Liability of the physician in the practice of dysthanasia

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Resumo

Hodiernamente, a responsabilidade civil médica se caracteriza pela conduta culposa do médico, do nexo de causalidade entre esta e o dano sofrido pela vítima. Tendo por fundamento o paternalismo médico desmedido, muitos pacientes terminais sofrem as consequências da obstinação terapêutica, o que resulta em uma morte sofrida e desumana. Com base nesses pressupostos, procurou-se no presente artigo analisar a responsabilidade civil do médico na prática da distanásia. Para a consecução desse objetivo, além de ter sido realizada uma pesquisa bibliográfica de matérias pertinentes à temática, formulou-se um caso clínico hipotético com o fulcro de melhor nortear a discussão. Disto concluiu-se que há responsabilidade civil do médico pela prática da distanásia, vez que é por meio desta que se instauram danos ao paciente terminal, o que por si só lhe subtrai o direito a uma morte digna e humana

Palavras-chave: Responsabilidade civil – médicos. Doente terminal. Morte.

Resumen

Responsabilidad del médico en la práctica de la distanasia

Actualmente la responsabilidad civil médica se caracteriza por la conducta ilícita del médico, la relación de causalidad entre éste y el daño sufrido por la víctima. Tomando por base un paternalismo médico excesivo, muchos pacientes terminales sufren las consecuencias de la terquedad terapéutica, lo que implica una muerte dolorosa e inhumana. Con base en estos supuestos, intentamos objetivar en este artículo, analizar la responsabilidad del civil del médico en la práctica de la distanasia. Para lograr este objetivo, además de haberse realizado una búsqueda bibliográfica de material relacionado con el tema, se compuso un caso clínico hipotético con el apoyo de mejor orientar a la discusión. Se concluyó que existe responsabilidad civil del médico por la práctica de la distanasia, ya que es a través de este que se establece el daño al paciente terminal, lo que por sí solo le resta el derecho a una muerte digna y humana

Palabras-clave: Responsabilidad civil – médicos. Enfermo terminal. Muerte.

Abstract

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Medical liability is nowadays characterized by the wrongful conduct of the physician, the causal link between this and the damage suffered by the victim. Having founded on the medical paternalism, many terminally ill patients suffer the consequences of medical futility, which entails in a painful and inhumane death. Based on these assumptions, the article aims to consider the liability of the physician in the practice of futility. To achieve this goal, and with a literature research of relevant material to the issue performed,, a hypothetical clinical case was elaborated to better guide the discussion. It was concluded that there is liability for the practice of medical futility, since it is through this that are established damage to the terminal patient, which alone will subtract the right to a dignified and human death.

Keywords: Damage liability – physicians. Terminally ill. Death.

Research article

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There is no conflict of interest.

Humans, as beings that are vulnerable to illnesses, found themselves dependent on someone who would take care of and/or heal their illnesses, from the early days. Thus, the first medical activities had mystical-religious nature, and the figure of the physician was represented by the mage or priest, who grounded their healing techniques in supernatural powers. There was, therefore, absolutely no knowledge about the disease etiology and consequences of the treatment on the human organism.

According to Kriger[1], the Code of Hammurabi provided for the amputation of the hands of the doctor who would not get succeed in surgical interventions. In ancient Egypt, the physician who would disrespect the methodology contained in the book of medical conduct was condemned to death, regardless of the evolution of the patient's condition. In Rome, with the advent of *Lex Aquilia,* it was possible to formulate the concept of culpability from medical procedures, such as the abandonment of patients and the refusal to provide medical assistance as well as errors arising from malpractice and dangerous experiments. As consequences of such illicit, Law Aquilia imputed the death penalty or deportation to the physician.

The medical liability was initially disconnected from the culpability and took a punitive nature, embodied in corporal punishment. As law evolved and medicine joined the scientificity, the liability of the physician assumed a subjective character, which, to set up, would require the identification of the culpable conduct of the physician as well as establishing the causal link between that and the harm suffered by the victim. Along with these considerations, the aim of this article is to analyze the liability of the physician in practicing the dysthanasia. The methodology refers to literature and analysis of a hypothetical case study to illustrate the discussion.

Medical liability and the legal system

In Brazilian history, according to Kriger[1], the first legal document that provides for the liability of professionals involved in the medical field was the Penal Code of 1890, that stipulated in Articles 296 and 306, the penalties incurred to faulty medical acts committed by imprudence, negligence and malpractice, or breach of any regulatory provision. In the civil context, the Civil Code of 1916 stipulated in Article 1545 the civil liability

of the physicians, who would be obliged to repair the harm whenever of imprudence, negligence or malpractice, professional acts resulting in death, disqualification from serving, or injury of the patient.

The article 951 of the current Civil Code[2] generally regulates the matter in determining that the articles 948, 949 and 950 are applied in cases of compensation payable by the one who, in the exercise of professional activity, by negligence, imprudence or malpractice, causes the death of the patient, worsen their suffering, causes them injury or disables them to work. Such responsibility has as its normative assumption the article 186 and the heading of the article 927, which provisions concentrate the illicit act in the culpable conduct of the agent.

Still, in this context, it is worth pointing out the distinction between culpability and medical error. According to Cavalieri[3], medical errors will be set when the professional conduct is correct, but the technique is not, there is a failure of the normal man, so that, for medical error to be excusable, besides having in mind the circumstances of the case, it should also be proven vincible to the average medical culture. Thus, there will be malpractice when the technique is correct, but the medical approach is incorrect – it implies a lack of diligence or prudence in relation to what is expected of a good professional.

In addition to the civilist legislation, subjective responsibility of the physician earns guard in the Code of Consumer Protection (Código de Defesa do Consumidor – CDC)[4], which provides, in Article 14, §4, that the responsibility of this professional is determined upon verification of fault. It is noteworthy that the subjective civil liability of the physician defended by CDC[4] refers only to the professional, not favoring, therefore, the legal entity for which they work as an employee or part in society, as described by Cavalieri[3]. Thus, if several physicians decide form a company, the liability of the legal entity will not be subjective.

According to Miragem[5], hospitals and other private health institutions are considered providers of healthcare services, finding themselves in this way under the auspices of Article 3 of the CDC[4]. As a result of this legal determination, and by virtue of Article 14, caput, of the CDC, such providers are responsible for the harm caused to patient-consumers, regardless of fault, ie, their responsibility is objective, accountable to the patients as they offer a defective service. A case of aggravation of illness by hospital infection exemplifies the statement.

Therefore, it is not enough just to set the culpable conduct of the physician to accuse them of

responsibility, it is also necessary that the imprudence, the negligence or medical malpractice cause any harm to the patient. According to Kfouri[6] medical compensable damage can be physical, material or moral. For the author, the physical harm becomes more important, given the medical activity to be exercised, as a rule, on the body. In this case, the body injury consists of elements and variables compensable separately, since the disability may be total or partial, permanent or temporary.

The author considers that material damages are mostly consequences of physical harm, including the loss of earnings (by stop working either temporarily or permanently), medical and hospital expenses, drugs, hiring other health professionals, in short, all costs related to the damage arising from medical conduct. Kfouri[6] concludes this argument claiming that the moral damages arising from medical services are those that arise from compromised aesthetics, pain and deep unease resulting from violations of personality rights. It is worth noting that some authors consider the aesthetic damage regardless of moral damage. Barros[7] defines aesthetic damage as one capable of offering psychosocial suffering, to the socially accepted body shape, so as to cause grief, humiliation and shame.

Notwithstanding the fault and the damage being necessary to characterize the liability of the physician, they are insufficient alone, considering the evident necessity of a link between the medical fault and the harm suffered by the patient, because, that way, the assumptions of this responsibility will be configured. According to Kfouri[6], the causal relationship between the conduct and the damage is still a matter of doctrinal discussion. For some, this relationship should meet the criteria of the theory of equivalence of causal conditions, in which the cause is any condition that has contributed to the result. Others advocate the calculation by the theory of adequate causality, in which the cause is seen as a condition that usually comes to the harmful result. Finally, there are those who opt for the theory of the cause itself, in which the cause is the factor, temporally closest, that determines the outcome.

Amid this divergence, Cavalieri[3] states that the identification of causation must meet the criteria of adequate causation theory. Therefore, through this, it may properly identify the cause as being one which, according to the ordinary course of things and the common experience of life proves to be the most suitable to produce the effect. Thus, for the patient-victim reach success in demonstrating the edical liability, it is necessary so as to reveal the presence of their assumptions, ie the medical voluntary conduct, the unfair harm suffered (which may be either on- or off- balance sheet) and the causal link relationship between the harm and the medical action or omission.

Legal nature of the medical liability

Currently, there is no univocal thinking about the legal nature of medical liability, considering the different ways in consolidating the provision of medical services. Thus, this can be both contractual and extracontractual, ie, the medical service may be due to previously established agreement between the parties - physician and patient - in which the patient freely chooses the medical professional and pay for their services, but may also result from the absence of agreement between the parties, as well observed in life circumstances, such as when the doctor rescues an injured patient in a public road.

This discussion on the nature of the liability of the physician is fundamentally scoped in probation aspect**.** According to Sá and Naves [8], the burden of proof assigned to the parties is diverse, with regard to the contractual and extracontractual liability. In contractual medical liability, as a rule, it is presumed the fault of the debtor in the event of breach of contract; so that, in this case, it suffices to prove the existence of the contract, the breach of the contractual obligation, the damage and the causal link. With regard to the extracontractual medical liability, the author must demonstrate that the harm is the result of negligence, malpractice or imprudence of the physician. Is worth mentioning that, regardless of the legal nature of the medical liability, the professional will be linked to duties, which once breached will give rise to compensation.

According to Miragem[5], these duties are grouped into three categories, and then analyzed: 1) the duties of information and explanation, 2) the duties of technique and expertise and, 3) the duties of care, diligence and prudence.

Duties of information and explanation

They are positivized in the Brazilian legal system, with regard to consumer relations (Articles 31 and 46 of the CDC), resulting in the incidence of the common law principle of good faith, present in articles 113, 187 and 422 of the Civil Code (CC). Thus, the good faith must be introduced into medical duty to inform the patient, accurately and clearly, the risks and benefits of a particular procedure that

they will undergo respecting thereby their autonomy before the treatment proposed. Thus, the patient's right to self-determination implies the duty to inform of the physician.

Duties of technique and expertise

They are, as a rule, the crux of the characterization of medical fault. They require, from the physician, constant updating of knowledge, given the evolution of the medical sciences, in order to employ the technique appropriate to the time of the execution of the treatment and thereby provide (the most possible) error free assistance.

Duties of care, diligence and prudence

Demanding doctor's duty of care is to force them to adopt all possible caution during exercise of their profession. In turn, the duty of care is related to the due attention that the physician should have towards patients. Prudence requires that the physician does not adopt procedures outside the standards of conduct medical technique, and does not suppress unrelated treatment phases of scientific judgments in order to promote themselves.

As can be seen, these duties are implicitly or explicitly inserted in the patient-physician relationship, so as to be irrelevant in this case, identifying its legal status. What is certain is that the damage suffered by the patient, arising from the noncompliance of one of these duties, the physician will have for the obligation to repair it.

The object of the obligation of providing medical services -

There is debate whether the objective of the medical requirement is restricted solely to the obligation of means, or whether it may be characterized as a result. The issue around this.

regarding the burden of evidence. However, to better understand this discussion, it implies the need to individualize the concept of these obligations.

According to Miragem[5], the obligation of result, there is impairment of the debtor with a particular purpose, ie, there is an objective criterion for identifying the due performance or not of the obligation, that is the realization or not of the outcome properly established by the parties. With relevance to the obligation of means, the author states that there is no commitment by the debtor to obtain specific purpose, ie, to achieve a predetermined result.

By these definitions it becomes easier to identify the burden of evidence on each obligation. According to Benacchio[9], in the obligation of means the creditor (the injured patient) must prove the wrongful conduct of the required one – physician –, that is, if the physician lacked attention, diligence and care in the provision of their services. With regard to the obligation of result, the injured patient should prove the existence of the contract and its consequent breach, or failure to obtain the result set. In this case, of the physician there is presumed fault for breach of contract, being responsible for the burden of proving that the damage was caused by force majeure, fortuitous events or exclusive fault of the victim.

Based on this reasoning, Brazilian jurisprudence and doctrine adopted as means the obligation assumed by the doctor, exempting them from the obligation to meet the specific interest of the patient, considering that the core of the medical art is embedded in the performance of professional with the utmost care, diligence and expertise as possible for the sake of healing the patient, which sometimes by factors beyond their control, may not occur. Opposed to this thought univocal, subsists in Brazilian law the determination to consider as an obligation of result, the result of cosmetic plastic surgeries. However, to better understand this positioning is prudent to differentiate cosmetic and reconstructive plastic surgery.

Merely aesthetic, are those made with thepurpose of beautifying: the patient undergoes certain physical intervention in order to change their appearance, making it more enjoyable for themselves. In this case, the physician undertake to the patient, the commitment to achieve the desired result. The reconstructive plastic surgery procedure concerns the correction or restoration of deformities, scars or bodily changes, professional and has no way the professional has no way to ensure the success of the operation or the patient's physical reconstruction. Thus, the dominant line of reasoning in jurisprudence is to consider the duty of care from purely aesthetic surgeries as a result, since the doctor agrees to obtain, by means of the procedure, the patient's specific purpose.

Still in the exceptional character of obligation of means, taken by physicians, it has an obligation of result, which is binding upon the anesthetist, as pointed out by Miragem[5]. For the author, the anesthetist should simultaneously instruct up falling asleep and awakening the patient, as well as pro-

vide assistance in post-anesthetic recovery. Any abnormality that may cause harm to the patient will import in noncompliance with the obligation by the professional, assuming their fault. Thus, the anesthetist will not be able to plead lack of knowledge of the possible reactions that the patient may present for the administration of a drug. It is noteworthy that this fact shall entail joint responsibility for the surgeon, making them also responsible for the obligation to compensate.

Given the above, it remains to strengthen the argument that the medical activity is not exact science. The success of the surgery and proposed treatment will depend not only on the technique, but also on organic reactions of the patient, as well as social, economic, psychological and spiritual factor.

Delimitations of dysthanasia

There is no way to live without, at some point, dying. Life and death are inherent stages of the life cycle. Even before this irrefutable statement, uproar arise, giving rise to numerous questions that go beyond the legal Cartesianism and walk to reach other areas of knowledge such as theology, philosophy, psychology and medicine, allowing the constitution of interdisciplinary dialectics.

The understanding of death passed by deep historical and social transformations. According to Áries[10], death, in the eighteenth century and early nineteenth century, was a public ceremony that occurred usually in the domestic sphere, in which the dying man knew his own protocol and, in most cases, came to preside over it. In this scenario it was important the presence of family, friends and neighbors. The rites of death were simply accepted and fulfilled in a ceremonial liturgy, but without dramatic character, or excessive gestures of emotion.

Even to the author, during the nineteenth century, it is deconstructed this natural view of death, which is seen with growing fear, becoming shameful and an object of prohibition. There is an enormous effort to deny it. The surrounding the terminally ill tend to spare them and hide the seriousness of their state. The truth begins to be problematic. The denial of human finitude is based, primarily, on scientific and technological advances in medicine.

With the advent of antibiotics, infectious diseases, once deadly became perfectly curable, while chronic and degenerative diseases have become the predominant causes of death. Biotechnology has brought sophisticated equipment for the recovery and preservation of vital functions, so that death came to be regarded as an accidental result, as a dissociated part from life.

Thus, the technological advances in the medical field and the foolish human search for immortality shifted the scene of death within the family to the hospital environment, which the dying is usually taken away from their loved ones, confined to reliance on equipment and invasive procedures, surrounded by professionals, for the obstinate cure of the disease, insist on prolonging the arrival of death, even though this is already imminent. Disthanasia is that therapeutic ferocity.

Lexically, the term dysthanasia means "slow death with great suffering". Based on this definition, Pessini[11] classifies dysthanasia as the action, intervention or medical procedure that does not reach the goal of benefiting the terminally ill person, and useless and painfully prolongs the process of dying, looking to distance death. The author stresses that this conduct does not extend life itself, but only the process of dying.

It is inferred from the above concept, that the dysthanasia is intrinsically related to the use of futile treatment to the terminally ill, considering this to be the biggest victim of this inhumane medical practice. But, after all, what is understood by terminal patient? Gutierrez[12] provides answer to this question by stating that the identification of the terminal patient is linked to evidence of having exhausted the possibilities of redemption for the patient's health, so that the possibility of imminent death seems inevitable and predictable. The patient becomes sunrecoverable, and walks to his death, unable to reverse this journey.

Of the delimitations exposed, it can be noticed that the dysthanasia is far from defending the right to life, given to identify the human being to a mere object of medical science. This argument stems from the fact that the current Brazilian Constitution[13] includes the right to life, in light of other higher values such as the dignity of the individual. Living is an asset regarded as fundamentally basic, but does not lead to an understanding that is absolute or preserved at all costs. "Living" under torture, even the torture a futile therapy, is nothing more than nullify the human character of the patient, it is simply objectifying it.

In this line, Dworkin [14] states that people who are denied the dignity may lose self-esteem that it protects, and such refusal, in turn, causes them to dive into an even more terrible suffering: the con-

tempt and aversion, which they come to feel for themselves. Opposed to the loss of dignity of the patient during the process of dying, the current Code of Medical Ethics (CEM) grounded items VI and XXII of Chapter I - Fundamental Principles:

VI - The physician will keep absolute respect for human beings and will always act in their benefit. Will never use their knowledge to cause physical or moral suffering, for the extermination of human beings or to allow and cover up attempt on their dignity and integrity.

XXII - In clinical irreversible and terminal situations, the physician will avoid performing unnecessary diagnostic and therapeutic procedures and allow the patients under their care all appropriate palliative care [15].

These items were undoubtedly a big step for the physician to recognize their fallibility before the human finiteness. Not that this professional becomes silent against the duty of care, but that their role is focused on palliative care that prioritize the basic needs of the patient, including the biological, the psychological and spiritual, in order to make the process of death less painful and more dignified possible. Being terminally ill does not mean being a biological residue in the hospital environment. The patient, even in front of their terminal illness, is above all a human being and therefore entitled to their rights, which is why the inviolability of their dignity must be safeguarded until their last breath.

The medical liability facing the practice of dysthanasia

In this article, in earlier times were discussed two distinct themes. In the first, the analysis of the medical liability from the perspective of the country legislation. In the second, under the medical and bioethical arguments, the concept of dysthanasia, and its consequences for the terminally ill.

According to Gifoni[16], nothing prevents the physician from being civilly held liable for failing the terminal patient autonomy, and the desire of their family, for providing great physical and moral discomfort. The author adds that Article 15 of the CC does not apply here, in defense of the physician, given that the risk of life of terminally ill is not, was not, nor ever will be changed by any medical act, for being a sine qua non of their disease, which will accompany up to the their last day of life. Benacchio[9] says there is no doubt as to it being forbidden to the physician to impose to the patient any treatment that might be overly painful and ineffective, and also the absence of the duty to save the lives of terminally ill, for which there is no known cure. Alongside this information, a hypothetical case study was formulated in order to pedagogically highlight the practice of dysthanasia, as well as to identify the assumptions characterizing the medical liability. Although the design of the hypothetical case does not arise - strictly speaking - the research or observation process brings conjectural elements relating to clinical practice. Thus, the production of this clinical case as a teaching tool encourages reflection on conflicts related, both for students and for professionals.

Clinical case

Mr. X, 64 years old, physician, holder of an advanced gastric carcinoma with lung, liver and kidney metastases, with no indications of chemotherapy and radiation, seeks a hospital feeling severe abdominal pain and mild dyspnea. At the time of admission, being clinically conscious and aware of his terminal illness, expressed to the physician, the desire to remain under palliative care and in the company of his family and not being transferred to the ICU in a possible clinical worsening and/or cardiac arrest. On the second day of hospitalization, Mr. X, in the presence of the treating physician and their family members, has a cardiac arrest. At that moment, the professional, not taking into account the wishes of the patient and his family, performs cardiopulmonary resuscitation and directs the patient to the ICU. Mr. X thus remains tied to several tubes, undergoing various invasive procedures; his body becomes just an extension of the machines. The family, dissatisfied with the contempt of the final will of the patient, pray that God will remove him from that torture. After a week in the ICU, Mr. X dies in a cold and lonely environment, without having the opportunity to say goodbye to those who loved him. His plagued body ended up resting "bundled" on a hospital gurney.

From the analysis of the above case it was evident the practice of dysthanasia, confirmed as the attending physician, even before the terminally ill patient, performed heroic measures culminating in the use of futile therapy. The death of this patient was already regarded as close reality and no treatment would reverse the progression of his disease. Therapeutic futility spoke louder than the patient's autonomy by depriving him from dying in a humane and dignified manner. In the clinical case described,

in which the procedure used can be characterized as dysthanasia it was possible to identify the following assumptions of medical liability: culpable conduct, injury and causal link.

rise to dysthanasia incurred the imprudence and malpractice. Consider this: their behavior was at least reckless, as their action has surrounded themseves with impetuosity, and devoid of caution, since even before the knowledge of the clinical status of the patient and of his will, they acted with paternalism, subjecting him to futile treatment, whose only scope was to prolong his suffering and death. Complementing this argument, we highlight the positioning of Kretzmann[17] about medical paternalism. To express the idea of Clotet the author states that the paternalistic doctor-patient relationship characterized by an imbalance in the care provided cancels the person object even favoring the passage unnoticed of knowledge to power, with unfortunate consequences, because the person comes to be written off as unique individuality.

As if this were not enough imprudence, the physician in question was too inexpert, given having employed unusual and contraindicated means of use in terminal patient care. Such an explanation is based on the medical literature, which emphasizes, unanimously, that the the technical procedure to be adopted by the physician in assisting the terminally ill should be the one facing palliative care, able to provide the patient humanized care and a dignified death.[15]

C ulpable onduct

As evidenced initially the personal liability of the physician's subjective, taking the fault as an intrinsic component of the illicit act. To Cavalieri3, the fault is characterized by the breach of duty of care or diligence. A breach of this duty of care makes the culpable conduct. In addition, it expresses a judgment of disapproval on the agent's conduct, for violating the duty of care when, under the circumstances of the case, should and could even have acted otherwise. It also highlights the noble counselor that the lack of caution, diligence, care and attention are the substrate end of the fault. Implicit in this statement is the characterization of imprudence as a lack of caution or care for commissive conduct, positive by action; negligence as the same lack of care for conduct and malpractice by omission as a result of lack of skill in the performance of technical activity, in which case requires, as a rule, the greater caution or care agent.

In light of these doctrinal underpinnings it can be stated that the physician whose conduct gave

In order to avoid malpractice of that order, the current CEM arranged in the chapter intended for the relationship between doctors and patients and families, the sole paragraph of article 41, which emphasizes that in cases of incurable and terminal disease, the physician must provide all palliative care available without undertaking diagnostic or therapeutic actions useless or obstinate, always taking into account the wishes of the patient or, in their absence, to their legal representative. When talking about dysthanasia and dignity of the patient, Sertã[18] drew on the words of Pessini to express that the doctor's responsibility is not limited to sustain life, but also encompasses the duty to provide palliative care at the time that maintaining life is not considered more reasonable. Keep life in the course of a terminal illness is no longer the main objective, which is why the relief and human care shifts to the unique concerns

Faced with such arguments, imprudence and medical malpractice are ratified in the case of dysthanasia, taking into account the therapeutic obstinacy that drives the terminal patient to inhumane and painful treatment.

Harm

As described, medical damage can be

though differing from those prevailing in society or that are accepted by health professionals.

physical, material or moral. With respect to physical damage, they are linked to the consequences of medical activity on the human body. That statement is not difficult to see that the patient-victim of dysthanasia suffered all possible iatrogenies, because the therapy used did not lead to a cure, but only the body decomposition. As for material damage, these involve medical and hospital expenses, medications, hiring other health professionals, in short, expenses related to the damage arising from medical conduct.

Regarding the damage suffered by the terminal patient, a victim of dysthanasia, it emphasizes the positioning of Celina Maria Bodin de Moraes[19]. She said the injury is damage to any of the component aspects of human dignity, namely, the principle of equality, the psychophysical integrity, freedom and solidarity. The fact of submitting the terminal patient at the same medical procedure for the sick with healing possibilities implies disregarding the condition of inequality in the terminally ill, which

leads to the violation of the principle of equality under the material aspect.

Respect for the patient's clinical condition that refers to the adoption of an undirected assistance for healing, but for palliative care to transform the process of death in this patient more humane and dignified. The futile treatment, arising from the ICU, provided strict violation of the psychophysical integrity of the terminal patient, preventing him from exercising the right to a dignified existence. This fact succeeded in victimizing the terminally ill to invasive medical procedures that detached from a curative intent gave him only an extension of his death and the isolation of those who truly loved him.

With regard to freedom, this was flatly struck, as have curtailed the autonomy of the patient. Autonomy means self-government, self-determination of the person[20] to make decisions that affect their lives, health and physical and mental integrity in social relations, so that the exercise of autonomy implies being free from external and internal constraints to make choices from among the options presented. It follows from this definition of Coast, Oselka and Garrafa [20] that respect for autonomy implies recognizing that they have the right to deliberate and make decisions according to their own plan, based on the beliefs, aspirations and values of their own,

Complementing this position, become relevant the words of Sarlet [21] on the autonomy of the will of Kant. To this, the man is the only being capable of directing their actions from goals rationally designed and freely desired. The dignity of the human being is, therefore, in its autonomy, which is the ability to formulate their own rules of life, ie, their individual freedom or free will. In this context, the current EMC[13] explained in Chapter IV - Human Rights, the following articles:

The physician shall not:

Art. 24. Not ensuring to the patient the exercise of rights to decide freely on their person or their well-being, as well as exercise their authority to limit it.

Art. 28. Disregarding the interest and integrity of the patient in any institution in which they are collected, regardless of their own will.

It is inferred that the terminal patient, clinically conscious and aware of their prognosis, has the right to the freedom of choosing a more humanized death and in the presence of their loved ones. Ignoring that patient autonomy is therefore denying their human condition, violating their personality and therefore lacking with respect for their dignity.

Causal link

It is impossible not to highlight the link between the wrongful conduct of the physician and the damage suffered by the patient-victim of dysthanasia. In this patient, it is known fact that death was certain and predictable, but the damages sustained through of an inhumane death had its origin in the wrongful conduct of the physician, given that it had been respected the autonomy of the patient and, by extension, the desire of his family had received attention, none of this would have happened.

Final thoughts

For a long time the Hippocratic paternalism prevailed in the practice of medicine. Backing up on their knowledge, the physician has invoked their ease in front of patient autonomy, under the pretext of doing him good. Today, the supremacy of the principle of human dignity, which recognizes the individual as an end in itself, preclude the maintenance of the paternalistic paradigm, which ignores the autonomy of the patient.

The doctor who disregards the autonomy of the terminal patient, which submits to the practice of therapy futile, incurs the obligation to repair the damage from such obstinacy that restricts the patient's right to choose a dignified death and human for themselves. Thus, at this moment, it is evident the medical liability before the practice of dysthanasia. However, the assumptions of this procedure and its legal effectiveness to the aggrieved party will be subject of a subsequent argument.

The assumptions that determine the liability of the physician, all were present in the simple example, selected under the guise of illustration. The imprudence and incompetence typified the culpable conduct of the physician as having acted brash and lacking skills in accorded treatment appropriate to the terminal patient, by submitting them to futile therapy, in disagreement with the technique used in those who have no healing prognosis.

The harm was consolidated in violation of the principle of equality, given the terminal patient having driven to the same therapy aimed at those who have the possibility of healing, ignoring their condition of inequality, which required a different treatment, ie, treatment focused on palliative care.

The harm also emerged in violation of the psychophysical integrity of the patient as well as the curtailment of individual freedom, reflecting thus directly on their autonomy and consequently the loss of dignity, considering it was not considered an end in itself, but only as a means to satisfy the paternalistic will of the physician. The causal link was present, since the damages sustained through of futile therapy and inhumane unfortunate death of the patient were due to the wrongful conduct of the professional.

Given these findings, it is clear that the liability of the physician in the practice of dysthanasia, is not mere fallacy. It is, rather, the concrete fact that can lead to the entry in the professional's duty to repair the damage suffered by the patients and their families, who in time of pain and grief have their dignity tarnished.

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Received: 13.11.2012
Revised: 27. 5.2013
Approved: 24. 6.2013

Research article