The elderly autonomy and dysthanasia

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Resumo

A pesquisa teve o objetivo de conhecer a opinião dos idosos sobre o exercício da autonomia, a utilização de medidas obstinadas e a escolha do local de morte para idosos na presença de doença grave e terminal. Foram entrevistados 112 (77%) participantes de programa da Universidade Federal do Amazonas orientado para o envelhecimento. O resultado mostrou que 67% foram desfavoráveis a que a vida do paciente fosse mantida "de qualquer jeito", ou seja, seria necessário que as condutas a serem tomadas nessas ocasiões fossem avaliadas levando em consideração a dignidade da pessoa humana em evitar o prolongamento do sofrimento de morrer. A lucidez foi o indicador de qualidade de vida mais apreciado (79%), seguido pela autonomia em poder respirar sem o uso de aparelhos (17%) e alimentar-se sem o uso de sonda (4%). A casa do paciente (63%) foi considerada o local de morte mais apropriado.

Palavras-chave: Bioética. Autonomia pessoal. Saúde do idoso.

Resumen

Autonomía del anciano y la distanasia

La investigación tuvo como objetivo conocer la opinión de los ancianos sobre su autonomía , la utilización de medidas perseverantes y la selección del lugar de muerte para los ancianos ante la presencia de una enfermedad grave y terminal. Se entrevistó a 112 (77%) participantes de un programa orientado para el envejecimiento en la Universidad Federal del Amazonas. El resultado mostró que un 67% no fueron favorables a que mantuveira la vida "de todos modos" o sea, es necesario que las conductas a ser tomadas en estos momentos sean evaluadas llevándose en consideración la dignidad de la persona humana en evitar la prolongación del sufrimiento al morir. La lucidez (79%) fue el indicador de la calidad de vida más apreciado, seguido por la autonomía del poder respirar sin el uso de aparatos (17%) y alimentarse sin el uso de sonda (4%). La casa del paciente (63%) fue considerada el local de muerte más apropiado.

Palabras-clave: Bioética. Autonomía Personal. Salud del anciano.

Abstract

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The purpose of the survey was to know the opinion of the elderly about the exercise of autonomy, the use of obstinate measures and the choosing process of the place of death for the elderly with terminal illness. The interview had 112 (77%) participants of the program for aging at the Federal University of Amazonas. The result showed that 67% did not agree that the life of patient should be maintained at any circumstance, meaning that measures are needed to be taken into account to consider the dignity of the person avoiding the extension of death suffering. The presence of awareness (79%) was the most appreciated indicator of life quality, followed by autonomy of being able to breathe without any apparatus (17%) and eating without a tube (4%). Patient's house (63%) was considered the most appropriate place to die.

Key words: Bioethics. Personal autonomy. Elderly health.

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This research discusses the exercise of autonomy of elderly people in relation to dysthanasia, in other words, medical conducts with the use of technology that in the rush to save lives may prolong the suffering of death when applied to cases in which the studies show that will not really benefit patients in the long term, but only bring more hours or days of life. The truth is that the conducts that promote dysthanasia have been created to save lives in cases when the patient, at determined time, presents dysfunction and needs to use machines to perform basic physiological functions such as breathing. It is hoped, however, that the evolution of the situation over the time promotes their recovery, bringing back the full use of their vital functions or the closest to normal. Thus, the application of these maneuvers as cardiopulmonary resuscitation, the use of respirators and enthrall nutrition in elderly with severe and terminal conditions must be analyzed, considering the extent to which presents benefit to the patient or just to prolong their suffering.

Based on interviews, the study surveyed the opinions of elderly people relative to dysthanasia and the more suitable place for the death to the dying elderly patients, and also which aspects of life quality they have interests in maintaining.

The autonomy bioethical principle

The word autonomy comes from two Greek terms – *auto* (self) and *nomos* (law, rule, norm) – that, together, mean self-determination to take decisions that affect their life, health, physical and psycho integrity, as well as their social relations. The autonomy principle, therefore, refers to the human capacity to choose on what is *good* and what is their *well being*. The person is autonomous when their thoughts are free, from internal or external constraints to choose between the proposals presented.

For this, it is also necessary that alternatives of action exist or that their creation is possible. There is no real exercise of autonomy when there is just one way[1]. When there is no freedom of thought or of choices, when you have only one option, or when there is no freedom to act according to the alternative desired, the action taken may not be judged as autonomous[2]. Autonomy expresses the principle of moral freedom, in which every human being is an autonomous and as such, must be respected by everybody who have different moral options. No moral can be imposed upon the humans against the dictates of his conscience[3].

The complete autonomy is an ideal. In practice, the human being is always constrained by the rules of society, the religious influences and other behavioral conditionals. Man is not born autonomous, becomes autonomous with the contribution of biological, psychological and socio-cultural structural variables. However, the autonomous person can act as non autonomous in certain situations. In the case of the elderly in medical treatment, although he may have enough lucidity to exercise his autonomy, he may not do so for various reasons such as: it depends on who takes him to the doctor, technological resources of the city where he lives, the purchasing power to buy special food or medicine, among others.In addition, physical changes, emotional and mental disorders may compromise the enjoyment and rationality of decisions to be taken. When the autonomy situation is reduced, it lies to third parties, family members or health professionals to decide for the non autonomous person[1].

The concept of autonomy is closely linked to the competency. The competence-incompetence judgment of a person should be considered in each particular decision and not extend to all the decisions of their life. It is not common to question the competence of the patient's decision when the decision is in accordance with the doctor´s. However, all patients must be judged competent until there is proof of his incompetence, a situation in which his autonomy is reduced [4]. In the legal ambit, it is assumed that an adult is competent until the Judiciary considers him incompetent and restricts his civil rights; however, for ethics, there is no incompetent person in all areas of his life[5].

Socioeconomically vulnerable groups, because of their lack of resources, have fewer alternatives to choose in their lives, what contributes to not fully develop the autonomy potential. Still, they should be seen and respected as autonomous people. In the treatment, doctors shall not decide for them under the allegation that they do not have the capacity or resources to decide [1]. Finally, autonomy does not mean following the individualism, since man lives in society and ethic is the form to regulate the relations between people, harmonizing individual and collective interests.

Dysthanasia or the use of obstinate measures

Dysthanasia is a neologism that combines the Greek prefix *dys*, that means *defective act*, and the complement *thanatos*, understood as death. Thus, the literal translation "defective death", would be referring to difficult or painful death due to exces-

sive and disproportionate prolongation of the act of dying by a treatment that prolongs the biological life of the patient. This attitude, which comes from the medical effort to save lives, results in the end, in a slow and often painful death, result of the obstinate prolonging of the patient's life when there is no hope of cure and any treatment has become futile, without benefits.

The cure of the disease and the relief of suffering, are accepted as the goals of medicine. The disease destroys the integrity of the body, and the pain and suffering destroys the overall integrity of the person. However, as much as it tries, medicine may not avoid death indefinitely. When medical therapy can no longer achieve the goal of healing, to insist on treatment only for keeping the person alive is futile. This dilemma indicates the need to stop what is being useless and intensify the efforts to reduce the discomfort of dying[6].

Historically, Hippocrates concebied three objectives for medicine: to relieve the suffering of the patient, to decrease the aggressiveness of the disease and to refuse to do the treatment in which medicine recognizes that it can no longer contribute. In the antiquity, if a doctor tried to prolong the life of a person, he would be considered *unethical* – this thought remained until the Middle Ages[7]. The Hippocratic writings inform that the physician should know the limits of his art and to avoid *arrogance*. At the end of the sixteenth century, Francis Bacon, *the father of modern science*, has considered three purposes for medicine: preservation of the health, cure of diseases and life prolonging. He insisted that it was necessary to find ways to make death less unpleasant[8].

The most common causes for dysthanasia are: the conviction that the biological life is a good, for which the maximum effort must be invested to extend it, regardless of the life quality presented; the lack of knowledge on this subject by the patients and family members, who could use their rights in order to avoid prolonging the agony of the dying patient; the physician's anxiety with the failure of the treatment and the difficulty of death acceptance.

The patients with more risks to be exposed to dysthanasia are the ones in the intensive care units (ICU), the born children with low birth weight (<650g) and lifetime under 26 weeks, chronic patients with a history of aggravation and remission, and terminal patients[9].

In situations when death is imminent and inevitable, treatments that would only extend life precariously and piously may be renounced (therapeutic obstinacy or medical futility), without, however, interrupting the normal care due to the sick in similar cases[10]. This was the case of Pope John Paul II, who in a state of advanced disease and after two hospitalizations in the Gemelli Clinic, has asked to remain in his quarters in the Apostolic Palace, in Rome, in order to conclude his mission[11]. This is a case of "orthotanasia," in other words, death at the right time, without abbreviation or unreasonable prolongation of the dying process[6].

Technological advances and success in the treatment of many diseases caused medicine to become increasingly directed towards healing. This way, the technical question is now to eliminate the death. Thus, the technical issue became to prolong vital signs; the quality of this life, a concept of difficult mediation to science and technology, was put as second plan[12]. Although it is the duty of the physician to cure while possible, in the case of a terminal patient he can reduce suffering by suspending the treatment with curative intent, since this objective is no longer achievable, and by providing the necessary medications to reduce the discomforts caused by the disease, with the consent of the patient or family [13].

In circumstances when death is inexorable, the most sensible way is to suspend the artificial means, expendable and superfluous. So, death can occur in its time. This way, if the individual is alive, he should be treated. If he is dead, there is no reason to keep him connected to devices. There is neither half life, nor half death[14].

In Europe, the dysthanasia is known as obstinate therapy and in the United States of America (USA), as *medical futility*. The term used in Europe was introduced by Jean Robert Debray, is understood as the behavior in which the therapeutic process brings more harmful effects than the disease effects to cure, because the cure is impossible and the expected benefit, smaller than the disadvantages. The cure of disease and the relief of suffering are acceptable as objectives of medicine. The disease destroys the integrity of the body, and the pain and the suffering, the overall integrity of the person[14].

The concept of futile treatment or therapeutic obstinacy should meet three criteria: effectiveness, benefit and burden. It is a guide of prudence that must involve physicians, patients and their representatives, because decisions will be taken in terms of therapeutic investments at the end of life. The first criterion, effectiveness, focuses on physicians, in measurable data of prognostic and therapeutic. It seeks to verify the capacity of the treatment to change the natural history of the disease, and make

a difference, in relation to the morbidity and the mortality known. The second criterion is the benefit, or, what contribution it brings to the patient under the optic of the patient himself or his representative. The third criterion is the burden, or, the emotional, economic and social costs to the physician and the patient. Every determination of futile treatment must be analyzed in the context of values and commitments of the person's dignity[15]. It does not mean abandonment of care, but a direction for the overall care in which the patient is comforted in his human aspect [16].

It is inconvenient to present the patient or his representative a treatment that does not change his continued vegetative state, does not change the deficiencies that are incompatible with survival, that leave permanently compromised capacities neurocardiopulmonary and for social life, and that does not help the patient to get rid of the devices used in intensive care. Thus, when patients are not benefited, in the sense of medical treatment, the doctor can use the principles of beneficence and non-malfeasance to avoid them. This assessment should not be influenced by the socioeconomic status of the patient[17]. According to the Code of Medical Ethics (CEM)[18], the doctor will accept the choices of their patients about the diagnostics and therapeutics conducts expressed by them, since they are fitted to the case and recognized by science.

Method

It was conducted a descriptive study, with cross-sectional cut. The research was conducted with the elderly inscribed in the program Happy Elderly Always Participates – University of the Third Adult Age, of Faculty of Physical Education and Physiotherapy, Federal University of Amazonas (Ufam), in Manaus. The data collection took place in November and December 2010. Of the 145 elderly registered for the annual activities, 112 (77%) participated of the survey.

Oriented to aging, this program of physical activities exists for 20 years and integrates the university extension programs. It takes place from Monday to Thursday afternoons, in our own facilities, campus *Ufam*. Among many physical activities that elderly perform, it can be cited: water aerobics, swimming, dancing, choreography and walk.

The questionnaire was tested by previous application of 10 elderly for adjustments. The data collection was done using standardized questionnaire (Appendix 1). The elderlies who participated of the pre-test were interviewed again in order to compose the sample.

Results and discussion

Sample characterization

There were interviewed 112 elderlies, 96 (85.7%) women and 16 (14.3%) men. As to age, 72 were 60-69 years old (64.3%); 32, 70-79 years old (28.6%) and eight aged 80 or over (7.1%). The percentage by gender confirms national data that indicated the feminization of aging in Brazil.

The higher proportion of women than men may be explained by the longer life average of women, lower mortality from external causes and less exposure to adverse conditions throughout the life cycle[19]. If it is considered the expectancy at birth, it is observed that women live on average five to seven years longer than men. Risk factors, such as work and traffic accidents, domestic accidents, homicides and suicides are more frequent in men. Furthermore, the difference in attitude towards the disease is demonstrated by the fact that women participate more of the health service, what enables them to receive diagnosis and earlier treatment [20].

Regarding to education, the distribution has showed that below 10 years of study there were 60 elderlies (44.6%) and with 10 or more years, 62 (55.3%). The highest percentage of education found was from 10 to 12 years of study, with 37 cases (33%), referent to the elderly who exceeded the Fundamental education without completing high school (Table 1). There were identified two cases of literacy (1.8%), confirming that this situation is increasingly less frequent. Although, generally, people in this age group have not had easy access to school in their childhood or youth, many of the illiterate overcame from that condition through popular education projects for youth and adults.

According to the Demographic Census of the Brazilian Institute of Geography and Statistics (IBGE) [21] the elderly population (above 65 years old) has shown good indicators on the evolution of literacy. In 1960, the percentage of literate males was 51.4% of women, 34.7%. In 2000, these percentages passed respectively to 64.9% and 59.7%. The increase in the literacy rate among the elderly population is beneficial because it allows the individual to be more active and participative. It is possible that this also works as a protective factor against the cognitive dysfunctions that affect the elderly[19].

Regarding marital status, respondents 11 were single (9.8%), 46 married (41%), 16 divorced (14.3%) and 39 widowers (34.5%). Joining unmarried, divorced and widowed is possible to infer that the majority of respondents (59%) live without partner. Live for a long time without company is a factor that contributes to the isolation[22]. The probability of been a widower, increases with age. So, loneliness is more common among women, who represent 72% of the cases of elderly people living alone[23].

Table 1. Distribution according to education

Years of studv	N	%
0 years (illiterate)	2	1,8
1 - 3 years	22	19,6
4 - 6 years	17	15,2
7 - 9 years	9	8,0
10 - 12 years	37	33,0
> 13 years	25	22,3
Total	**112**	**100%**

Use of obstinate measures

When asked about the use of obstinate measures for the stubborn maintenance of life "*anyway*" in the case of the elderly terminal patient, the result showed that 33% are favorable and 67% are not favorable (Table 2). In the interview, the elderly favorable "*to do everything to keep life anyway*" cited some important phrases to be recorded: "*While there is life there is hope*", "*Only God can take someone's life*" and "*The devices [*technological resources*] exist to be used*."

The dysthanasia, also known as obstinate therapy, damages the patient's right to die in peace and with dignity[24]. The patient in terminal stage can be considered a patient who presents a clinical state in expectation of death in short term.

In accordance with Article 51 of the CEM, *in cases of incurable and terminal disease, the doctor should not practice diagnostic and / or therapeutic actions useless or obstinate, should create opportunities all palliative care that the case indicate, always considering the wishes of the patient or his representative* [18].

The patient has the right to decide about the techniques or procedures that eventually it will be applied. This idea leads to the principle of autonomy, very accepted in the United States. The patient has the right to decide about all the possibilities of treatment and should be informed of the consequences of non-adherence to any treatment. In Europe, with a different culture, patients are not fully informed about their health status, especially in cases of severe disease leading to death in the short term. The clinical practice is still paternalistic and hinders the autonomy of the patient [26].

Table 2. Use of obstinate measures in the presence of severe and terminal disease

Use	Nº	%
Yes	37	33
No	75	67
Total	**112**	**100%**

The 75 elderly not favorable "to do everything to keep life anyway" (67%) responded that they would need some "indicator of life quality" to insist on it such as lucid (79%), breathing without the use of devices (17%) and to eat without the aid of the probe (4%) (Table 3). The term "indicator of life quality" was understood by them and proposed by the researcher, as something that showed clearly that the years of life to gain with the use of the obstinate measures in elderly with severe and terminal allows the patient some performance or participation autonomously.

According to the CEM[18], in clinically irreversible and terminal situations, the doctor should not perform unnecessary procedures, diagnoses or treatments, but provide all palliative care indicated to the case, as predicted in article XXI in Chapter I.

Table 3. Indicator os life quality cited by elderly favorable to obstinate measures

Indicator	N	%
Lucidity	59	78,7
Breathing without the use os devices	13	17,3
Eat without the aid of the probe	3	4
Other	0	0
Total	**75**	**100%**

Part of the interviewees stated clearly the fear of "not recognizing the children", "need to eat thought the hands of others", "bed rest" and "live like a vegetable". Many reported their experience with friends or family in a vegetative state and recognized the suffering that the situation imposed everyone: patient and family. About the place of death for serious and terminal elderly patients, 63.4% considered the home as the best place. Other 36.6% found that the ICU would be the appropriate environment (Table 4).

Table 4. Place of death for serious and terminal elderly patiens

Local	N	%
UTI	41	36,6
Hom	71	63,4
Total	**112**	**100%**

Humans can not live without the help of others in all vital circumstances and, mainly in key moments like death[27]. The awareness of this fact, made in a time, that the passage from life to death was a part of life. The society and community sheltered helplessness, especially because the convivial with death was almost every day.

If the needs of the patients did not change over time, there is the inability to satisfy the emotional issues of patients facing death. When death at home was accompanied by the satisfaction of the desires of the patient, thought the spiritual company and the presence of the family, today remains the technical care with the body and the loneliness of the professional environment[24]. Death changed from the house to the hospital, being absent from the familiar world of everyday life. Because he does not see it, modern man believes he can forget about it [28].

When analyzed the relation between the use of obstinate measures and the choice of the place of death, it was found that there was an association, among the 75 seniors who decided on the "no use of obstinate measures", most (72%) found that the right place of death was home. From the 37 interviewees "favorable to the use of obstinate measures", 54% considered the ICU as the most convenient place of death (Table 5).

Table 5. Estudy of the association between the use of obstinate measures and the place os death

	Local de morte		
Use of obstinate measures	**UCI**	**Home**	**Total**
No	21 (28%)	54 (72%)	75
Yes	20 (54%)	17 (46%)	37
Total	**41 (36,6%)**	**71 (63,4%)**	**112**

Association test , chi-square p value=0,007.

In the interview, some elderly commented that "to die at home among theirs" would be "something natural." They would receive the affection of family, ask and give forgiveness to people, bless the children, say goodbye to friends, decide about the patrimonies, prepare according to the rituals of their religion. Others mentioned that by taking the patient home, they can use home measures to help them, as the use of tea, broth, compresses, and baths, among others. Therefore, it is essential to highlight the importance of respect for the individual patient. Even (or especially) at the end of life anyone can be enforced on behalf of paternalistic beneficence of nature, something they do not want. Their self determination and autonomy must be respected. The person has the right to choose to die with life quality in the environment they consider the best[29].

Respondents who considered the ICU the most suitable place to die alleged that there are human, technological and materials resources in it, that can meet the needs of patients, such as physicians, nurses, respiratory pain, medicines etc. They consider that at home there is no money to buy medicine or way to transport the patient at the time that his state is worse, there is nobody who knows how to accompany and assist them, besides the fact that family members need to work or there is no one to take care of the sick.

When studied the association between years of schooling and place of death, there was no association. Both, the least educated (less than 10 years of study) as the most educated (more than 10 years of study) considered home as the most suitable location. The percentages were 70% and 58%, respectively (Table 6).

Table 6. Estudy of the association between education and place os death for terminally ill patiens

	Place of death		
Years of schooling	**Home**	**UCI**	**Total**
< 10 years	35 (70%)	15 (30%)	50
> 10 years	36 (58%)	26 (42%)	62
Total	**71 (63,4%)**	**41 (36,6%)**	**112**

Association test, chi-square p value=0,192.

The association between gender and place of death also showed there is no association, both women (64.6%) and males (56.2) consider that the best place is the home (Table 7).

Table 7. Association between gender and place os death for terminally ill patients

	Place of death		
Gender	**Home**	**UCI**	**Total**
Female	62 (64,6%)	34 (35,4%)	96
Male	9 (56,2%)	7 (43,8%)	16
Total	**71 (63,4%)**	**41 (36,6%)**	**112**

Association test, chi-square p value=0,522.

Likewise, when studied the association between gender and the use of obstinate measures, no association was found, women (67.7%) and men (62.5%) are not in favor of using measures to keep life "anyway" for the elderly in serious condition with terminal illness (Table 8).

Table 8. Estudy of the association beween gender and the of obstinate measures

	Use of obstinate measures		
Gender	**Yes**	**No**	**Total**
Female	31 (32,3%)	65 (67,7%)	96
Male	6 (37,5%)	10 (62,5%)	16
Total	**37 (33%)**	**75 (67%)**	**112**

Association test, chi-square p value = 0,682.

Final considerations

This research showed that 67% of elderly respondents said they were not favorable to the life of the elderly patient in the presence of terminal illness be maintained "by any means", in other words, find it is necessary that the conducts to taken in these occasions be evaluated taking into account the dignity of the human person on help to avoid the prolonging of the suffering of dying. More than technical solutions are necessary attitudes that can contribute to life quality for the time remaining. In parallel, 33% considered that life should be preserved at any cost and under any condition. Some have argued that life was "given by God and only He can take it."

These findings contribute to the guidance that is important to realize the aspirations of the elderly in the type of document "anticipated policy". With the will of the elderly patient expressly documented it is easier for the family and the doctor to take decisions without disrespecting their autonomy.

Lucidity was the indicator of life quality most enjoyed, indicated by 79% of the elderly as what should be considered to insist with obstinate measures. The fact that the patient can breathe without the use of breathing apparatus (17%) and feed in a natural way without the use of the probe (4%), were the other indicators mentioned by seniors as important to be favorably taken into consideration by physicians when investing in obstinate measures.

In the case of elderly patients, in the presence of serious and terminal illness, respondents answered that the best place of death would be their own home (63%). In association studies, it was found association between the choice of place of death and the use of obstinate measures, most people who considered correct to insist on the use of obstinate measures for elderly with the serious and terminal disease, preferred they died in the ICU. Meanwhile, respondents who considered better the death of the patient at home were those who were not favorable to insist with obstinate measures.

In interview with elderly it was possible to talk about why to choose to die at home or in the ICU. Summarizing the answers, the ones who found it is better to die in the ICU claimed that there, they would be continued attended by specialists and apparatus, the family would have less work and suffering to follow. The focus was to prioritize the requirements of the disease.

The elderly who considered most suitable to die at home emphasized the care (teas, massages, special food etc and the care and attention of the family (ask and give forgiveness, bless children and grandchildren, perform religious practices, decide on goods, among others) would be determinant for the solace of that hour. They would feel death in a natural form, not so lonely as in the ICU, but surrounded by family.

Some were very explicit about wanting to "die at home", but left the option in the ICU checked.

They claimed that at home there was no structure (required drugs, appropriate devices and people available).

Therefore, it should be clear that the measures that may lead to dysthanasia, such as cardiopulmonary resuscitation, use of re-breathed and enthrall nutrition, among others, are of large value for the Emergency Medicine to save lives. However, if misapplied, or used in cases where studies show there is no to bring benefit the patient in the long term, this will only extend the agony of death.

The findings of this research serve to prove that the orientations proposed by the new Medical Ethics Code from 2009 will meet the expectations of the society when they propose the complete attend to patients, respecting the dignity of human and rational use of technology. In the case of terminal patients, advising against unnecessary procedures and with dubious efficacy, to recommend palliative care that propose falling the person that suffers, not the disease in an advanced stage.

In conclusion, it is necessary that the evolution of the studies and that Brazilian law promotes the use of appropriate medical procedures at the right

moment of treatment, avoiding the maintenance of false hope to the dying patient and their family members, overspending, when life can no more be rescued, suffering where death has been announced and lawsuits against doctors who favor human dignity and make rational use of technology.

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References

1. Muñoz DR, Forte PAC. O princípio da autonomia e o consentimento livre e esclarecido. In: Costa SIF, Oselka G, Garrafa V, coordenadores. Iniciação à bioética. Brasília: Conselho Federal de Medicina; 1998.
2. Pessini L, Barchifontaine CP. Problemas atuais de bioética. 4ª ed. São Paulo: Loyola; 1997.
3. Gracia D. La bioetica medica. In: Bioetica temas y perspectivas. Washington: Opas; 1990. p. 3-7.
4. Culver CM. Competência do paciente. In: Segre M, Cohen C, coordenadores. Bioethics. São Paulo: Edusp; 1995.
5. Harris J. The value of life: an introduction to medical ethics. London: Routledge and Kegan Paul; 1985. p. 197-8.
6. Cinà G, Locci E, Rocchetta C. Dicionário interdisciplinar da pastoral da saúde. São Paulo: Paulus; 1999.
7. Amundsen DW. The physician's obligation to prolong life: a medical duty without classical roots. Hastings Cent Rep. 1978;8(4):23-30.
8. Jecker NS. Medical futility: the duty not to treat. Medical futility: demands, duties and dilemmas. Camb Q Healthc Ethics. 1993; 2:151-9.
9. Leone S, Privitera S, Cunha JT. Dicionário de bioética. São Paulo: Editora Santuário Aparecida; 2001. Distanásia.
10. João Paulo II. Evangelium Vitae: carta encíclica sobre o valor e a inviolabilidade da vida humana. São Paulo: Paulinas; 1984.
11. Pessini L. Bioética: um grito pela dignidade de viver. 3ª ed. rev. São Paulo: Paulinas; 2008.
12. Martin L. Eutanásia e distanásia. In: Costa SIF, Oselka G, Garrafa V, coordenadores. Op. cit. p. 171-92.
13. Associação Médica Mundial. Declaração de Veneza sobre o paciente terminal. Aprovada na 35ª Assembleia Geral AMM; out. 1983; Veneza. In: França GV. Medicina Legal. 8ª ed.reimp. Rio de Janeiro: Guanabara Koogan; 2008. p. 522.
14. França GV. Medicina legal. 8ª ed.reimp. Rio de Janeiro: Guanabara Koogan; 2008.
15. Conferência Nacional dos Bispos do Brasil. Questões de bioética. Brasília: Edições CNBB; 2010.
16. Pellegrino E. Decision at the end of life: the use and abuse of the concept of futility. In: Corrêa JDV, Sgreccia E, editores. The dignity of the dying person: proceedings of the Fifth Assembly the Pontifical Academy for Life; 24-27 feb. 1999; Vatican City. Vaticano: Libreria Editrice Vaticana; 2000. p 219-41.
17. Drane J. El cuidado del enfermo terminal: ética clínica y recomendaciones practicas para instituciones de salud y servicios de cuidados domiciliarios. Washington: Opas; 1999.
18. Conselho Federal de Medicina. Código de Ética Médica: resolução CFM nº 1.931, de 17 de setembro de 2009 (versão de bolso). Brasília: Conselho Federal de Medicina; 2010.
19. Telarolli Jr R, Machado JCMS, Carvalho F. Perfil demográfico e condições sanitárias dos idosos em área urbana do sudeste do Brasil. Rev Saúde Pública. 1996;30(5):485-98.
20. Papaléo Netto M, Yuaso D, Kitadai F. Longevidade: desafio no terceiro milênio. In: Pessini L, Barchifontaine CP, organizadores. Bioética e longevidade humana. São Paulo: Loyola; 2006. p. 259-88.
21. Instituto Brasileiro de Geografia e Estatística. Censo Demográfico 2000. [Internet]. [acesso 12 jul. 2011]. Disponível: http://www.ibge.gov.br/home/estatistica/populacao/default_censo_2000.shtm
22. Veras RP. Atenção preventiva ao idoso: uma abordagem de saúde coletiva. In: Papaléo Netto M, editor. Gerontologia. São Paulo: Atheneu; 1996.
23. Berquó ES, Cavenaghi SM. Oportunidades e fatalidades: um estudo demográfico das pessoas que moram sozinhas. Anais do 6º Encontro Nacional de Estudos Populacionais; out. 1988; Olinda. Olinda, PE: Associação Brasileira de Estudos Populacionais; 1988. v. 1, p. 155-81.
24. Kluber Ross E. Sobre a morte e o morrer. São Paulo: Martins Fontes; 1996.
25. Jonsen A. A short history of medical ethics. New York: Oxford University Press; 2000.
26. Serrão D. Ética das atitudes médicas em relação com o processo de morrer. In: Serrão D, Nunes R, organizadores. Ética em cuidados de saúde. Porto: Porto Editora; 1988.
27. Cassorla RMS, coordenador. Da morte: estudos brasileiros. Campinas: Papirus; 1992.
28. Ariés P. Sobre a história da morte no ocidente desde a idade média. 2ª ed. Lisboa: Teorema; 1989.
29. Pessini L. Distanásia: até quando prolongar a vida? São Paulo: Loyola; 2001.

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Appendix 1

Questionary for data collection

1. Identification data:

Name: _____

Address: _____

Telephone: _____

Gender: 1. M____ 2. F____

Age:____1. 60-64 years____2. 65-69 years____3. 70-74____4. 75-79 years____5. 80 years and over____

Schooling years:
1. Illiterate____2. 1-3 years____3. 4-6 years____4. 7-9 years____5. 10-12 years____6. 13 years and over____

Marital status:____1. Single____2. Married____3. Widower____4. Divorced____

2. Use of obstinate meajures

In case of sever and/or terminal disease, you wish:

2.1. That everything to keep you alive is done (cardiopulmonary resuscitation, use of re-breathed and enthrall nutrition) _____

2.2. That everything to keep you alive would not be done, only if there is some life quality such as:

2.2.1. Breathe without the use of devices _____

2.2.2. Eat without the aid of the probe _____

2.2.3. Lucidity _____

2.2.4. Others (specify): _____
_____
_____
_____

3. Place of death for terminal patients

In case the elderly has a terminal disease such as cancer and with imminent death (patient with no more chances to live), you consider it is better to:

3.1. Keep the elderly in the intensive care unit until the end _____

3.2. Take the elderly to die at home _____