

Is dysthanasia the only obstacle to a dignified death?

Leonardo Bocchi Costa¹, Nathalia da Fonseca Campos¹, Patricia Borba Marchetto¹

1. Universidade Estadual Paulista, Franca/SP, Brasil.

Abstract

This paper aims to show that the phenomenon of mysthanasia is an obstacle to achieving the right to a dignified death in Brazil. Traditional bioethical discussions on dignified death, influenced by the American principlist school, tend to prioritize microethical and emerging issues. Brazil's social reality contrasts with this view, as it is characterized by hierarchies and historical processes of social exclusion, factors that contribute to the phenomenon of miserable and unassisted death. Given this context, the study discusses the need to expand the debate on dignified death to include persistent macroethical issues and address the impact of social exclusion on the dying process of vulnerable populations. A deductive methodology was used to analyze the data collected from a narrative literature review and the DataSUS system.

Keywords: Health services accessibility. Bioethics. Right to die.

Resumo

O único obstáculo à morte digna é a distanásia?

Este trabalho tem como objetivo demonstrar que o fenômeno da mistanásia é um obstáculo a ser superado para a concretização do direito à morte digna no Brasil. A discussão bioética tradicional sobre a morte digna, influenciada pela escola principialista norte-americana, direciona maior atenção a questões microéticas e emergentes. Contraopondo-se a essa visão, encontra-se a realidade social brasileira, marcada por verticalidades e processos históricos de exclusão social, fatores que provocam o fenômeno da morte miserável, em abandono. Considerando essa situação, a pesquisa discute a necessidade de expandir o debate sobre a morte digna para abranger questões macroéticas persistentes, a fim de desnudar a influência da exclusão social no processo de morte de populações vulneráveis. Empregou-se metodologia dedutiva para analisar dados levantados por meio de revisão narrativa de literatura e pesquisa no sistema DataSUS.

Palavras-chave: Acessibilidade aos serviços de saúde. Bioética. Direito a morrer.

Resumen

¿Es la distanasia el único obstáculo para una muerte digna?

Este trabajo tiene como objetivo demostrar que el fenómeno de la mistanasia es un obstáculo que superar para lograr el derecho a una muerte digna en Brasil. La discusión bioética tradicional acerca de la muerte digna, influenciada por la escuela principialista norteamericana, dedica una mayor atención a cuestiones microéticas y emergentes. Para contrarrestar esta visión, se encuentra la realidad social brasileña, marcada por verticalidades y procesos históricos de exclusión social, factores que provocan el fenómeno de la muerte miserable, en el abandono. Teniendo en cuenta esta situación, la investigación discute la necesidad de ampliar el debate acerca de la muerte digna para abarcar cuestiones macroéticas persistentes, con el fin de revelar la influencia de la exclusión social en el proceso de muerte de poblaciones vulnerables. Se empleó una metodología deductiva para el análisis de datos recopilados mediante revisión narrativa de literatura e investigación en el sistema DataSUS.

Palabras clave: Accesibilidad a los servicios de salud. Bioética. Derecho a morir.

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Guided mainly by the dominant principlist discourse, bioethical discussions on the right to a dignified death have increased in Brazil in recent years. Consequently, the concept of dignified death has often been associated with patients suffering from terminal illnesses, the practice of orthothanasia and the establishment of advance directives.

These approaches are based on the recognition of the influence of biotechnological innovations on the dying process of humans. Therefore, in Brazil, dignified death as a bioethical subject is linked to situations where the indignity of death stems from iatrogenic factors related to the misuse of biotechnology. This connection frames the discussion as part of emerging bioethical issues.

Based on this set of bioethical assumptions, dignified death stands in contrast to the concepts of therapeutic obstinacy, curative medicine and, especially, the practice of dysthanasia. In this sense, these phenomena are manifestations of behaviors that violate the autonomy of patients with terminal illnesses and ignore the scientific impossibility of curing the sick, subjecting them to futile and disproportionate extraordinary treatments.

However, it should be mentioned that in Brazil, this discussion has been largely and directly transplanted from the social context in the United States, the birthplace of the principlist bioethical school¹. American principlism is the hegemonic bioethical paradigm in the West and the main source for the majority of bioethics scholars in Brazil.

This requires examining whether such bioethical discussions on the dignity of death, influenced by the American principlist school, are aligned with the Brazilian context, characterized by social exclusion and various forms of inequality. In this sense, it is essential to understand whether the phenomenon is solely related to biotechnology, whether the discussion about the right to a dignified death should relate exclusively to terminal cases, and whether the obstacle to achieving dignity in the dying process consists solely of dysthanasia procedures adopted by healthcare providers.

In view of the above, this study aims to answer the following question: How does the Brazilian

context, characterized by social hierarchies, impact the discussion on the right to a dignified death? In order to challenge the idea that the indignity of dying is solely a result of dysthanasia, the initial hypothesis assumes that dysthanasia contradicts the principle of a dignified death.

In a country with high levels of social exclusion, discussions on the right to a dignified death should go beyond the microethical level to encompass macroethical dimensions. Thus, the goal here is to highlight social factors that contribute to an undignified death, which may occur even in cases of curable diseases and not only terminal illnesses.

Method

This is a qualitative and descriptive study carried out through a narrative literature review, using a deductive approach method. The data were collected by means of an indirect bibliographic review in databases, along with targeted searches, mainly linked to established literature on Latin American bioethics and the right to a dignified death. The theoretical framework was built by drawing on some of the main authors of the Latin American bioethical school, including Volnei Garrafa, Dora Porto, Léo Pessini and Luiz Antonio Lopes Ricci.

Moreover, to add a quantitative focus to the debate, a search was carried out in the DataSUS database to collect information on the number of deaths recorded due to malnutrition or insufficient medical assistance between 2018 and 2021. These figures were then compared with the total number of deaths in Brazil in each year.

Dignified death and end-of-life issues in traditional bioethics

Previously limited to social and psychological care, medicine has now become a powerful set of diagnostic and treatment techniques. Innovations such as antibiotics, hormonal therapy, chemotherapy and advanced surgeries have resulted in a significant increase in human life expectancy, from 40 years in the 19th century to around 80 years in most parts of the world today².

Thus, advances in medicine and biotechnology have provided cures for numerous diseases, improved quality of life and increased life expectancy for humans³. On the other hand, the majority of older adults suffering from severe illnesses remain without access to the most modern resources of biomedical science⁴. In addition, according to records from the World Health Organization (WHO), of the 58 million deaths that occur annually worldwide, 34 million are due to chronic, degenerative, disabling and incurable diseases, as noted by Gomes and Othero⁴.

In other words, although the advancements have provided solutions for various diseases, approximately 60% of deaths worldwide are caused by incurable/terminal illnesses. Thus, biotechnology has not only increased the quality and life expectancy of individuals but also enabled the emergence of a new profile of patient: the terminally ill. *This patient will directly experience the dying process, which may unfold in a humane manner or deteriorate under the grip of therapeutic obstinacy*⁵.

Another noteworthy fact resulting from the biotechnological revolution is the increase in the incidence of chronic diseases. Currently, there are about one million deaths per year in Brazil, 650,000 of which are due to this type of disease. Moreover, approximately 70% of these deaths occur in hospitals, especially in intensive care units⁴.

In other words, scientific advances in the biological sciences have led to the “hospitalization” of death, making it impossible for the sick to die close to their loved ones and in a peaceful location, free from the chaotic hospital setting. It is therefore essential to analyze the influence of the aforementioned biotechnological advances on human understanding of death and end of life.

The question to be asked is: Given the significant advances in the biological sciences and healthcare technologies, can we say that humanity has gained the wisdom⁶ and knowledge required to live better and face death and the dying process more effectively?

Indeed, the human psyche and consciousness seem to resist accepting the natural process of

death, given the perceptible feelings of anguish and dread that the mere mention of death evokes in Western society. Death as a whole *has been viewed as taboo, a deeply unpleasant subject to be avoided*⁶.

Therefore, there is an increasing number of patients with incurable diseases who will become terminal at some point. Due to the phenomenon of the hospitalization of death, they will mostly be under the care of a physician in a hospital when the final stage of their illness arrives. It should be noted, however, that physicians, as members of Western society, may also experience anxieties about end-of-life issues and struggle with the idea that a patient is inevitably approaching death.

In this context, the hospitalization of death and the inability to accept that life must end are interconnected. Thus, the hospitalization of death inevitably grants physicians or healthcare providers greater authority over decisions regarding terminally ill patients, while the inability to accept the limitations of life may also affect the very professionals responsible for caring for those patients. As a consequence, such professionals may be reluctant or even refuse to discontinue extraordinary treatments, thereby prolonging the patient’s suffering unnecessarily⁷.

This gives rise to one of the greatest fears surrounding 20th-century biotechnological innovations: the artificial prolongation of life in agony, a suffering that dehumanizes, delays death and fails to respect human dignity at such critical times². This relates to the practice of dysthanasia, which represents a profound distortion of the art of medicine, as it reduces life to its biological and physical dimensions, viewing death as an enemy and denying the notions of mortality and the end of life—characteristics that are intrinsic to human beings⁸.

In short, dysthanasia relates to using all available therapeutic means to prolong the existence of terminally ill patients to the utmost, even if this inevitably extends their suffering and clinical reversal is scientifically impossible⁷. In turn, traditional bioethics, associated with the American principlist school, addresses the right

of terminal patients to a dignified death. In this context, a dignified death is entirely opposed to dysthanasia, lying at the heart of restrictive medical practices that enable orthothanasia, i.e., death at the natural time.

Based on this discussion, it can be concluded that the right to a dignified death has no relation whatsoever to euthanasia or assisted suicide, as it solely aims to legally oppose dysthanasia resulting from therapeutic obstinacy. In the context of the right to a dignified death, the opposite of dysthanasia is necessarily orthothanasia, which involves adopting palliative care and ensuring that terminally ill patients receive all other ordinary treatments that benefit them.

Therefore, traditional bioethics argues that the right to a dignified death does not advocate for shortening a patient's life, but focuses solely on preventing the futile and disproportionate prolongation of a life that has already become undignified due to unbearable pain and suffering. Thus, any argument seeking to justify the shortening of a patient's lifespan in order to ensure the right to a dignified death is invalid and should be rejected.

The defense of shortening a patient's life through euthanasia or assisted suicide pertains to a different legal argument, one which supports the so-called "right to die." It should be noted that all these "thanasias" are discussed in the context of the application of technological innovations in patients with terminal illnesses.

Inequality and access to healthcare

The approach outlined above, based on a liberal view that supports the principlist bioethical school, is limited to the ethical issues that pervade the practice of healthcare providers, to the point that any subject that transcends this context is not taken into account. For this very reason, traditional bioethics seems to assume that access to healthcare is equitable and not a relevant issue to be discussed in the context of dignified death.

However, in Brazil, context is quite the opposite; far from such presumed equality in

healthcare access, vulnerable groups have faced significant problems when seeking healthcare. The historical processes of social exclusion significantly affect this area as well, with direct consequences on the dying process of these individuals.

Assuming the direct association between dignity in the dying process and healthcare services, it is essential to address issues of inequality—a defining factor in Brazilian society. For instance, it should be investigated whether access to healthcare has been equitable. This is a key issue in bioethical discussions related to the dignity of death, especially considering the importance of resource distribution for the due provision of ordinary care to the sick.

In this sense, scientific studies in the field of health show that low-income individuals face greater obstacles to accessing healthcare services at all levels. When they do manage to obtain care—since denial of service is also a prevalent issue for those living in poverty—the quality of the services they receive are often suboptimal and the professionals involved tend to be less qualified or more demotivated. This demotivation stems from issues like low salaries and inadequate working conditions⁹.

Related to class domination, geographical oppression also influences the quality of healthcare. In the public health system, there is a strong correlation between geographical regions inhabited by poor populations and the inadequacy of resources provided by the Unified Health System (SUS)¹⁰.

In other words, in geographical areas where most of the population lives in poverty, the likelihood of receiving substandard healthcare is higher compared to regions with high-income populations. Therefore, one does not have to be poor to experience inadequate healthcare; simply residing in a poverty-stricken region may be sufficient. Thus, poverty extends its deleterious effects even to individuals who do not directly experience it.

Beyond class domination and its consequent geographical discrimination, poor access to healthcare is also linked to racial oppression. Thus, black people face not only racial prejudice

in interpersonal relationships but also arbitrary and illegitimate discrimination within both public and private institutions.

This amounts to institutional racism, a phenomenon characterized by racial discrimination observed within the operation of public and private institutions. Since these institutions are predominantly controlled by white individuals, its managers are able to create operational rules aimed at maintaining racial inequality in the social context. This type of racial discrimination may relate to denial of opportunities, difficulty in being promoted within the institution or different treatment in the provision of or access to services¹¹.

In the institutional context, therefore, racism operates subtly within the functioning of institutions and organizations, causing inequalities in the distribution of services, benefits and opportunities to different racial segments of the population¹². When institutional racism is mentioned in the context of healthcare, this study will specifically examine the influence of racial divides on the quality of healthcare delivery and the challenges in accessing such care.

Despite its significant relevance, this discussion will hardly contribute to resolving the problem proposed by this study. Thus, it should be initially mentioned that the universal social policies implemented in Brazil following the promulgation of the Federal Constitution of 1988¹³ had significantly beneficial effects on minimizing the Brazilian social divide. The SUS, for example, is a historic milestone in the effective promotion of the right to health for historically marginalized groups in Brazilian capitalist society.

In a country historically marked by the phenomenon of racialization of poverty—i.e., by the predominance of the correlation between black people and poverty—such universal social policies were a relevant and indispensable step in fighting racial inequalities. However, in the last 20 years, these policies have progressively proven to be insufficient for effectively reducing racial differences. Consequently, racism and its role in perpetuating the disadvantaged condition of the black population in Brazilian society have

increasingly been at the core of discussions involving healthcare¹⁴.

When analyzed in the context of healthcare, institutional racism mainly affects black and indigenous populations. Consequently, these groups experience the neglect of specific diseases, the exclusion of racial issues from training programs, challenges (or effective barriers) to accessing healthcare, poor healthcare quality and inadequate availability of health supplies¹⁵.

Regarding access to healthcare supplies by black individuals, based on data collected between 2003 and 2010 by the National Hospital Ambulatory Medical Care Survey (NHAMCS) in the United States, Goyal and collaborators¹⁶ present significant results on the implicit (and even unconscious) discrimination constantly faced by the black population of that country. The study evaluated patients aged 21 or younger who were admitted to the emergency room and subsequently diagnosed with appendicitis. The goal was to determine whether there were racial disparities in the treatment of pain in children with appendicitis in emergency facilities.

When patients who fit the analyzed profile were ranked by pain score and adjusted for ethnicity, it was found that black patients with moderate pain were less likely to receive analgesics compared to white patients. Among those who with severe pain, black patients were less likely to receive opioids compared to whites¹⁶.

These results corroborate the existence of a myth among health professionals—generated and perpetuated by racial discrimination—that black people are more resistant to pain than whites¹⁷ or even less capable of feeling pain. This indicates the explicit insensitivity of these professionals when faced with the complaints of black patients.

Mysthanasia as an obstacle to dignified death

The problem of inequality in access to healthcare and its implications for dignified death is an issue that cannot be addressed from the classical bioethical frameworks linked to clinical relationships. The principlist bioethical

model is insufficient and inadequate to deal with challenges that go beyond the consulting room and the physician-patient relationship¹⁸. Therefore, the microbioethical approach of principlism falls short when the aim is to analyze an eminently macrobioethical issue, such as social exclusion in the context of access to healthcare.

This phenomenon is common in the daily lives of most people in peripheral countries, and events related to this issue have been consistently observed in Brazil for centuries. Therefore, it can be said that this form of exclusion is a persistent bioethical problem that, as a public health issue, needs to be discussed according to specific bioethical frameworks.

A case in point is intervention bioethics, a bioethical model developed specifically to address macroethical issues arising from social exclusion and injustice in Latin America. This paradigm was created by Volnei Garrafa¹⁹, who, realizing the limitations of principlism, sought to establish a model of bioethical intervention to address the moral conflicts of the contemporary world. It strives to achieve the greatest possible benefit for the greatest number of people, especially the most vulnerable and socioeconomically disadvantaged populations.

There is an evident desire to collectivize bioethical discussions in Latin America, where bioethics cannot overlook issues of poverty and social exclusion²⁰. Therefore, the concern with viewing health as a public rather than merely individual issue is one of the fundamental characteristics of Latin American bioethics, largely due to the socioeconomic context.

Thus, in Latin America, bioethics adopts a transdisciplinary approach regarding not only academic knowledge but also political action²¹, since it emphasizes production of knowledge aimed at theoretical constructs that enable the actual transformation of social reality. While recognizing the importance of biological and health sciences in the everyday lives and health of individuals, this framework has been developed from a more humanized perspective, drawing on contributions from human sciences.

Consequently, Latin American bioethics addresses issues and knowledge related to social

sciences, humanities, public health and human rights, advocating for a macroethics of health as an alternative to the principlist microethical tradition. That is why it also encompasses equity in resource allocation and healthcare distribution²⁰, highlighting the phenomenon of *mysthanasia*.

Mysthanasia is a bioethical term coined by the Brazilian bioethicist Márcio Fabri dos Anjos²², who developed this concept to challenge the previously adopted idea of “social euthanasia.” Etymologically, the word “*mysthanasia*” is composed of the Greek elements *mys* (unhappy, miserable, hateful) and *thánatos* (death), and refers to a miserable, agonizing and painful death.

In healthcare, it is caused by negligence, inadequate treatment or total denial of access. Outside this field, *mysthanasia* occurs when people die of hunger, deprivation of essential resources or at the hands of the State²².

Substituting “*mysthanasia*” for “social euthanasia” is justified by the fact that euthanasia is typically associated with terminally ill patients—though there is no bioethical consensus on euthanasia in cases of completed life or existential exhaustion. *Mysthanasia*, in turn, involves a different situation, as it may affect patients with both curable and incurable diseases, and encompasses issues that go beyond the medical-hospital setting. In addition, euthanasia is linked to the idea of a good death, a dignified and happy end for a suffering patient, whereas *mysthanasia* is characterized by agony, suffering and abandonment.

Without prejudice, it should be noted that, strictly speaking, there is a direct link between euthanasia and patient voluntariness. Although euthanasia is classified as voluntary (carried out with the patient’s consent), non-voluntary (when the patient does not express an opinion regarding the procedure) and involuntary (cases in which the patient expresses the desire not to undergo euthanasia), it is important to stress that only voluntary euthanasia can be considered a legitimate form of euthanasia²³.

In a bioethical scenario characterized by respect for the principle of autonomy and horizontal relationships, euthanasia is inconceivable in cases where a health provider acts without the patient's consent. In turn, mysthanasia occurs in social reality regardless of an individual's voluntariness, given that abandonment and negligence by healthcare professionals and institutions often happen without the patient even being aware of it.

Therefore, as it necessarily involves cruelty and suffering, mysthanasia differs not only from euthanasia but from other "thanasiases" addressed in traditional bioethical discussions. Individuals affected by a miserable death experience intense suffering and neglect, further aggravated by their vulnerability. It should also be noted that many of the diseases involved in this kind of death are curable and reversible²⁴.

Within medical-hospital settings, these premature, untimely, unseen and undervalued deaths, with predictable and preventable causes²⁵, may occur in three main ways. The first involves patients who die prematurely because healthcare is either insufficient or inadequate. The second is caused by medical errors in different healthcare facilities, such as hospitals, health centers or private clinics. The last form occurs due to medical malpractice, when a healthcare professional purposefully subjects a patient to a painful and/or hastened death, with no regard for their dignity²⁶.

It is important to discuss mysthanasia in bioethics because this practice challenges the need to associate dignified death with the end of life. As a rule, there are four categories of study on the end of human life in bioethics: euthanasia, dysthanasia, orthothanasia and mysthanasia. However, mysthanasia is often neglected in discussions on the right to a dignified death and considered less relevant than the other concepts²⁷. Traditional bioethics, rooted in American principlist values, tends to regard euthanasia, dysthanasia and orthothanasia as the only truly pertinent procedures in the debate on dignified death.

Based on the distinction between frontier bioethics and everyday bioethics proposed by

Giovanni Berlinguer, Latin American bioethics has shifted its focus from frontier discussions to everyday bioethical issues. By proposing this paradigm shift, Berlinguer aimed to redirect attention—usually concentrated almost exclusively on extreme cases of biotechnological intervention—to bioethical issues that are more relevant to the general public and everyday life²⁸.

According to Berlinguer²⁸, the very issue of death aligns with the concept of everyday bioethics. However, it should be noted that although the number of deaths caused by terminal illnesses has recently increased in Brazil, miserable, avoidable and unattended death is far more prevalent among vulnerable groups. The dignity of the dying process for these individuals is compromised whenever mysthanasia occurs, whether in the medical-hospital setting (involving terminal illnesses or not) or in the broader social context.

Therefore, breaking with frontier bioethics requires recognizing that discussions on the dignity of death should be extended to cases that go beyond the end of life. It is not only patients with terminal illnesses whose dignity must be respected, but all individuals who eventually face the risk of death. This is because death is a phenomenon inherent to life—insofar as it affects anyone who is alive—and thus, dignity must be present in death in order to guarantee the fundamental right to a dignified life⁷.

In fact, even before worrying about the notion of a dignified death, vulnerable populations need to struggle daily for a life with a minimum of dignity¹, given the inadequate life conditions they endure due to historical processes of social exclusion. It is therefore impossible to discuss bioethics in Latin America without acknowledging the precariousness of the lives of vulnerable populations and the challenges they face in living and dying with dignity (whether affected by terminal illnesses or not).

Mysthanasia and dignified death must also be discussed from the perspective of the dichotomy of persistent versus emerging issues. For Garrafa²⁹, who proposes a division of bioethical discussions based on these issues, the bioethics of persistent situations focuses on

issues that relate to people’s life experiences and that have stubbornly persisted since ancient times, such as social exclusion, patriarchal domination and so on. On the other hand, the bioethics of emerging situations addresses conflicts arising from the contradiction between biotechnological progress and the dignity of human beings.

Traditional bioethics basically focuses on an emerging approach, raising issues that are closely related to the ethical limits of biomedical activity in applying biotechnological innovations to patients with terminal illnesses. These issues involve to what extent life should be prolonged by artificial (and biotechnological) means or how to optimize the comfort of these patients with biotechnology, etc.

On the other hand, Latin American bioethics, by proposing to shed light on the role played by mysthanasia, seeks to raise persistent issues in society, such as social exclusion and its impact on effective access to healthcare. This is a clear paradigm shift that redirects the focus of bioethical discussions to the vulnerabilities generated by different forms of social domination.

For Stelmach²⁵, the intrinsic relationship between the concept of mysthanasia and the bioethics of persistent issues is the main factor that distinguishes the former from the notion of cacothanasia, developed by Giovanni Berlinguer. The Italian bioethicist coined this term to refer to premature, predictable and avoidable deaths in the context of the use of biotechnology, drawing on frontier bioethics. In turn, mysthanasia relates to the fact that the social context of affected individuals makes their life precarious, and is therefore linked to persistent and everyday issues.

Thus, the bioethical debate on mysthanasia seeks to emphasize persistent issues related to the

right to a dignified death, drawing attention to the harmful effects of social exclusion on vulnerable populations. In Brazil's social context, mysthanasia takes on an antagonistic role regarding the concept of dignified death, a position exclusively held by dysthanasia in traditional bioethical analysis. Consequently, in Brazil, miserable deaths are recognized as an obstacle to be overcome.

This approach extends far beyond the principlist microethical analysis associated with emerging issues, delving deeper into the formation of Brazilian society and the social consequences of historical processes of social exclusion. By doing so, it aims to reveal the influence of the economic-health field on the dying process, illustrating how society determines the fate of the sick, whether through inadequate living conditions or insufficient healthcare²⁵.

To provide a clearer picture of the precariousness of death in Brazil, this study gathered information available in the DataSUS database to quantitatively measure the impact of mysthanasia-related deaths on the total number of deaths in the country. To this end, the number of deaths recorded due to malnutrition or insufficient care between 2018 and 2021—the last four annual periods recorded by DataSUS—was compared with the total number of deaths in Brazil in each year.

This procedure does not quantify the total cases of mysthanasia-related deaths but only the minimum number. While all deaths resulting from malnutrition or insufficient medical care are inherently miserable, mysthanasia is not limited to such cases and may occur in many other ways. The goal was to minimally quantify mysthanasia-related deaths in order to generate percentages between such cases and the total number of deaths in the analyzed period (Table 1).

Table 1. Impact of malnutrition and insufficient medical care on deaths in Brazil between 2018 and 2021

| Cause | 2018 | 2019 | 2020 | 2021 |
|---------------------------|-----------|-----------|-----------|-----------|
| Total | 1,316,719 | 1,349,801 | 1,556,824 | 1,832,649 |
| Malnutrition | 5,282 | 5,309 | 4,664 | 4,717 |
| Insufficient medical care | 10,833 | 10,253 | 10,815 | 9,716 |

Source: Adapted from DataSUS³⁰

According to Table 1, deaths caused by malnutrition or insufficient medical care (hereinafter referred to as unquestionably mysthanasia-related) totaled 16,115 in 2018, 15,562 in 2019, 15,479 in 2020 and 14,433 in 2021. Proportionally—and considering the limit of two decimal places—unquestionably mysthanasia-related deaths account for approximately 1.22% of the total in 2018, 1.15% in 2019, 0.99% in 2020 and 0.79% in 2021. This means that of every thousand recorded deaths, unquestionably mysthanasia-related deaths account for approximately 12 in 2018, 11 in 2019, 10 in 2020 and 8 in 2021.

Between 2018 and 2021, unquestionably mysthanasia-related deaths averaged approximately 1.04% of the total deaths recorded in DataSUS³⁰. It can also be stated that for every thousand deaths recorded during this period, more than 10 were unquestionably mysthanasia-related.

Despite the apparent reduction in the ratio of total to unquestionably mysthanasia-related deaths, one must consider the impact of COVID-19, which significantly increased the number of deaths in Brazil in 2020 and 2021. Therefore, it is necessary to wait for new updates to the DataSUS data to determine whether the drop in this ratio is the result of the new coronavirus pandemic or other factors.

Furthermore, there is no downward trend in deaths caused by malnutrition (increase in 2019, decrease in 2020 and new increase in 2021) or by insufficient medical care (decrease in 2019, increase in 2020 and new decrease in 2021). Therefore, based on the information from DataSUS, it is not possible to outline a promising scenario for overcoming mysthanasia, as more up-to-date data is required to draw more reliable conclusions.

The fact is that the official data provided by the Brazilian government indicate the significant presence of mysthanasia in death processes in the country. It is important to note that the numbers collected above refer solely to deaths caused by malnutrition or insufficient medical care (classic forms of mysthanasia). On the other hand, the survey is unable to quantify mysthanasia-related deaths caused by other forms of abandonment, poverty or suffering.

Considering only the cases of unquestionably mysthanasia-related deaths, the collected data reveal a troubling health scenario. When these deaths are combined with mysthanasia cases that could not be identified through DataSUS³⁰, the situation becomes even more precarious. All this confirms the need for Brazilian bioethics to focus more intently on the phenomenon of mysthanasia in order to overcome uncritical imports of the principlist school among Brazilian bioethicists and facilitate a realistic debate that does not overlook the country's social challenges.

Final considerations

The monopoly of bioethics of emerging issues in the discussion on the right to a dignified death in Brazil must be urgently challenged. The subject cannot be developed through the uncritical application of principlist contributions rooted in the US context. Undignified death is not an issue that solely affects patients with terminal illnesses; many individuals suffering from curable illnesses face undignified existential conditions and inadequate healthcare.

The Brazilian context significantly influences the analytical framework of the right to a dignified death, since the realities of social stratification and the phenomenon of mysthanasia make it clear that dysthanasia is not the only obstacle to achieving dignity in the dying process.

This challenges the notion of dysthanasia as the exclusive antagonist of a dignified death, positioning mysthanasia as an obstacle to be overcome. This is because the high levels of social exclusion in Brazil prevent the discussion of dignified death exclusively at a microethical level and as an emerging issue.

To effectively confront the barriers to achieving a dignified death, the macroethical factors involved in the issue need to be addressed, revealing the influence of social exclusion on the indignity experienced by vulnerable populations in their dying process. Only then will miserable, painful and unassisted deaths cease to be ignored and start to be recognized as a problem to be addressed.

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Leonardo Bocchi Costa – PhD student – leonardo.bocchi@hotmail.com

 0000-0002-2425-7105

Nathalia da Fonseca Campos – Undergraduate – nah-fonseca@hotmail.com

 0000-0002-6251-0626

Patricia Borba Marchetto – Associate professor – patricia.marchetto@unesp.br

 0000-0002-7507-961X

Correspondence

Leonardo Bocchi Costa – Rua Amparo, 165, Vila Tereza CEP 19600-452. Rancharia/SP, Brasil.

Participation of the authors

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