Impact of Resolution CFM No.1,805/06 on physicians dealing with death

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Abstract

The preservation of life is considered inherent to medical performance, which may increase patient's survival through the usage of technological methods. This raises questions concerning the ethical aspects of prolonging life, which fosters the creation of CFM Resolution 1,805/06. This paper derives from (was created as a result of a) research aimed at raising physicians' profile working at Marilia Medical School hospitals (Famema), as well as seizing their opinion about euthanasia, dysthanasia and orthotanasia, regarding the provisions of resolution, and investigating the impact of such document over their professional routine.

Key words: Euthanasia. Medical ethics. Attitude toward death. Palliative care.

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The publication of CFM Resolution 1805/06, due to its wide repercussion, has the potential of provoking significant repercussions either on medical class or on society. If everything related to the handling of the dying process was previously an issue handled with great fear, it is natural that the decision has brought changes in attitude and behaviors, not only by professionals who deal every day with death, but to the routine at the centers that deal daily with terminal patients. Recognizing its impact on the medical class allows forecasting how in our society people can expect to be assisted during the final moments of their lives. After all, there is the possibility that the terminal moments of each one be assisted by a professional who may (or may not) accept and practice proposed guidelines.

Such context of novelty and ambiguity reinforces the importance of knowing the opinions, attitudes and

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practices of professionals who handle daily with the dying process, as well as the possible impact of CFM Resolution 1805/06 on their professional daily life. Such distinct views on the issue effectively make the subject relevant, which re-emerges vividly with the current Medical Code of Ethics (CME), which tends to become even more significant in our reality through new legal provisions being introduced to the society.

Historical and Symbolic Context

The Hippocratic oath contains: *I will use those dietary regimens which will benefit my patients according to my greatest ability and judgment, and I will do no harm or injustice to them. I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan*[1].

Since the ages of Medicine's father, the advances in the care to the terminal individual reinforce such conception by increasing the survival of patients considered terminal. If in the beginning of the 20th century the time for the advent of death, after the finding of a serious disease, was five days, the advances achieved along that century made it possible that today such interval is tenfold greater. [2] Accordingly, the student of medicine is molded, since early stages, to face death as a great adversary that shall be fought and, if possible, defeated thanks to the best science or competence available [3]. Such characterization of the professional physician such as the one that defeats death is seen in the next mythical and poetical narrative, in the myth of Asclepius, the Greek god son of Apollo who, during his apprenticeship with centaur Quiron, would have acquired the power of providing live to the dead [4].

The imperative associated to such representation of physician's role contributes to future professional not receiving in his/her formation pedagogical contents to deal with human terminality. According to Hill [5], only

4% of Medical Schools in the United States (USA) are concerned in transmitting lessons on the death process. Therefore, when death occurs, the feeling of anguish caused by the perception of defeat is capable of undermining the willingness of the professional; after all, death causes a feeling of frustration and exposes a narcissistic wound in the medical prepotency [6].

Here are the first problems: the technology advances inserted into medicine permit that life, even in terminal instances, be extended for a considerable time. Added to this is the fact that physician, in his/her formation, receives as a dogma that he/she is the caretaker of that life, which he/she should preserve at any cost, preventing its end. How, within such context, to face the patient's autonomy, in case he/she expresses the wish of dying due to the fact of being restricted to a painful and irrecoverable situation? At to which extent an individual under such condition has the right to intervene, make an opinion and be heard when the issue is his/her own death? Or, furthermore: until when it is considered ethical to extend or abbreviate a life? Prior to such question, it became necessary to deepen the understanding on the process of dying and death itself. It occurs, then, the definition of the ways of such process: euthanasia, dysthanasia and orthotanasia.

Euthanasia, from the Greek *euthanasia*, is a neologism created in 1623 by the philosopher Francis Bacon. At the time, that word was used to mean a good death. Euthanasia, therefore, is the attitude that provides an easy and no suffering death to the person who suffers from an incurable or very suffering illness, by reducing the extended suffering and providing him/her a fast and painless death [7]. It is the active medical assistance to death. Dysthanasia has exactly the opposite meaning: a word composed by the prefix *dys* (meaning contraposition) and the original Greek word *thanasia*, meaning slow death, a lot of suffering. It would be the case where the physician uses all and any resources available to extend the life of a terminal patient. Such process is also called therapeutic obstinacy [8]. A word being increasingly used is orthotanasia, death at the correct instant. It would be facing death at the adequate instant, with no extensions or abbreviations. It further embodies the notions of sensibility to the humanization process of death and the relief of usual pains at that instant [8].

Nevertheless, it is also necessary to deepen the definition of euthanasia, including its several classifications, as well as the basic differences related to euthanasia, regarding agent's execution mode. In orthotanasia, methods to extend a life, which would cease naturally or even to abbreviate it are not used. Euthanasia, in its turn, uses practical means to interrupt life, even when it could be extended. In this sense, it could be divided into *active* and *passive*. The first, happens when death derives from a positive conduct, and the second when gotten from an omitted stand[9]. A very common mistake is the confusion between passive euthanasia and orthotanasia, also known as restricting medical conduct. The former, as well as its active mode, has as finality to promote

death and, secondarily, cease suffering. In orthotanasia the wish is not killing but preventing the extension of death - when using, often, procedures that dishonor human dignity at the end of life [9].

With the purpose of clarifying the controversy on the issue, CFM published Resolution 1805/06, defining that: *At the terminal stage of serious and incurable illnesses, it is allowed to physician to limit or suspend procedures and treatments that extend patient's life, assuring him/her the care required to alleviate the symptoms that lead to suffering, in the perspective of a full care, respecting patient or his/her legal representative's wish* [2].

The publication states that it is the physician's duty to clarify patient or his/her legal representative, the therapeutic modalities adequate to the case, indicating that a second medical opinion is patient or his/her representative's reserved and acquired right. Finally, it resolves that the patient shall continue receiving all assistance for the symptomatic relief, in order to prevent suffering. It is assured his/her physical, psychic, social and spiritual comfort, including with right to hospital discharge, if he/she so desires.

Resolution CFM 1805/06 was not unanimously accepted; sectors from the society showed discomfort and rejection. The argument to reject it was that medical extravagances could provoke hastened deaths. Target of criticisms, particularly by legal sectors, the CFM document was suspended by a preliminary injunction in 2007, thus increasing its relevance when indicating the inability of certain sectors in the society in handling with the bioethical discussion of issues related to death [10].

But what is a necessity may calm down with time, but not be silenced forever. In December 2010, after three years of legal discussion, it was published Judge's decision at the 14th Federal Court from the Federal District, revoking the preliminary injunction that suspended the resolution [11] and ruling as groundless the public civil suit brought by the Federal Public Attorney's Office against the Federal Council of Medicine. It was recognized that the permission to interrupt the treatment at the request of the patient on a terminal situation does not violate the Federal Constitution and, thus, the resolution was in force again.

In the Civil Justice realm, it was approved by the Federal Senate the Bill No. 6,6715/09, which decriminalizes orthotanasia [12]. In that text, within the scope of palliative care to terminal patient, it is not considered a crime to suspend disproportional and extraordinary means, provided that the inevitable death is attested by two physicians. Here, it is also necessary the patient's express consent or, if unable, by his/her legal representative [13].

Finally, the new Medical Code of Ethics (CEM) [14], in force since March 2010, sets forth in Chapter V, Article 41, that it is prohibited to abbreviate the patient's life, even at his/her request. A repetition of what was stated in revoked code.

Original is the single paragraph which sets forth that in the cases of incurable and terminal illness, the physician should offer every available palliative care, but without undertaking useless or obstinate diagnosis actions, always taking into account patient's express will or, if unable, that of his/her legal representative.

It can be noticed that the idea reappears and is perpetuated. With a text cautiously written in order to prevent confusion, CEM brings the same principles of abdication of therapeutic obstinacy already seen in the text of the polemic resolution. In synthesis, the difference of CFM Resolution 1,805/06 and CEM is not a conceptual one, but rather in writing. In all CEM one notices the principle of humanization. Such concern is perceivable when emphasizing that the palliative care should be made to the terminal patient, i.e., although procedures that extend life artificially may be suppressed, the same shall never occur with basic care, aforesaid palliative, responsible for the comfort at final instances [15].

The importance of such thematic inclusion in the CEM is significant: in addition to belonging to the great ruler of good medical practice conducts, there will be no excuse of not knowing the orthotanasia issue based on the fact that the rules pertaining to the subject were allocated in separate resolutions. Now, they are all compiled in one single (and more important) document.

One realizes, retroactively, the importance of the original document, rescued in CFM Resolution 1.805/06, which may be signed after heated debates on the subject within the medical, legal and society realm so that, years later the idea of preventing unnecessary suffering at the time of death would reappear strongly, evidencing as a landmark of respect to human dignity .

Objectives

The overall objective of the Project, from which originated this article, was to know the profile of physicians who deal in their daily professional routine with the dying process at a university medical institution, assessing their opinion regarding euthanasia, dysthanasia and orthotanasia practice. The specific objective was to evaluate the knowledge, opinion and changes in the daily work of such professionals with the emergence of CFM Resolution 1,805/06.

Materials and methods

This refers to a transversal study, with a quantitative and qualitative analysis carried out through questionnaires, without the interviewees' identification, applied to medical professionals who frequently face the death process at the hospitals in the Famema complex (Clinics Hospital I and II).

The criteria for inclusion in the study was to be a medical professional and act in one of the specializations that face death and the dying process most: intensive care worker, physicians working in first aid/emergency units ambiance, oncologists, neurologists, geriatricians, pediatricians, gynecologists and obstetricians,

as well as general practitioners allocated in areas intended to terminal patients, in addition to interns of the above areas. Another criterion was the acquiescence regarding the free and clarified consent term (FCCT). Physicians who for whatsoever reason did not agree or did not accept signing the FCCT were excluded from this study.

Data collection was performed through self applicable questionnaire (attached), with closed and open questions – an instrument that brings objective and detailed explanation of the terms euthanasia, dysthanasia and orthotanasia. The interviewee is asked if his/her knowledge on each issue is in accordance to provided definition. In case of inconsistency, it is requested in the open question to expose, on a dissertational way, his/her notion on the concept. Follow then direct and sequential questions, on his/her opinion and experience on each of the mentioned terms.

The second part of the questionnaire aims at answering to the specific objective of the research. To this end, it is provided a detailed explanation of CFM Resolution 1805/06, followed by closed questionings on its knowledge, opinion, change or not in his/her work practice.

Quantitative data were analyzed with the software Epi-Info, 6.02 release. Single frequencies and the correlation between the categorical variables with the chi-square test were examined. The significance level is of 5%. The qualitative data were examined through a consultancy with the professors of the Evidence Based Medicine course, from the techniques of phenomenological analysis and the analysis of the qualitative contents, particularly summarization.

With the purpose of assuring the safety and the anonymity, all answers were received in a sealed urn, open only at the time of the data analysis. Eighty-three participants were interviewed (Table 1), chosen through a random sampling. All the nominated accepted to participate on the research and were included in the criteria of inclusion in the project. The study was approved by the Ethics in Research Involving Human Beings Committee, CEP/Famema, pursuant to the provisions of Resolution CNS 196/96

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Results and discussion

Profiles of the 83 professionals who participated in the study is summarized in the table below:

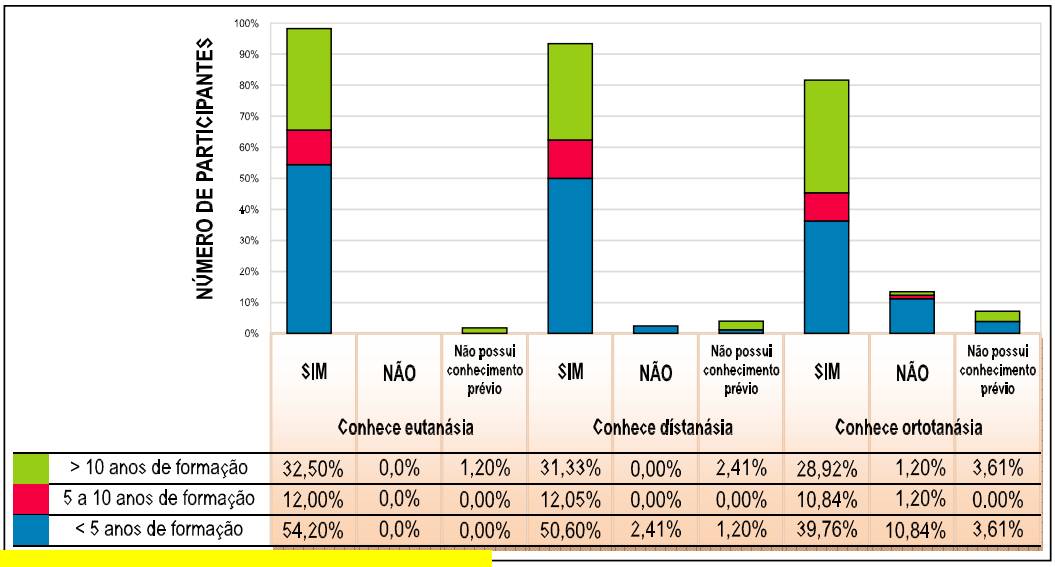
Sex	Nº	%
Male	50	60.2
Female	33	39.8
Total	83	100

Time of graduation	Nº	%
Less than 5 years	45	54
From 5 to 10 years	10	12
More than 10 years	28	34

From the three surveyed terms, euthanasia is the oldest and most known, but which causes more polemic. Almost all (98.8%) of the sample affirmed having adequate knowledge of it. When questioned about the other concepts, more mistakes were found.

Dysthanasia is correctly known by 94% of the interviewees and orthotanasia by 79.5%. One may suppose that the lack of knowledge about the last two terms derives from their several definitions and inaccuracies [16] and to the fact of been relatively recent.

Chart **1** Knowledge of the terms analyzed x time of training of interviewees



	Conhece eutanásia			Conhece distanásia			Conhece ortotanásia		
> 10 anos de formação	32,50%	0,0%	1,20%	31,33%	0,00%	2,41%	28,92%	1,20%	3,61%
5 a 10 anos de formação	12,00%	0,0%	0,00%	12,05%	0,00%	0,00%	10,84%	1,20%	0,00%
< 5 anos de formação	54,20%	0,0%	0,00%	50,60%	2,41%	1,20%	39,76%	10,84%	3,61%

NUMBER OF PARTICIPANTS >10 years of training 5 to 10 years of training <5 years of training

The analysis of the discursive answers, in cases where interviewee admitted not knowing the concept of euthanasia, enabled to understand some of the obstacles to understanding. One of them, for example, defined the practice as "*euthanasia is letting patient to evolve naturally to death, with no interferences*". One may notice the confusion between euthanasia and orthotanasia, specifically the passive form of the first and the restrictive medical conducts pertinent to the second.

Failures in understanding may be identified also when participants in the study were able to expose what they understood by orthotanasia, when the detailed explanation of the concept, previously provided by the questionnaire was not similar to knowledge that they had until then. It was then possible to verify that among the most common terms in the bioethics discussion involving death and the dying process, orthotanasia is the one which generates more conceptual confusion.

Analysis of answers points out two nuclei of ideas, respectively represented in the examples: "*I thought orthotanasia was suspending an already started treatment*" and "*I thought orthotanasia was the synonym of palliative care*". The lack of conceptual knowledge in the first example refers to the fact that orthotanasia only occurs if patient is

without prognostic, since in case of the non-terminal patient the removal of treatment would be classified as active euthanasia. Palliative care appearing in the second example, are care provided to patient in his/her terminal moments, with the main objective of improving the quality of life, not interfering in the illness evolution [17]. In other terms, is the multi-professional practice aiming at offering to the terminal patient care involving the physical, emotional, social and spiritual aspects with the objective of attaining the best quality of life possible for him/her and their families [18]. They are examples of palliative care, among which: hygiene, comfort, symptomatic medications and religious support.

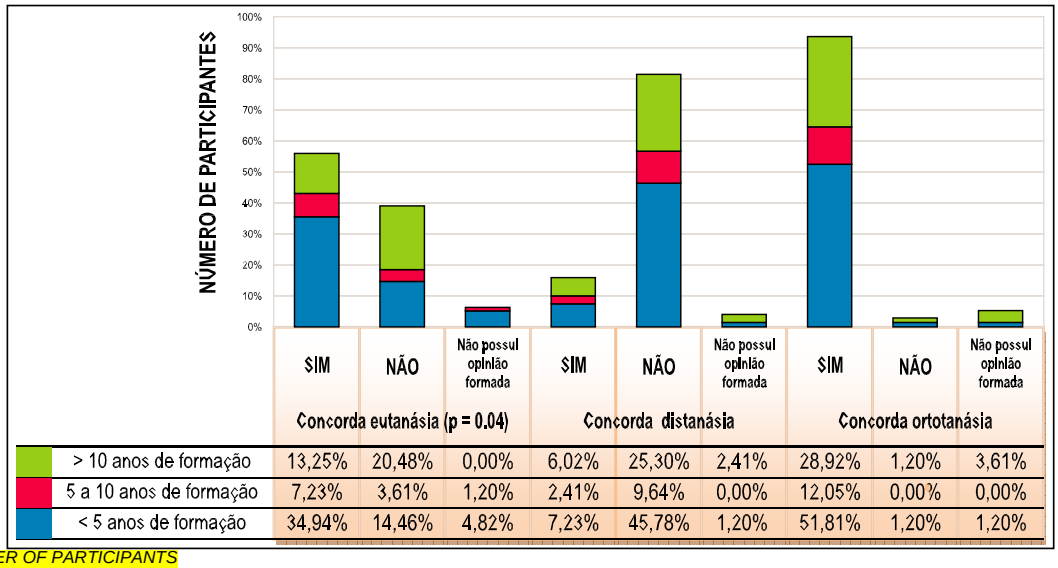
As to agreement regarding the three terms, most part of the sample is favorable to the practice of euthanasia (55.4%). But, when the term is dysthanasia, 80.7% of the interviewees were contrary to the practice, noting that among the evaluated concepts it is the most rejected by the sample. A justifiable result, bearing in mind the change in focus of medicine since the second half of the 20th century, with the backward movement of the paternalist practice toward respect to autonomy, whose center of attention is the sick. For the latter often it is not relevant to extend his life time if it is at expense of useless suffering. Thus, the answers by professionals who participated in the study seem to be in consonance with such trend of medicine, based on the respect to the patient.

Still, in the perspective of such change in behavior, it was verified the acceptability of orthotanasia in 92.8% of interviewees, thus, noticing that professionals consider undeniable the acceptance of death in the time of each one, seeking to avoid unneeded suffering, abbreviations or extensions[19]. The percentage analysis reveals a trend to adopt therapeutics that enables the reduction of suffering by such patients, including even euthanasia. In summary, the universal language is of repudiation to the therapeutic obstinacy.

Such aversion to dysthanasia and a favorable attitude to orthotanasia and even to euthanasia occurs because the studied population understands the dynamics of beneficence and non-maleficence along an individual's existence. Under conditions in which the treatment and the cure are possible, beneficence should overlap non-maleficence. In practical terms: salvation actions (dialysis, mechanical ventilation, amputations, and transplants) should be applied, even if they bring along some degree of suffering. On the other hand, when death is inevitable, the cure is no more possible and the non-maleficence principle should prevail. If heroic conducts are established during that stage there will be only a temporary and usefulness postponement of the death event, at the cost of suffering.

The understanding and acceptance of the other ethical principles may also be assessed. If is to the patient to decide and make an opinion on how his/her terminality will be, his/her principle of

Chart 2 Opinion on analyzed terms x time of training of interviewees



> 10 anos de formação	13,25%	20,48%	0,00%	6,02%	25,30%	2,41%	28,92%	1,20%	3,61%
5 a 10 anos de formação	7,23%	3,61%	1,20%	2,41%	9,64%	0,00%	12,05%	0,00%	0,00%
< 5 anos de formação	34,94%	14,46%	4,82%	7,23%	45,78%	1,20%	51,81%	1,20%	1,20%

NUMBER OF PARTICIPANTS

>10 years of training 5 to 10 years of training

<5 years of training

autonomy shall prevail. Furthermore, the principle of justice is also respected: it is understood that resources with therapeutic obstinacy shall be preserved to individuals with a favorable prognostic.

As to the practice, in the evaluated population 8.4% had made euthanasia. It is a considerable figure in view of the reality of the Brazilian laws, which characterizes it as a crime. When inquired on which practices made would characterize euthanasia (in such case practiced or observed), 29 different types of answers were noticed. When organizing them, two nuclei of ideas could be identified. The first one covers answers such as: *"use of medication inducing respiratory arrest", "sedation in high doses", "administration of a cocktail of drugs with a sedative effect and respiratory depressor", "M1 on a large scale", "use of M1 and M2".*

This set of answers is about the use of drugs to accelerate the patient's death.

M1 means sedative drugs administered in significant doses, with a potential to induce respiratory depression. M2 doubles the doses since the smaller amount used previously was not capable of producing the sedation or death, depending on the intent of its application of euthanasia, now focused on the intent of the subject practicing it, dividing it in direct and indirect (or of double effect).

The first, direct, occurs when the main objective is the postponement of death; the second, indirect, when life is shortened, although the main objective is to promote comfort to the patient - such circumstance occurs when the medication doses used with the purpose of minimizing suffering to the patient anticipates the death, although the intent was only to reduce or suppress suffering [9]. The capacity of some analgesics and sedatives, such as morphine, providing a respiratory depressor effect is already known, when administered in high doses.

To abolish unbearable pains and anguish, drugs like these are administered in large amounts, even though death is considered as an adverse effect. Data seem to reveal that it is precisely due to the fact that it is characterized as a charitable action, with the purpose of minimizing excruciating pain and suffering, that the practice is accepted with certain tranquility.

Although the Catholic Church is ideologically against euthanasia and every form of life abbreviation, gaps in such thinking are found in its archives when it refers to that particular type of euthanasia, the indirect one. In *Pope Pius XII Speech on the moral and religious Implications of analgesia* it may be noticed the favorable position to the practice of indirect euthanasia. In that document, the Pontiff affirms that *if the administration of narcotics causes itself two distinct effects, to wit: on one hand, the relief of pains and on the other hand abbreviation of life, it is licit* [20,21]. The dilemma seems to be solved in favor of the patient during his/her final moments, when in pondering between the certainty of suffering and the risk of acceleration of the already certain death, one opts for the second alternative [22].

Although the practice of double effect euthanasia is justifiable under the mentioned situations and intents, one cannot consider use of each and all sedative and analgesic medications as exempt of ethical deceit. As seen, it is not the use of the drug that will make the action acceptable in bioethical terms, but the intention that motivates it. When analyzing the responses obtained in surveyed sample, when focused in the practice of euthanasia, it was found that the use of drugs was the most common. It should be emphasized, however, that the main intention seems not to have been to alleviate pains and occasionally cause death, but rather promote death to secondarily cease pain, which characterizes direct euthanasia.

The other nucleus of ideas that one may withdraw from the answers to the questionnaire is well represented by these examples: "*analgesia plus sedation without supplementary food and hydration that is not intended to infuse medication analgesia"*; *"non realization of orotracheal intubation"*; *"non treatment with antibiotic of presumed infection"*. There has also been a report of a conduct in which one opted for not introducing vasoactive drugs when they would improve the patient's clinical conditions. All those attitudes may be identified as omission or suspension of the vital support, usually characterized by the disconnection or the non-introduction of mechanical ventilation, omission or interruption of vasoactive drugs, order for non-resuscitation, non-introduction of antibiotics, suspension of nutrition and hydration [9]. In summary, these are measures that, once omitted, they will inexorably lead the patient to death.

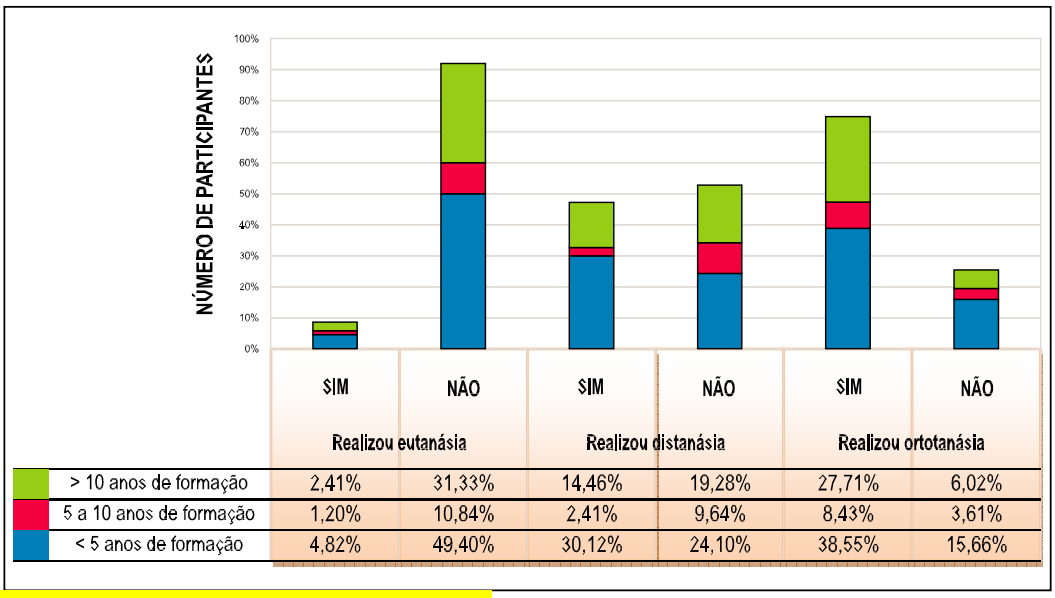
Although considered vital, the adoption of such measures may not always be related to euthanasia, since the omission of such support may occur in a patient without a prognostic. Nonetheless, the Pontifical Academy of Science recommends that hydration and nutrition be part of the palliative care and that, under any condition, be removed. The suspension of the other artificial mechanisms may cause directly the death, even though it is more

probable that it occurs from the illness itself required the omitted artificial assistance. Otherwise, when one stops feeding and hydrating, such actions become, in alliance with basic pathology, the direct causes of death.

When questioned on dysthanasia, 47% of the interviewees affirm that they have done it already. However, of those who did it, 66.7% do not agree with its practice - number that meets the observations in the medical literature [23,24]. The causes for the discrepancy between acceptance/realization of dysthanasia are centered in the lack of understanding between the health team and the family; in the adequate communication of professional care-takers and in the less than professional behavior by these, according to the literature [25]. These are situations that make the physician to insist in the maintenance of life even when it is not anymore feasible. Such kind of perseverance occurs due to the bad relationship between the health professional and the family, making it difficult the understanding that everything has already been done in trying to save the patient and that the best thing would be facing death with dignity and less suffering – or also derives from legal pressures, feared by the physicians. Other causes studied are also the request by the patient himself/herself and the uncertainty as to the diagnosis and prognostic [24].

Finally, the comparison between the three practices regarding the realization shows that orthotanasia is most practiced. Among the interviewees, 74.7% have done it already, which shows again that this procedure is the medical class ideal, as far as dignified and human assistance to the terminal patient is concerned.

Chart 3 Practice of terms analyzed x time of training of interviewees



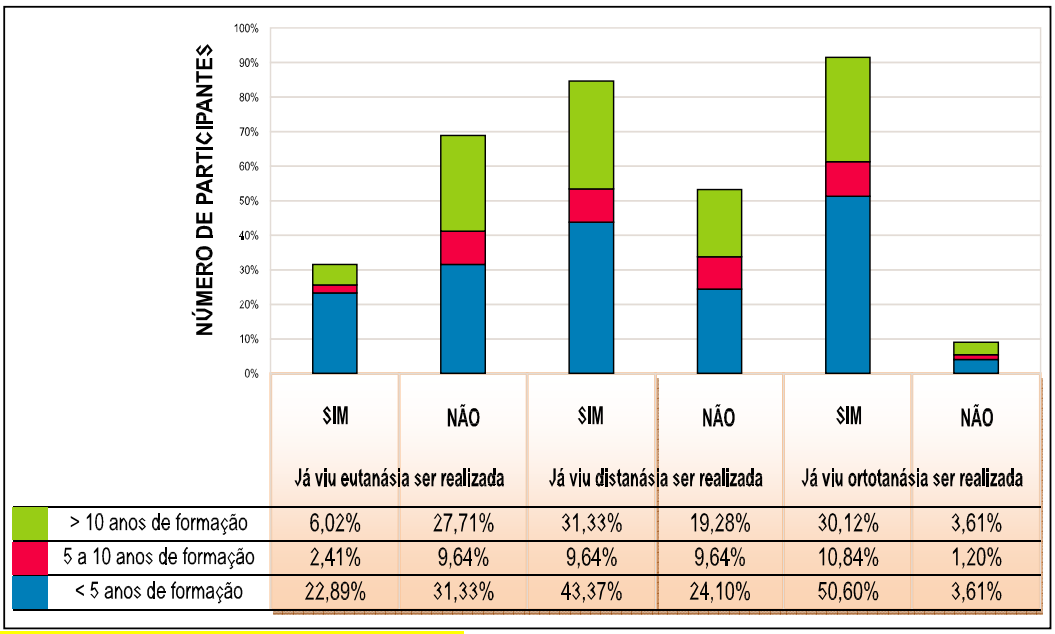
	Realizou eutanásia		Realizou distanásia		Realizou ortotanásia	
	SIM	NÃO	SIM	NÃO	SIM	NÃO
> 10 anos de formação	2,41%	31,33%	14,46%	19,28%	27,71%	6,02%
5 a 10 anos de formação	1,20%	10,84%	2,41%	9,64%	8,43%	3,61%
< 5 anos de formação	4,82%	49,40%	30,12%	24,10%	38,55%	15,66%

NUMBER OF PARTICIPANTS >10 years of training 5 to 10 years of training <5 years of training

It should be emphasized that, in this case, no conflicts have been found between acceptance and realization, such as those detected in relation to euthanasia and dysthanasia.

When questioned IF they had seen as observers (and not as agents) any of the three practices, the number of occurrences was significantly greater, which provides evidences to believe that, being a controversial issue, discussed defensively, there is a resistance in admitting the active practice, especially of euthanasia and dysthanasia, topics discussed with a certain fear since they are not accepted by the morality existing in our society and also, in the case of euthanasia, in the legal dimension.

Chart 4 Observation of terms analyzed x time of training of interviewees



	Já viu eutanásia ser realizada		Já viu distanásia ser realizada		Já viu ortotanásia ser realizada	
	SIM	NÃO	SIM	NÃO	SIM	NÃO
> 10 anos de formação	6,02%	27,71%	31,33%	19,28%	30,12%	3,61%
5 a 10 anos de formação	2,41%	9,64%	9,64%	9,64%	10,84%	1,20%
< 5 anos de formação	22,89%	31,33%	43,37%	24,10%	50,60%	3,61%

NUMBER OF PARTICIPANTS >10 years of training 5 to 10 years of training <5 years of training

It was sought to correlate the time of formation of the interviewee for a series of variables. It was concluded that there is no influence ($p>0.05$) of the time of formation in the knowledge of what euthanasia is or in having seen (or not) the same. There is also no significant correlation between time and knowing, agreeing, carrying out, having seen or having knowledge that third parties have done dysthanasia and orthotanasia, knowing or not CFM Resolution 1,805/06, agreeing with the same and having the quotidian and the work environment changed by it also did not suffer a significant alteration according to the years of profession of the participating physicians.

Still in the analysis of the probable correlations with the time of formation, this revealed to be determinant to agree or not with euthanasia ($p=0.04$). It was verified that those with less time of formation agreed more with the procedure when compared to those with more time. When disaggregating data regarding the participants who are favorable to such practice

it may be noticed that 77% of them have less than ten years of professional activity, 63% have less than five years of career. In that same sense, of those who have less than ten years of work, 63.6% agree with the practice; of those with more than ten years of profession, 39.3% are favorable to euthanasia.

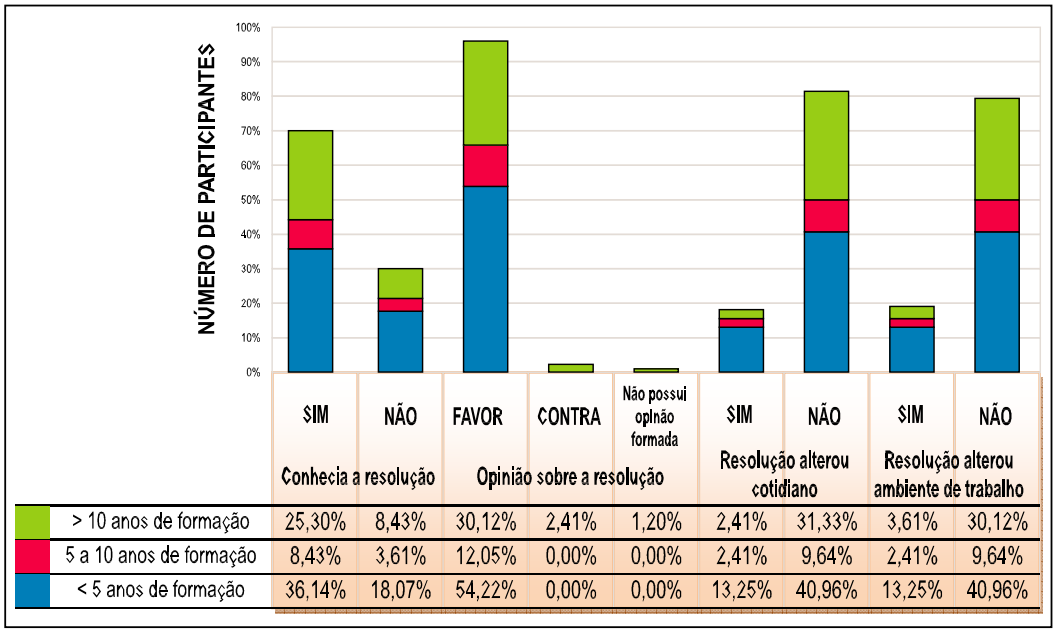
It may be noticed, then, that such results reflect the change of the focus established in medicine. With a more recent formation, it is easier for the newcomers to the profession to accept that even euthanasia may be established for the patient's wellbeing, a perspective seen with a certain preconception by the most experienced ones who, often may have less easiness to accept such transformations. It may be noticed that, although still formed based on an idealist medicine, which abominates death as a possible result of the medical profession, the new professionals started to consider such outcome not as a failure, but as a natural destiny which, sometimes, no technology and knowledge is capable of changing. Another data corroborates such affirmative: 71% of those who committed euthanasia had less than 10 years of formation.

By analyzing CFM Resolution No. 1,805/06 (Chart 5), we find that 30.1% of the sample did not know it. It may be concluded, then, that although most of them were aware of its existence, its use as an alternative form of promoting knowledge and awaken the medical population for the bioethical issues related to death still did not achieve universal success, considering the mentioned percentage of those not aware of the document.

It is important to emphasize the significance of the impact of the media with the emergence and suspension of Resolution 1805/06, which may collaborate to most participants of the study to know the document and the subject dealt with. It may be inferred that projects on related subjects, but without importance in the communication media – most of them – continue not reaching their main function: generate debates, influence conducts and promote a greater quality of life at terminal moments.

Although data allow supposing such problem, the message of the resolution is well accepted by most of them, since 96.4% declared themselves favorable to its contents. Even those who did not know it, after reading text presentation in the questionnaire generally declared themselves favorable. Thinking that the main theme of the document is orthotanasia, it is understood such peculiarity given the acceptance of the bioethical topic. The impact of the resolution on the environment and daily life of the interviewees is a reason for debate. For 18.1% of participants, their working place underwent some change and, for 19.3%, the daily routine itself was changed as a result of CFM text. Those interviewees do not correspond to the majority of the sample, although they do not represent a despicable amount. That is particularly noticed when the practice of orthotanasia is questioned even before the resolution and when we have in mind the difficulty that documents, considered by some as simple papers, provide effective changes in the life of each one.

Chart **5** Aspects of Resolution CFM 1.805/06



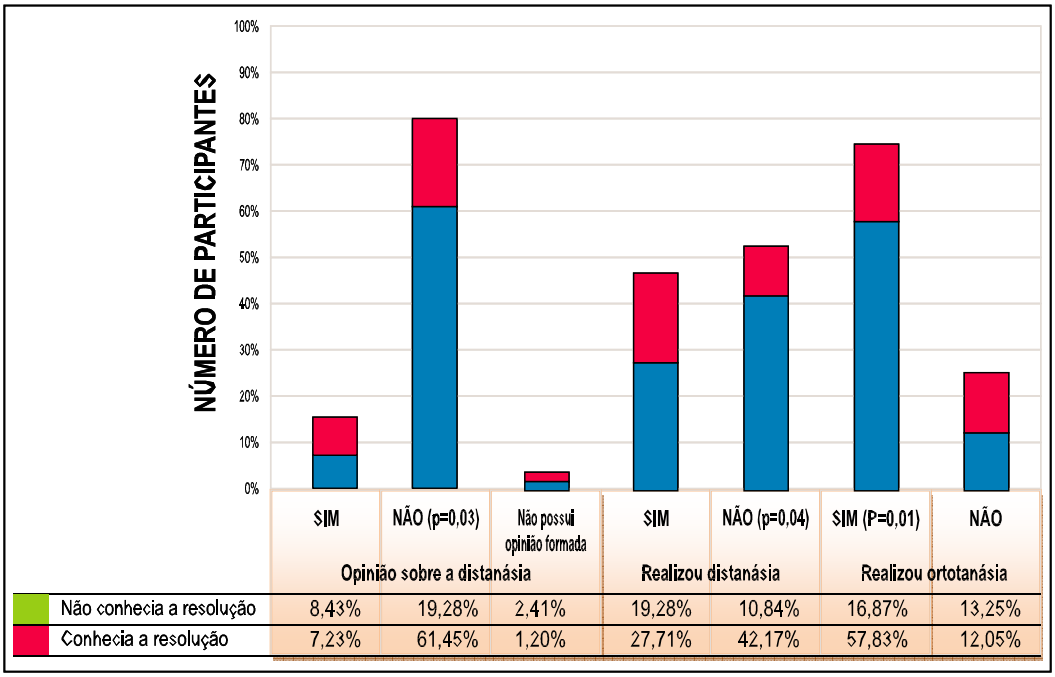
	SIM	NÃO	FAVOR	CONTRA	Não possui opinão formada	SIM	NÃO	SIM	NÃO
	Conhecia a resolução		Opinião sobre a resolução			Resolução alterou cotidiano		Resolução alterou ambiente de trabalho	
> 10 anos de formação	25,30%	8,43%	30,12%	2,41%	1,20%	2,41%	31,33%	3,61%	30,12%
5 a 10 anos de formação	8,43%	3,61%	12,05%	0,00%	0,00%	2,41%	9,64%	2,41%	9,64%
< 5 anos de formação	36,14%	18,07%	54,22%	0,00%	0,00%	13,25%	40,96%	13,25%	40,96%

NUMBER OF PARTICIPANTS >10 years of training 5 to 10 years of training <5 years of training

It stands out on behalf of the common practice of orthotanasia, even before CFM Resolution, the fact that 56% of those who did not know the document already practiced orthotanasia. Such situation may occur not only due to the fact of being considered an ideal of good medical practice, regarding terminality of life, but also because that resolution was not the pioneer in dealing with the subject; several previous publications that consecrate the patient's right to medical restrictive conducts or which, at least, seek to spare the patient from being exposed to situations that were not desired by him/her. As examples, we may cite the '*Cartilha dos Direitos do Paciente'* [26], Article 15 of the 2002 Civil Code [27] and the Statute of the Elderly [28].

Detailing the answer regarding the resolution, it is ascertained that knowing it is a factor related to the non-acceptance (p=0.03) and non-realization (p=0.04). That data can be interpreted considering that the resolution is – although on a non-ideal way - a form of educating, of taking knowledge to the medical class. Therefore, its knowledge would imply being aware of said change on the focus of practices related to the end of life, which by the stimulus from bioethics started to orient the medical praxis from the middle of the 20th century. As a consequence of the knowledge and reflection on such process, many professionals became more critic and contrary to the practice of dysthanasia. Finally, it was observed that knowing the resolution is directly related to the practice of orthotanasia (p=0.01). Of those who knew it, 82.8% had practiced it and of those who did not know it, 56% had done it.

Chart 6 Impact of CFM Resolution 1.805/06



NUMBER OF PARTICIPANTS >10 years of training 5 to 10 years of training <5 years of training

Final considerations

In summary, as to knowing, practicing, observing, agreeing or disagreeing with the terms studies in this research, we have a triad ill-supported by the incompatibility of its pillars. We have technologies to maintain life beyond an acceptable limit, considering the situations in which its maintenance causes more damages that the suspension, at the same time in which, actually, we have the mentality that recognizes the sovereignty of the patient's autonomy. We need, however, to deepen the reflection between the medical class on how ethical is to influence the terminality of a life and, in the circumstances in which that may be revealed as a genuinely beneficent measure, as making it in order to respect autonomy, beneficence, non-maleficence, and maintaining the principle of justice.

To encourage such reflection, it would be natural to initiate the teaching of such subject from where it is also supported the medical apprenticeship, but Hill [5], has already shown in his studies that, currently, that does not happen. However, the undeniable lack of discussion on death and the subject that involves it, at colleges and universities, should not justify the inertia of discussions.

Reforms should be initiated to enable the inclusion of the subject in the academic environment. However, while that does not occur, it is urgently to approach the subject by other trends.

Due to such rather complex picture, and aware of the impossibility of postponing a discussion of such importance, entities, representing the society started positioning themselves on such topics. Unquestioned is the more and more trivial use of the mentioned terms. It may be noticed, however, that they are still unknown by an expressive part of the population, and which is worse: there are physicians that still make confusion when defining them.

It can be inferred the urgent need of promoting and deepening such discussion, and also disseminating subjects related thereto. For this reason, it may be defended, with no doubt, CFM Resolution 1805/06, whose impact may be felt in the medical environment and in the society. Knowing its contents brought effective changes in the behavior of the professionals studied, who expressed themselves in the practice of their professional daily life becoming more ethical and in line with the humanitarian values.

Resumo

Impacto da Resolução CFM 1.805/06 sobre os médicos que lidam com a morte

A preservação da vida é considerada inerente à atuação médica, que pode aumentar a sobrevida do paciente com o uso de métodos tecnológicos. Surgem, então, questionamentos acerca dos aspectos éticos do prolongamento da vida, o que fomenta a criação da Resolução CFM 1.805/06. O presente artigo decorre de pesquisa destinada a levantar o perfil dos médicos que atuam nos hospitais da Faculdade de Medicina de Marília (Famema), bem como apreender suas opiniões sobre eutanásia, distanásia e ortotanásia, considerando o disposto na citada resolução, além de investigar os impactos desse documento sobre seu cotidiano profissional.

Palavras-chave: Eutanásia. Ética médica. Atitude frente à morte. Cuidados paliativos.

Resumen

Impacto de la Resolución CFM 1.805/06 en Brasil acerca de los médicos que tratan de la muerte

La preservación de la vida es considerada inherente a la actuación médica, que puede aumentar la supervivencia del paciente con la utilización de métodos tecnológicos. Eso plantea cuestionamientos sobre los aspectos éticos de la prolongación de la vida, lo que favorece la creación de la Resolución CFM 1.805/06. El presente artículo se deriva de la investigación destinada a levantar el perfil de los médicos que trabajan en los hospitales de la Facultad de Medicina de Marília (Famema) así como aprender sus opiniones sobre eutanasia, distanasia e ortotanasia, teniendo en cuenta lo dispuesto en la resolución, además de investigar los impactos de ese documento sobre su cotidiano profesional.

Palabras-clave: Eutanasia. Ética médica. Actitud frente a la muerte. Cuidados paliativos.

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Authors participation in article

Thiago Vasconcelos is responsible for designing, assessment of literature, undertaking the survey project, application of the pilot questionnaire, application of definitive questionnaire, qualitative and quantitative data analysis, and writing the final version. Natalia Imamura worked in assessment of literature, application of definitive questionnaire, qualitative and quantitative data analysis, and supervision of writing the final version. Heloisa Villar is responsible for overall guidance, and supervision of all stages of project design.

Questionaire
Impact of CFM Resolution No. 1,805/06 on physicians dealing with death

1) Euthanasia is the attitude that provides an easy and no-suffering death to the person who suffers from an incurable or very suffered illness , by reducing extended suffering, giving him/her a fast and painless death. It is the active medical assistance to death. Conceptually, it needs the practice of some action, which will result in the death.

A) Did you have previous correct knowledge on what euthanasia was?

( ) Yes
( ) No
( ) Has no previous knowledge on euthanasia

B) If your previous knowledge was not correct, what did you understand by euthanasia?

C) Do you agree with the practice of euthanasia?
( ) Yes
( ) No
( ) I have no opinion on the subject

D) Have you, in your professional life, ever made euthanasia?
( ) Yes
( ) No

E) If you answered that you have already made euthanasia, what have you made to practice it? (do not answer if in the previous question you Said that you have never made euthanasia)

F) Have you ever heard of colleagues in the profession who have made or seen the practice of euthanasia?
( ) Yes
( ) No

If you answered Yes (you have already seen colleagues in the profession practicing euthanasia), which was the practice made by them that resulted in euthanasia?

2) Dysthanasia, known as synonym of therapeutic obstinacy, would occur when the physician uses every and all resources available to extend the life of a terminal patient. It is the opposite of euthanasia.

A) Did you have previous correct knowledge on what dysthanasia was?

( ) Yes
( ) No
( ) Has no previous knowledge on dysthanasia

) If your previous knowledge was not correct, what did you understand by dysthanasia?

B) Do you agree with the practice of dysthanasia?
( ) Yes
( ) No
( ) I have no opinion on the subject

C) Have you, in your professional life, ever made dysthanasia?
( ) Yes
( ) No

D) Have you ever watched the practice of dysthanasia in your work environment?
( ) Yes
( ) No

E) Have you ever heard of colleagues in the profession who have made or seen the practice of dysthanasia?
( ) Yes
( ) No

3) Orthotanasia, also known as passive euthanasia, is facing death in an adequate moment, without extensions or abbreviations. Synonym of natural death. It does not include the practice of measures aiming and shortening life, even in a terminal patient or a patient with a disease causing much suffering. In opposition, no medical attitudes also occur aiming at prolonging life beyond an acceptable limit.

A) Did you have previous correct knowledge on what orthotanasia was?
( ) Yes
( ) No
( ) Has no previous knowledge on orthotanasia

If your previous knowledge was not correct, what did you understand by orthotanasia?

B) Do you agree with the practice of orthotanasia?

( ) Yes
( ) No
( ) I have no opinion on the subject

C) Have you, in your professional life, ever made orthotanasia?
( ) Yes
( ) No

D) Have you ever watched the practice of orthotanasia in your work environment?
( ) Yes
( ) No

E) Have you ever heard of colleagues in the profession who have made or seen the practice of orthotanasia?
( ) Yes
( ) No

4) In November 2006, the Federal Council of Medicine published CFM Resolution 1,805/06 (DOU, Nov. 28, 2006, Section I, p. 169), establishing that in the terminal stage of serious and incurable illnesses the physician is permitted to limit or suspend procedures and treatments prolonging the life of the patient, assuring him/her the necessary care to alleviate the symptoms that lead to suffering, in the perspective of a full assistance, by respecting the wish of the patient or of his/her legal representative. The resolution also provides the assurance to the patient or his/her representative the legal right to request a second medical opinion..

A) Were you aware of CFM's resolution?
( ) Yes
( ) No

B) What is your opinion on CFM Resolution No. 1805/06?
( ) In favor of
( ) Against
( ) I have no opinion on the subject

C) Has Resolution CFM 1805/06 changed you working life?
( ) Yes
( ) No

D) Has Resolution CFM 1805/06 affected in any way your work environment?
( ) Yes
( ) No