals suffering from psychological distress.

Kovács [10] carried out a critical review on suicide and ethical conflicts involving the subject, indicating that suicidal behavior has effects on healthcare providers, who may try to prevent it at any cost. The author underscores individual convictions and values, added to professional assumptions based on saving lives, which are contested, leading to reactivity, aggressiveness, anger, contempt, judgment and criticism. Such reactions, in turn, tend to generate guilt, anxiety and embarrassment in attempters.

Kovács [10] notes that the phenomenon of suicide may involve legal issues, since it is related to death. Thus, the fear and risk of lawsuits may cause professionals to act defensively through involuntary hospitalization and administration of tranquilizing and/or antipsychotic medication, without proper investigation of the patient's suffering and medical history. Given this context, the author asks: shouldn't involuntary hospitalization and use of medication also be liable to legal proceedings, since they harm the person's autonomy?

Lima [6,24] interviewed physicians, nurses and nursing technicians in charge of providing first care after a suicide attempt. Modern perceptions of the stigma of suicide, based on sin, crime and madness or mental disorders, were detected in the interviewees' reports. Thus, as reproducers of the hegemonic social discourse, healthcare providers use morality as a guide to their behavior.

The author argues that patients who attempt to commit or commit suicide remove control over life from the state and hospital, challenging the power and knowledge of those institutions. In line with Kóvacs [10], Lima [24] notes that the

feeling of affront and professional inadequacy are shared by medical staff, leading to reduced care, negligence, facetious remarks, direct or indirect offenses, religious, pedagogical or encouraging messages, hypervigilance, criticism, exclusion, hostility and punishment.

Constrained by a setting that lacks greater information, training or awareness about the phenomenon, such behavior reveals poor technical and ethical resources to deal with attempters, reflecting the taboo and social and moral values surrounding the subject. That said, health professionals and institutions, rather than setting a benchmark in care, end being a source of greater vulnerability to people in distress [6,24].

Another reference source in this debate is the technical report of the Observatory of Human Rights of Patients [26], regarding the human rights of people at risk and attempters in Brazil, based on interviews with healthcare providers, family members and attempters. These patients are protected by the following rights provided in international standards that are directly connected with the context of health care: right to life; right not to be subjected to torture or cruel, inhuman or degrading treatment or punishment; right to personal liberty and safety; right to respect for private life; right to information; right not to be discriminated against; and right to health.

The interviews that supported the report revealed violations of all patients' human rights. Albuquerque and collaborators [19], in an article that provides a summary of the report, noted the inadequacy and even lack of a preventive approach to new suicide attempts, since the professionals had no training and found it difficult to notify, identify and refer patients to specialized psychosocial care services. Thus, the provision of adequate information about diagnosis, treatment and support possibilities seemed to be compromised.

The reports also point to discrimination in care; episodes in which attempters were passed over in care lines; unfounded or careless prescription of medication; procedures without access to analgesia; isolation in hospitalizations; intense monitoring; confinement to bed and forced feeding, etc.

As reported by Lima [6,24], to the hostile, humiliating and inhuman treatment offered to attempters are added educational, moral and religious lectures to make them "learn" from the experience and not attempt suicide again. Included here are reports of cases in which healthcare providers, viewing the suicide attempt as a way to draw attention, "taught" how to achieve an effective death without "mistakes." In Brazil, it is a crime to induce, instigate or help someone to commit suicide (Art. 122 of the Penal Code) [2].

Among the main violations, disrespect for the patient's autonomy was recurrent, since the widespread idea that attempted suicide relates to mental disorder is used to justify control over individuals in institutions. The interviewees also referred to stigma, indicating the correlation between it and the violations, stress and suffering caused [26].

Silva, Sougey and Silva [15] carried out an integrative review about the social stigma associated with individuals who attempted suicide. Stigma is a phenomenon that negatively affects autonomy, protection, care and adherence to treatment, in addition to culminating in other comorbidities and hindering further search for help, increasing the risk of new attempts.

Stigma also affects family members, who suffer with labelling, retaliation, judgment, exclusion, among other negative impacts. Conversely, studies show that, in societies where no stigma is associated with suicide, search for help tends to increase significantly.

Lastly, the study by Rocha, Araújo Filho and Ávila [20] analyzed physicians with the aim of understanding information, conceptions, attitudes and professional management on the subject and interaction with attempters and at-risk patients. Among the results found, it was observed that physicians are well instructed in the administration of urgency and emergency, while they seem to have inaccurate information regarding compulsory notification.

The participants reported that they were not adequately prepared during their undergraduate studies to deal with mental health, especially suicide. According to the authors, university education should take into account the Brazilian Code of Medical Ethics [29] based on the four principles of bioethics [20]. Would that be enough?

Moral dilemmas and principles of bioethics

This section addresses dilemmas and moral and philosophical questions about suicide for which

solutions and answers are sought based on the principles of bioethics.

Heck [11] compares bioethics with Kantian ethics, indicating that from this viewpoint suicide is a violation of duty not only to oneself, but also to third parties, being morally forbidden, since Kant believes that all men are the property of God. In this sense, Heck [11] argues that the philosopher understands suicide as a self-contradiction of freedom, a misuse of reason, linked to irrational feelings and/or passions.

The idea of autonomy as the core of human dignity does not include suicide, since it is not a perfect moral action and therefore cannot be universalized. In Kantian terms, suicide can be interpreted as a misconduct [11].

Lima and Weber [23] review Kantian ethics from another perspective, considering the plausibility of defending the right to death based on the idea that forcing someone to live, including in situations where this implies the violation of dignity, can be a form of tyranny. In this light, according to the authors, Kant's categorical imperative should be relaxed or updated in situations where the individual is on the verge of suffering and/or an unworthy condition. Thus, death is understood as a right and suicide as a consequence of a rational decision, if the person is in full command of their mental faculties.

Kovács [10] addresses the right to suicide, which is different from the incentive or obligation to kill oneself, based on the principle of autonomy. From this perspective, one of the key issues put forth by the author is the legitimation of the desire to die, which raises the following questions:

- Does the individual's age and/or specific life experience influence the way in which the choice of suicide is socially recognized and accepted?
- Which decision is more tolerable, an older adult at an end-of-life stage or a young person with psychological distress?
- Which pain is more intolerable, that produced by illness, also known as a disabling symptom, or existential emptiness, helplessness?
- How to define the intensity of suffering and dignity in the face of living and dying?

Based on the assumption that each individual enjoys self-ownership, Kovács [10] reiterates that people's autonomy must be respected by healthcare providers, who may try to reduce the suffering of attempters without letting themselves be guided by criticism or moral and legal issues.

Complementarily, Fukumitsu and Kovács [27] argue that in assisting people with suicidal behavior, one should not pose as of savior, but as a facilitator in the search for dignity in life. While claiming that dignity relates to a personal, singular and non-transferable idea, they also argue that dignity means removal from oppression and torment in the achievement of purpose in life. The process of health and healing implies, on the one hand, respect for autonomy and, on the other, acknowledgment that suffering and helplessness have a significant impact on people and that, in the real world, freedom is limited and choices are restricted.

In turn, Rocha, Araújo Filho and Ávila [20] stress that physicians may intervene in cases of risk of death, breaking confidentiality to prevent or change the outcome of suicidal behavior. This configuration, according to the authors, points to a possible overlap and even greater importance of beneficence and non-maleficence in relation to respect for the autonomy of the patient, whose decision-making capacity may be questioned or hindered, including through compulsory hospitalization.

Kovács [10] and Lima [6] underscore the asymmetry between the protection given to healthcare providers and to patients when there is a suicide attempt. As mentioned above, retaliation, criticism and various kinds of punishment to those who attempt against their own life are common among the former; nevertheless, even when they harm or violate the patient's autonomy and human rights, healthcare providers receive no warnings or institutional or legal sanctions, especially if the misconduct was committed with the purpose of preserving life. Fukumitsu and Kovács [27] call attention to the need to expand coping resources when it comes to preserving lives.

Wünsch and collaborators [16] argue that the right to life is fundamental and includes the right to goods and services required for individuals and groups to live with dignity and integrity, which must be provided and guaranteed by society. In their point of view, the right to life must be defined, in a privileged way, by the ethics of care. Mental health care should provide information, awareness and guidance for professionals and the population

in order to achieve a comprehensive, multifactorial and effective approach to suicide prevention.

To support the ethics of care, Wünsch and collaborators [16] prefer the theological and personalist bioethics approaches. The Catholic Church defends the principles of promoting human life, dignity and the sacredness of life—a sacred and inviolable gift—in opposition to manifestations of a culture of death. Personalist bioethics is based on the principles of defending physical life; freedom and responsibility; totality or therapeutic principle; sociability; and support.

In this sense, the authors argue that the principles of personalist bioethics and of the Catholic Church can support actions of care, treatment and prevention of suicide, especially with humanized care, responsibility and collective care actions in favor of the defense of life [20].

In a contrasting perspective, suicide is seen as a manifestation of personal decision-making power, according to which the interruption of existence results from rational reflection, an idea defended by Cabrera [25]. The author's criticism is twofold: of the aforementioned psychopathology perspective and of the absolute value of life in contemporary Western society—a principle that underpinned the idea of social condemnation of suicidal behavior, considered morally wrong or even politically incorrect.

For Cabrera [25], suicide has nowadays been metamorphosed by the logic of medicalization, by the abstraction of autonomy and by the principle of beneficence. Thus, the value of a patient's life is greater than the value of the actual patient, for whom the end of life may be seen as solution rather than the destruction of an infallible supreme good.

Dadalto, Santos and Pereira [21] equally defend the centrality of rationality in the so-called "rational suicide"—defined as the abbreviation of life by any autonomous person based on the meaning each one gives to living. The authors debate the subject, prioritizing the principle of human dignity as a way to advance in the debate on a dignified life.

The authors stress that although it is a fluid concept that is difficult to define, this principle aims at a healthy, comfortable and pleasant existence which, in this sense, has a unique meaning for each human being. Quality of life is subjective and therefore no one can better decide what it means to have a dignified life than the individual who lives it. The exception concerns individuals with some kind of mental disorder, whose condition points to the continuous need for action in favor of prevention [21].

Barreira [17] states that the complexity of suicide narrows down precisely in the strain between autonomy and heteronomy in the democratic rule of law, at which core lies the individual's autonomy to make existential and ethical-political choices. In his analysis, he also focuses on the principle of human dignity and, like other authors, questions the intrinsic value of life, advocating that the right to a full life does not imply the obligation to continue living at any cost and in extreme circumstances.

Barreira [17] follows Walzer's approach, which presents three typical models of social ties of Western cultural tradition regarding the political obligation of life: 1) of the Athenian city-state; 2) of the classical monarchical model; and 3) of the revolutionary movement. These political-philosophical conceptions supported the attempts to ethically and legally determine the criminalization of suicide, based especially on the moral duty of political obedience of the citizen, by the state stimulus to life.

Historically, suicide is also viewed as a response to unhappiness or oppression, a stance which the individual/citizen takes against the state that pursues, excludes or tortures him. In the author's words, *undignified conditions of poverty and despair cannot require someone to be loyal to the political community or state that allowed them to happen* [30].

For Schramm [13], life is a resource for coping with helplessness, and suicide is a possible solution to the harm received, since self-inflicted death became a way out or answer to the extreme evil that spread in the 20th century through totalitarian practices. From this perspective, the author notes that bioethical questions about the phenomenon are supported by two principles: sacredness of life and quality of life. The decision of which one should prevail must be left to each individual, for therein consists the double identity of life, which is at the same time property and instrument of the owner-agent.

Daolio [12], in turn, politicizes the debate and argues that individuals are being condemned and led to their death within the logic of a widely promoted toxic existence, emphasizing another bioethical principle, that of protection, also highlighted by Silva, Sougey and Silva [15]. Those authors claim that protection will mediate and/or give back to vulnerable individuals the autonomy over their actions so they can decide their future with freedom and discernment. This reasoning presupposes that the principle of protection precedes that of autonomy, since vulnerable individuals are subjected to a situation with no possibility of change.

In an argumentative dialogue, Lima [6,24] uses the contributions of the bioethics of protection to reflect on suicide and, based on the principle of protection, as well as the recognition of the right to die, suggests imperative bases to move forward in the debate. First, she indicates the need to question the production of knowledge in suicidology, which ranges from poor public policies in Brazil to the absence of a scrutiny of forms of suffering, oppression, violence and inequalities, which in turn determine a social network of illness and compromise the exercise of autonomy.

Second, she stresses the need for an ethical unlearning of the concept and practice of autonomy, shifting from the individualistic and paternalistic conception to one of true autonomy, in both relationship and context. In short, the limitations of supposed individual autonomy are evident in a poor, unequal country with overlapping layers of precarious living.

Ethical and political analysis of suicide

Kovács [14] follows the history of suicide from its criminalization in law through its characterization as a mental disorder to the debate of dignity in the field of bioethics.

To contextualize ways of dying, she examines different worldviews and cultures, reporting, for example, that in ancient Greece, the Stoics viewed suicide as a rational act, and the Romans believed that one could prepare one's own death, especially in situations where life was considered unworthy. In this context, the only ones who could not consider self-inflicted death were slaves, as they were seen as merchandise. That said, this author critically analyzes interpretations woven and manufactured over time by different discourses of power which determine understandings and actions in suicide prevention [14].

Among the challenges and reflections that address the complexity of the theme, there are, albeit to a lesser extent, bioethical studies that emphasize contexts and intersectionality. Kovács [10], Wünsch and collaborators [16] and Lima [6] highlight dissimulated statistics and studies that indicate a predominance of self-inflicted death in low- and middle-income countries, as well as in vulnerable groups such as blacks, indigenous populations, LGBTQIA+, older adults, unemployed persons, etc.

While stressing critical epidemiology, those authors indicate that categories such as race/color, gender identity and/or sexual orientation are commonly neglected in discussions and even in official notifications. The overlapping of prohibitions seems to impede progress in the production of knowledge in suicidology, especially with regard to intersecting oppressions and ignored risk factors [6].

Lima [6] stresses that considering vulnerabilities in understanding suicide means considering its multifactorial nature, sociopolitical contingencies beyond psychopathological factors and the discontent generated by culture. In this way, attention is given to the oppressive aspects of society and the multiple forms of violence, which are a source of inequities, suffering and psychological illness, such as racism, sexism, xenophobia, LGBTphobia, and ableism.

Based on other arguments, but also from an individual-society dialectic perspective, Kovács [10] emphasizes that self-destructive processes can be a response to the values of post-modern society, in which violent behavior emerges as a way to stop the flow of displeasure, impotence, uprooting and helplessness. The precariousness of the symbolic, typical of our times, seems to be accompanied by another criticism, the fragility of bonding and social support, and the lack of ethical and political action in the field of affective relationships. In the dearth or impossibility of building existential meanings, the state becomes yet another reason for hopelessness [17].

Daolio [12] refuses the unambiguous analysis of the phenomenon, which privileges individuals

and their mental disorders, or even the rationale of autonomy as an individual exercise of living or dying. Thus, he extends the debate with the premise that society fosters a toxic existence, which spreads messages and practices of a project of death, *of living in suicide* [31].

The author argues that private lives suffer intense pressure from collective behavior and social facts, so that the act of suicide reveals not only the burden of unbearability, but also the individual's denunciation of the impossibility of living in the surrounding environment. In the assessment in question, seemingly individual conflicts and suicides reflect chaotic social frameworks of unsuccessful political and subjective projects [12].

As a key to interpreting suicide, Lima [6,24] and Lima and Flor do Nascimento [22] use biopolitics, a concept coined by Foucault [32,33] that is based on two fundamentals: 1) maximization of the productive forces and vitality of populations; and 2) neglect and abandonment of worthless lives, which tend to remain outside state protection, those that the government ignores or simply allows to die. Individuals with suicidal behavior subvert the orders and discourses of power and do not conform to social norms, thus becoming the target of exclusion, abandonment or neglect by state policies, which make certain conditions of existence unfeasible.

Although the National Policy for the Prevention of Self-Mutilation and Suicide (Law 13,819/2019) [34] was created in 2019, there is no corresponding national plan to support it. As a consequence, there is no funding, investment, training spaces and, especially, spaces for debate and suicide prevention actions in the social field.

In addition to recording the aforementioned problems, Lima [6] and Lima and Flor do Nascimento [22] observe, alongside the setbacks of the New Mental Health Policy, based on Technical Note 11/2019, of the Brazilian Ministry of Health [35], that the Psychosocial Care Network it is doomed to survive without funding until 2036. In view of this, they echo Sulear in asking [36]: Is our political context conducive to suicide risk? Can society also lead individuals to commit suicide?

Lastly, the works by Lima [6] and Lima and Flor do Nascimento [22] highlight the imperative of repositioning death and dying within a political field of dispute. As part of the fundamentals of modernity, the ethics of life are based, above all, on the decision on the value or worthlessness of certain existences, with a population hierarchy that makes some lives more prone to politically provoked mortality than others. The authors state that suicide is yet another death project that not only reflects individual projects, but is also a possible reaction to structural projects whose side effects include killing oneself.

Final considerations

Bioethical studies on suicide in the past twenty years are largely linked to other end-of-life phenomena, such as euthanasia and assisted suicide, and, to a certain extent, do not distinguish it from those situations. Although is it considered a situation that is both persistent and emerging, Brazilian research on the subjects is scarce, especially if one considers that a) only one dissertation was found in graduate programs in bioethics; and b) only six women authors account for 75% of the publications found.

This fact seems to show, on the one hand, a deeper interest in the subject by those researchers and, on the other, a reduced number of people studying suicide from the perspective of bioethics. How is it possible that a global public health problem is so poorly researched and debated in a country with alarming indicators? What are the origin and rationale for this silencing in the field of Brazilian bioethics?

The results of this work were classified into three pillars: 1) general reflections around the stigmatization of suicidal behavior and its repercussions on health; 2) moral dilemmas about suicide and bioethics principles; and 3) ethical-political analysis of the phenomenon of suicide.

The first pillar presents a discussion about the historical stigma of suicide, widely updated and reproduced in health practice. In review works and interviews with attempters, family members and healthcare providers, it was observed that care, communication, interaction and follow-up are often mediated by morality and intra-institutional conduct based on ideas of criminalization, pathologization, control, religiosity, etc. This situation violates the

principles or human rights of patients and compromises the relationship between patients and professionals, adherence to treatment, new search for help by people in distress and, consequently, suicide prevention.

The second pillar scrutinized a range of bioethical principles to show the complexity of the ethical and moral debate about suicide. Despite the theoretical diversity, there was a significant clash between two principles: 1) sacredness of life, marked by the intrinsic value of life, of strong religious heritage; and 2) defense of autonomy.

This second principle does not necessarily imply autonomy in relation to and in the context of the specificities of the Brazilian socio-political situation, riddled with violence, inequalities and vulnerabilities, which ultimately make lives precarious and limit self-determination. Furthermore, there was a lack of works on the subject in dialogue with Latin American currents, closer to the Brazilian reality.

The third pillar has a more current, inquiring and marginalized nature in suicidology, as it goes beyond the psychopathological perspective and/or individual responsibility, strongly linked to the deliberate right to autonomy as a response to moral conflict. The studies emphasize critical and dissimulated interpretations and/or epidemiology, liking suicide with intersectionality, the current political economic system and its state policies, not to mention death projects.

The dimension of care provided to people with suicidal behavior not only involves the compulsory avoidance of death—a conduct commonly based on surveillance, guardianship, lack of dialogue, etc.—but also requires considering the serious ethical and political implications that provoke and are provoked by such acts. In this sense, national bioethical studies, for their plurality and interdisciplinarity, are extremely valuable to better understand the problem in Brazil, as well as to implement and improve efficient measures and policies for suicide prevention.

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Luana Lima conceived the study, wrote the article and did data analysis and interpretation. Wanderson Flor do Nascimento supervised the research and writing and revised the article.

Received: 11.11.2022
Revised: 6.15.2023
Approved: 8.14.2023

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