

Editorial

Mysthanasia x Quality of life

We watch over our dead, bury their bodies, and keep memories of their lives and our coexistence. We have inherited the fight against death from our ancestors, hunters and farmers of the Neolithic, who made the struggle for survival the means of preserving the species. Today, the battle is against non-aging and death, governed by vanity and the attachment to life, including the good things it can provide; or against the simple fear of the unknown, the uncertainties of *when* and *how* death will happen.

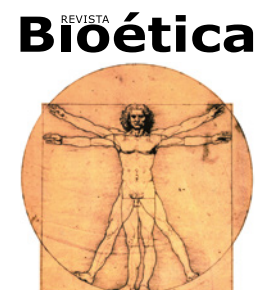
Billions are spent every year on research in the field of genetics with the objective to clone extinct creatures, make humans less subject to stress, and more resistant to disease that can wear down the body. The technology is also used to not let the body age and to combine the use of modified animals with our life projects, whether in peace or in war. The obstinate and boundless struggle against death affects all society and collective representations about the meaning of life and the value of the body, but it reaches the daily lives of those who care for terminal patients.

Doubts cause disturbance in the minds of health care professionals, who try every way possible to keep patients alive. Is it their absolute duty to keep them alive? Does death result from the failure of medical procedures and knowledge? Is there the possibility of ethical, civil and criminal liability for death? These are common questions, frequently presented by the research articles published in the *Revista Bioética* (Bioethics Journal), which can cause health care professionals to feel anguish and mentally distressed. Such feelings mainly reach those who work by deathbeds with irreversible scenarios.

Therefore, it is important to understand and accept death, as well as the dimension of our primordial nature, whose knowledge reifies the existence of human dignity in the face of the limits of medicine, science, the self, and those who are being cared for. Society must accept the finiteness of life as an ineluctable fact, without the *blasé* look of those who believe that death will affect only the *other*, and without the atavistic panic of those who try to ignore death in order to push it away.

Both ways of reacting to death characterize the taboo that has arisen around the issue. Just as the subject is banned in our society, learning to deal with the end of life is not dealt with in most medical schools. We have learned from childhood about medicalization: for every pain, deception, or fear there will be some water and a few miraculous drops, which creates unrealistic expectations. We have heard dozens of times: “There is a remedy for everything, except death.” But there is no solution to everything and we do not accept that there is no remedy for death.

Even though we have learned during our training that “prevention is better than cure”, we still have a hard time helping patients to accept therapy aimed towards health promotion and protection. This resistance implies the “immediate” conclusion of the diagnosis and treatment for the disease in order to restore health. Based on that, we sometimes forget that “caring is more than just healing”.



We prefer not to discuss death; so, how can we ever talk to patients and their families about it?

Technical and ethical limits are exceeded, and patients who experience extreme agony, or those who have no chance for a cure, are kept in intensive care units (ICUs). By prolonging pain and suffering, and extending them to family and friends, health care professionals exercise the ignoble power to extend the meaningless death process. Defining life as supreme, absolute, being above anything else, like freedom and dignity, means to create a myth, placing other assets such as health and family aside.

Attractive technological paraphernalia is available, from which we can really benefit, but they can also cause more harm than good. Different processes, but intended for similar purposes, were used in the past, such as the construction and ornamentation of the pyramids that housed the bodies of sovereigns (identified with the gods), their belongings, and even servants and pets, hoping that they could return to use them in another life. Temples were filled with icons that kept “staring” at those being honored, reinforcing the memory of their presence in the world of the living. It was a ritual meant to ensure that death had come and the life within the body was gone, which only represented a brief passage through the path towards eternity.

Today, technological paraphernalia and doubts about death have caused and legitimized abuse and the omnipotence of some professionals — the therapeutic obstinacy of prolonging life at any cost and overcoming death. According to Pessini, *the acceptance and understanding of death should be an integral part of medicine’s main objective: the pursuit of health*¹. Potter adds: *a dilemma that must be faced by medical ethics today is when not to apply the technology available*².

The terminality of life is not reversible; there is no possibility of “cure” with the knowledge currently available. Death will occur inexorably within a short period of time. The American College of Physicians Ethics Manual lists five aspects that classify a terminally ill patient: *irreversible condition, treated or not; high probability of dying within a short period of time, between three and six months; therapeutic failure of existing medical resources, or that have been already used. The patient will evolve inexorably and eventually dying; currently, there is no scientifically proven medical device capable of preventing such evolution*³.

In 2006, the Conselho Federal de Medicina (Federal Council of Medicine) published the CFM Resolution 1.805/2006: *During the terminal stage of serious and incurable diseases, physicians are allowed to limit or suspend procedures and treatments that prolong the life of patients, ensuring the necessary care to alleviate the symptoms that lead to suffering, taking into consideration integral care*⁴. *This resolution is the first ethical dilemma for physicians prior to the end of life*, as José Henrique Rodrigues Torre states⁵. The Ministério Público Federal - MPF (Federal Public Prosecutor’s Office) asked the Federal Court to repeal the resolution on the grounds that it represented euthanasia, which is prohibited in Brazil; and that orthothanasia should be regulated by the National Congress in compliance with specific laws⁶. During the process, the MPF acknowledged the pertinence of the resolution and requested the extinction of the proceeding. The federal judge ruled against the validity of the resolution, which has not been disputed again so far⁷.

The Código de Ética Médica - CEM (Code of Medical Ethics)⁸ in force as of 2009 maintains the content of the CFM Resolution 1.805/2006⁴, prohibiting euthanasia and assisted suicide; and opposing the practice of dysthanasia, while approving

orthothanasia. Physicians are not allowed to *shorten the life of a patient, even if at the request of his/her legal representative*; the code also advises that *in cases of incurable and terminal illness, physicians must offer any palliative care available without undertaking useless or obstinate diagnostic or therapeutic actions, always taking into consideration the patient's will, or that of his/her legal representative, if unable to express his/her own wish*⁸. In force since April 2019, the new CEM maintains these regulations⁹.

The CFM Resolution 1.995/2012, which deals with the advance directives of will and living will¹⁰ was disputed, but the Federal Justice's decision closed the case confirming that the document *is legal and constitutional; the CFM is fulfilling its role; the resolution respects the principle of human dignity; the patient's decision is free; there is a legal void and the Resolution only regulates medical conduct; there is no extrapolation of power; it is compatible with the principles of autonomy and human dignity; the patient's decision is free, but the family is invited to participate in the process as well*¹¹.

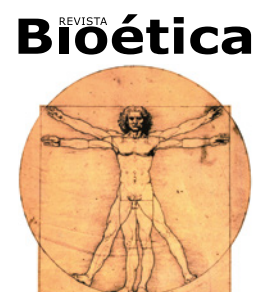
It is essential that health professionals who care for such patients and their families have enough knowledge of the subject, which is discussed in several publications and addressed by specific concepts, as follows: Federal Constitution¹²; 2019 Code of Medical Ethics⁸; CFM Resolution 1.805/2006⁴; CFM Resolution 1.995/2012¹⁰; bioethical principles, values and concepts; concepts of euthanasia, mysthanasia, dysthanasia, assisted suicide, and palliative care, so that they can dialogue with each other, on a daily basis, improving their communication skills with the patient or legal representative, as well as relatives, who may be present or not. It is imperative for the terminally ill patient: the right to know, to decide, not to be abandoned, to receive palliative treatment, and not to be treated as an "object".

Finally, Pessini¹³ recalls that in 1989, Márcio Fabri dos Anjos coined the neologism "mysthanasia", which refers to a crime not yet specifically defined in the Penal Code¹⁴, but clearly prohibited by the Constitution¹². The term comes from the Greek (*mys* = unhappy, *thanathos* = death, "unhappy death"); which means miserable, precocious, and avoidable death. Ferreira points out that *death is impinged by the three government levels through the maintenance of poverty, violence, drugs, lack of infrastructure and minimum conditions for a decent life*¹⁵.

The systematic reduction of health financing; the misuse of money available in the budget; the closure of beds, services, and health units; the indiscriminate opening of medical schools; the contempt and devaluation of physicians and other professionals; the lack of commitment of the three powers towards the quality of life of the population, eroded by corruption, incompetence, and inhumanity are the facets of mysthanasia that affect life and death, increasing the vulnerability of the most needy¹⁵.

The concept of mysthanasia can also be applied to the education budget, an area that is directly interconnected with health; since both are intertwined with the continuous process of promoting citizenship. Education is the key to social and economic growth; to the suppression of iniquity; the definitive and palpable achievement of fundamental human rights. So much so that the Human Development Index (HDI) interweaves *three basic dimensions of human development: income, education, and health*¹⁶.

There is no contemporary nation that has emerged from poverty and underdevelopment without promoting education, in a political process that stems from the genuine will to emancipate the population. South Korea¹⁷ and Finland¹⁸ illustrate the key role of education for social and economic development,



introducing policies that have been systematically invested for few decades, supplanting historical and social conditions that have hindered the development and well-being of their populations.

At times when health and education in Brazil seem to be seriously threatened by budget cuts stemming from the declining of growth expectations projected for the Produto Interno Bruto - PIB (Gross Domestic Product), the editors of *Revista Bioética* (Bioethics Journal) are urged to join educators, researchers, sanitarians, doctors, and nurses who call for more consideration regarding the allocation of Union resources. Health and education must be a priority. Maintaining and constantly improving the quality of public policies that ensure universal access to these areas are essential for establishing justice and civil consciousness.

The editors

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