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Bioethical reflections on the end-of-life care

Abstract

The influence of technological pragmatism on the health care offered to critically ill patients, especially to those who are at the end of their lives, makes most of them end up in intensive care units. As we advocate a more humanized care for these people, we have prepared this article, which proposes a bioethical reflection on this matter. The text is divided into three parts: first, we discuss the reality of intensive care units in Brazil, based on the resolution of the Brazilian Federal Council of Medicine that regulates medical practice in intensive care units (Res. No. 2,156/16); second, we compare some aspects of the end-of-life care in 4 different countries: the USA, Japan, Italy and Brazil; finally we analyze euthanasia and assisted suicide, considering the technical and moral arguments presented by the American bioethicist Dr. Ezequiel Jonathan Emmanuel.

Keywords: bioethics, intensive care unit, Palliative care, euthanasia, assisted suicide

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Abbreviations: WMA, world medical association; ICUs, intensive care units; CFM, council of medicine; ADW, advance directives of will; PUCPR, pontifical catholic university of paraná; ANCP, national academy of palliative care, E, euthanasia; AS, assisted suicide

Introduction

The ethical issues and critical care techniques offered to patients at the end of their lives have been the subject of heated academic and legal debates in the field of bioethics since its emergence in the USA in the early 1970s. This discipline today represents a valuable instrument for proposing changes in the Western culture, which still considers death as a "taboo subject" and denies the most elementary aspects of the finitude of life. We have noticed the emergence of edifying examples of medical professionals who "elegantly embrace their finitude",[1] as well as a growing number of scientific events related to the field. Also, this subject is been introduced in the curricula of health care courses in order to train professionals with humanism and rescue the classic figure of medicine as an art, without underestimating the necessary technical qualification. Literature on end-of-life issues has grown significantly lately.[2,3] The World Medical Association (WMA) promoted in 2017 a series of conferences around the world to highlight that "these events can organize and consider a review of its policy regarding euthanasia and assisted suicide".[4,5] Over the past few years, the WMA has produced a series of documents alerting physicians to the use of disproportionate procedures in the treatment of patients with terminal diseases (www.wma.org).[6] Considering, therefore, this new reality, we organize the present text in four parts: first, we present a critical assessment of the reality of our intensive care units (ICUs), based on a recent resolution from the Brazilian Federal Council of Medicine (CFM) that established ICU admission and discharge criteria of critically ill patients, a condition that is still far from consensus among us. On the same line of reasoning, we rescue a metaphor that we presented in a previous publication, when we treated our ICUs as "modern cathedrals of pain",[7] second, we present the results of a survey conducted by the Kaiser Family Foundation and published in The Economist about how people want to be treated at the end of their own lives, taking into account four countries: Japan, Italy, the United States and Brazil ; third and finally, we bring to light the instigating provocation from the American oncologist and bioethicist Dr. Emanuel Jonathan Ezequiel regarding the unsatisfactory approach to assisted suicide and euthanasia issues. Considering the way that these problems are routinely reported by the international media, it is clear that the health care system neglects the essential bio psychosocial and spiritual care of terminal patients.

Ia.Admissions and discharges criteria in brazilian ICUs

In 2016, one of the most prestigious medical publications in the world, the New England Journal of Medicine, published a courageous statement by a Brazilian intensive care physician, Dr. Flavia Machado, in which, she denounced the chaos that prevailed in the Brazilian healthcare system and expressed her optimism and commitment to find solutions to existing problems. She also described her dramatic day-to-day care of patients in critical situations in a public hospital in the city of São Paulo, Brazil. At the time of the publication, she was also responsible for the intensive care unit of the anesthesiology discipline at the Federal University of São Paulo (UNIFESP) and coordinator of the Latin American Institute of Sepsis (Ilas). The article published on line had an unprecedented repercussion and attracted the attention of health care professionals from all over the world. The text had more than 50,000 views and 3,000 shares on Facebook. In Brazil, the repercussion was timid, commented on two articles published by Claudia Colussi in the newspaper Folha de S. Paulo on 03/30/2017 and 05/07/2017, entitle "In the country of disparity, the difficult task of deciding who should go to ICU",[8] and "At the end of life, Brazilians prefer to prolong days to feelings of pain",[9] respectively. Right at the beginning of the text, Machado.[10] narrates a flagrant of her daily life with the following words: "We start another day of work at 7:00 a.m., and once again we need to decide who will receive a bed in the ICU (...) A 55-year-old grandmother with colon cancer? An elderly man with liver metastasis? A young woman who suffers from pain and needs an arthrodesis (spine surgery) to continue working so she can feed her family? Should we choose or deny assistance to cancer patients? Should we choose on the basis of age? About the patients' previous quality of life? Or on the social impact, for example, if a patient has four children to raise? Should we give the bed to a patient we already had to turn down once? Or maybe we should just stop playing God and give it to whoever asks first?".[11] Because of this dramatic panorama of the day-to-day work of an intensive care physician who reveals a reality of much suffering for those in need of care, the CFM, at the end of 2016, published resolution No. 2,156, establishing ICU admission and discharge criteria. The norms aim to optimize the flow of care in face of the chronic shortage of beds in intensive care medicine, especially in public hospitals around the country. These rules of conduct will be of great value to intensive care physicians when making decisions regarding the admission or discharge of patients.

For the lay public, far from these medical dilemmas, it is necessary to make these CFM guidelines more easily understandable and, to do so, we will summarize the main definitions presented in the resolution:

a) **Intensive care unit (ICU):** a highly complex medical care sector where human and material resources provide advanced life support to treat patients in critical situations. The objective of these procedures is to make patients clinically and hemodynamically stable, essential for the maintenance of life;

b) **Critical patient and advanced life support interventions:** patients who present potentially deadly instability of one or more organic functions. These patients often require ventilatory and circulatory support, and hemodialysis. This equipment is usually available only in emergency units or ICUs. The critically ill patient needs immediate intervention, because, in most cases, they have diseases that are accompanied by multiple organ failure, with a time-dependent prognosis. Several researchers have shown that a delay of four hours or more in the admission time to the ICU will contribute to the increased mortality of these patients;

c) **Worrying data from the Brazilian healthcare system regarding the availability of ICU beds:** there is consensus that Brazil has a chaotic public healthcare system, especially when one considers the large deficit of ICU beds. According to data from the Ministry of Health, there should be 2.5 to 3 hospital beds for every 1,000 inhabitants, and the number of ICUs beds in these units should represent between 4% and 10% of the total number of beds in each hospital. According to a CFM survey conducted with data from the Ministry of Health, 40,960 ICU beds are available in the entire country (ratio of 1.86 bed for every 10,000 inhabitants). Of this total, 20,173 belong to the Sistema Único de Saúde (SUS), aimed to serve 150million users of the public health system (ratio of 0.95/10,000 inhabitants). In the private network, there are 10,787 ICU beds available to 50 million people (ratio of 4.5/10,000 inhabitants In addition to this, in the 19 of the 27 states of the Brazilian federation, the ratio of ICU beds per inhabitant in the public network is lower than the recommended number by the Ministry of Health. As we can observe, the lack of beds is clear, a circumstance that imposes the so-called "Sofia's choice" on intensive care doctors, which is the impossible task to choose those who should benefit from their monocratic decisions.

Ib. Brazilian ICUs: some fundamental concepts and daily problems

Faced with these extremely poor conditions, we have added another layer of complication: the admission to ICUs of severely ill patients who have reduced chances of recovery and even so receive all conventional intensive care treatment. This practice is disproportionate or futile as it only prolongs the dying process and invariably results in greater suffering to patients and their families. This is what we call therapeutic obstinacy or dysthanasia.[12,13] On the other hand, it is equally common that clinically stable patients, who only need semi-intensive care treatment, remain in ICUs without a plausible clinical justification. Among the recommendations of the CFM, there is guidance for the intensive care physician to consider not only the diagnosis, but also the patient's chances of recovery.

Ic. ICUs admission and discharge criteria

According to the CFM resolution guidelines, physicians are recommended to use conduct codes that are based on scientific criteria and ethics in order to offer the best care to critically ill patients who need intensive care. According to the norms, doctors should take into account the following aspects for ICUs admission: a refined evaluation of the patient's clinical recovery possibilities, based on the best medical practices, as well as the number of beds available in the institution. The criteria listed in the resolution follow the following order of priorities: 1st. Patients who need life support interventions, with high probability of recovery and no limitation of therapeutic support; 2nd. Patients who require intensive monitoring because of the high risk of immediate intervention, without any limitation of therapeutic support; 3rd. Patients who require life support interventions, with low probability of recovery or with limitation of therapeutic intervention; 4th. Patients who require intensive monitoring because of the high risk of immediate intervention, but with limitation of therapeutic intervention; 5th. Terminally ill patients unlikely to recover. In general, these patients are not appropriate for an ICU admission. However, they may be admitted on an exceptional basis, considering the peculiarities of each case and the judgment of the intensive care physician. "We created a five-step ladder. Each one translates a more precise indication, until we reach step 5, which generally has no indication to remain in ICU", explained the coordinator of the Technical Chamber of Intensive Care Medicine of the CFM, Herman Von Tiesenhausen (CFM RESOLUTION 2.156). Finally, patients who do not fit these criteria established by the resolution should not occupy an ICU bed, even if physicians are under pressure from relatives who mistakenly believe that patients can recover only in hospital ICUs. This does not mean that we should ignore the understandable cries from family members, but the admission of patients who do not fit these criteria will result in an unreasonable occupation of ICU beds, depriving patients with life-threatening diseases with real possibilities of recovery of this benefit. Obviously, these decisions must be preceded by respectful and enlightening dialogue with family members. Regarding the decision to discharge patients from the ICU, the resolution also presents quite clear guidelines. According to them, patients should only be discharged when their vital signs are stable and they no longer need to remain in the ICU. On the other hand, terminal patients should be transferred to Palliative Care Units. Each institution, therefore, should provide care based on the criteria established by the resolution and doctors should follow them with the utmost professional commitment. Although decision-making in the ICU setting will always require wisdom and smart thinking, the perception that the healthcare system does not provide adequate care for all critically ill patients is sometimes reason for indignation and distress. In addition, it is imperative that end-of-life and palliative care disciplines are introduced in the curriculum of health care professionals. ICUs are insufficiently and poorly distributed around the country, and the population has no adequate access to them. If we do not use ICUs beds appropriately, we will impose an additional burden to the healthcare system.

End-of-life bioethical research in Japan, Italy, the United States and Brazil

Curiously, "The Economist", one of the most respected international publications on economics, has proved in recent years to be the information vehicle that gives the most publicity to matters concerning the end-of-life care. In 2010, for instance, it published a report commissioned by the Lien Foundation under the title: "Quality of death: the end of life ranking in the world".[14] Also, the Report 2015 updated the quality of death index, considering the number of palliative care units in the world.[15] More recently, in April 2017, in partnership with The Henry J. Kaiser Family Foundation*,* the magazine published a new report entitled: "Visions and experiences with end-of-life medical care in Japan, Italy, the United States and Brazil".[16] Because of the importance of the 2017 report, we will highlight some data that we consider essential. The study should be of interest to all professionals who work with critical and end-of-life care because it highlights valuable information about this complex area of medical care. The authors of the report initially considered patients' opinions on how they would like to be assisted at the end of their own lives. Thus, the authors have chosen five of the most emblematic issues and asked patients the following:

Question 1. "When it comes to assistance and care, what do you consider the most important at the end of your own life?

The answers were the following:

A. To prolong life as long as possible: Japan, 9%; USA, 19%, Italy, 13%, Brazil, 50%;

B. To help people die without pain: Japan, 82%; USA, 71%; Italy, 68% and Brazil, 42%.

The fact that 50% of Brazilians were in favor of prolonging life as long as possible was astonishing. We believe that this mistaken perception might be caused by the inappropriate use of ICUs beds around the country and because Brazil is one of the few countries in the world that provides palliative care in ICUs.

Question 2. "When thinking about your own death, what do you consider to be extremely important?"

The answers were the following:

I. Not leaving the family in financial difficulties: 59% in Japan and 54% in the USA;

II. Being at peace spiritually: 40% in Brazil, a percentage that deserves attention;

III. Having the company of loved ones on the occasion of the death process: 34% in Italy.

Question 3. "On prolonging life as long as possible"

This question was asked only to Brazilian subjects, and the different levels of schooling were taken into consideration to further understand the situation.

Fifty one % of those with elementary education expressed a favorable opinion, 53% of those with secondary education had the same opinion, and only 35% of those with higher education supported the indiscriminate extension of biological life. These data show that Brazilians with the highest levels of schooling favored pain relief and physical and emotional comfort over artificial prolongation of life.

Question 4. "to help people die without pain, discomfort and suffering"

Forty one percent of the interviewed subjects with elementary schooling, 40% of those with secondary education, and 58% of those with university degree were in favor of such measures.

Question 5. "Who should decide on the medical treatment to be adopted in patients at the end of their lives?"

Including all countries, 57% believed that patients and relatives should take these decisions, 40% believed doctors should do, and 2% could not answer.

In summary, most of the interviewees in Japan, Italy and the USA, when dealing with serious and incurable diseases, opted to receive care that would reduce pain and allow the company of family members in the moments near the end of life, rather than procedures that would provide an artificial prolongation of life. Also, according to the data, 50% of Brazilians, when stimulated to express an opinion about their own end-of-life issues emphatically expressed the desire to remain in ICUs, while in the USA, Italy and Japan the rates were lower than the rates in Brazil, between 9% and 19%. In these countries, the choice for palliative care and death without pain and suffering prevails. On the contrary, in Brazil, only 42% of subjects considered this option as "very important". The survey also identified a remarkable prevalence of religiosity among Brazilians: nearly 40% of respondents believed that it is "extremely important" "to be at peace spiritually" at the end of life. Eight out of ten Brazilians (83%) made clear the importance they devote to religious and spiritual convictions. This is the most important datum regarding the treatment they wish to receive at the end of their lives. In the survey, 54% of adult Brazilian identified themselves as Catholics and three out of ten declared themselves as evangelicals. The question that arises from the fact that a high number of Brazilians consider important "being spiritually at peace" at the imminence of death is how such care is offered. On the other hand, in the USA and Japan, where medical service expenses are usually very high, the preservation of the family's financial security after the patient's death gains importance. In Italy, the greatest concern expressed by patients was that they could count on the presence of their "loved ones by their side" at the final moments of their lives, followed by the "certainty that their personal wishes about medical procedures adopted in the finality of their lives would be respected." Given the concern revealed by the researchers, considering the four countries studied, the lack of communication with patients about the terminality of life was a systematic observation. In Japan, for example, only 31% of adult patients and 33% of those over 65 years of age claimed to have had the opportunity to talk about the subject with a loved one, and only 7% said they had discussed the matter with their doctor; only 6% said they had formally made their advance directives of will (ADW), and 64% did not formulate it because they were unaware of this alternative. Similarly, we point-out a survey conducted in a private home care service for patients with terminal diseases in the city of Florianópolis, Brazil, which was the subject of a Master's dissertation presented to the Bioethics Master's Program of the Pontifical Catholic University of Paraná (PUCPR) in 2016. In this study, researchers evaluated the degree of knowledge that 55 assisted patients had about the ADW. Of the total, only one patient had registered his ADW, 3 patients expressed the desire to carry them out after discussing the subject with the main author of the research. The other 51 patients declared that they had not been offered the opportunity to talk about it.[17] It is known that the number of formal registrations of ADW is small and varies greatly from country to country. Regarding the four countries studied, the results obtained on the subject were the following:

a. Considering the overall population: 6% in Japan and Italy, 27% in the USA, and 14% in Brazil;
b. Considering only the population over 65 years of age: 12% in Japan, 5% in Italy, 51% in the USA, and 13% in Brazil. Another fact that deserves reflection is the fact that in the USA, approximately 1/3 of the people who die after the age of 65 were admitted to an ICU in the months before death and 1/5 of them underwent a surgical procedure in the month before death. It is estimated that by 2020 at least 40% of the US population will die in their own homes or in nursing homes for elderly people unaccompanied by their relatives. Contrarily, Brazil has a chaotic public health service, characterized by unsatisfactory reference and counter-reference system, lack of a proper national service network, insufficient resources, and inadequate hospital infrastructure. In addition to these problems, the insecurity and misinformation about the end-of-life controversies help consolidate the idea that orthothanasia, i.e., not using futile or disproportionate therapies in patients with terminal incurable diseases, is abandonment of care or omission of medical assistance. Distrust of the country's public health service qualities encourages this misunderstanding. In Brazil, we have 110 palliative care services registered with the National Academy of Palliative Care (ANCP), while in the U.S. this number is 1700 units. Another enormous challenge is the almost total absence of contents related to terminality of life and palliative care in the curricular grid of undergraduate courses in the health care area.

A study published in *The Lancet* Magazine in November 2010 showed worrying results about the qualification of 2420 medical courses around the world.[18] The first pedagogical project used by medical schools at the beginning of the 20th century, after the reforms proposed by the Flexner Report, emphasized teaching in tertiary hospitals. The second model, known by the English acronym PBL (Problem Based Learning), conceived in the 1970's by the Universities of Maastricht, the Netherlands, and MacMaster, Canada, was widely accepted in health care courses. The third model, known as the "Health Education Systems", promises to train professionals with greater social responsibility, based on the principles of the ethics of otherness. However, initiative to implement this model is still lacking. In this study, twenty educators from around the world with extensive experience in medical education composed the "The Lancet Commissions". The main goal was to define an appropriate model of professional education for the practice of medicine in the 21st century. Many experienced educators still defended the idea that it is necessary to form health care professionals who are better prepared to make reasonable and prudent decisions in face of the complex ethical conflicts of a modern society marked by moral plurality. Nonetheless, this proposal is in conflict with higher education institutions that are governed by market rules and prefer to train physicians to attend as many patients as possible, regardless of the quality of service provide to the community. Thus, unfortunately, we have to recognize that we are not yet able to train professionals who are prepared to recognize patients as bio psychosocial and spiritual beings. These patients have the autonomy to give opinions and participate actively in the decision-making about their own medical procedures. In a survey conduct in 2010, Pinheiro and collaborators interviewed 5th and 6th grade medical students from the city of São Paulo, Brazil about palliative care and terminality of life, even though these students do not receive any humanistic education on the subject during graduation. The survey identified that 83% of students had not received information on how to care for patients with terminal diseases and 63% on "how to give bad news", and 76% said they did not know the clinical criteria for optimizing pain treatment in cancer patients.[19] Aggravating this situation is the fact that our universities have placed too much emphasis on teaching countless disciplines without establishing a logical connection between them, preventing students from understanding that, no matter which disease the patient is suffering from, the situation will always involve the entire bio psychosocial universe of the sick. The slicing of the human body into organs and systems that is practiced in most medical schools prepares students, and of course future physicians, to treat diseases and not people. Edgar Morin is emphatic when he states: "disciplinary developments in science have not only brought the advantages of the division of labour, but also the drawbacks of over-specialization, confinement and the shattering of knowledge. Not only did they produce knowledge and elucidation, but also ignorance and blindness".[20] The incipient multidisciplinary approach introduced in medical schools is welcome, however, it is insufficient to address the complex moral problems present in end-of-life situations. In relation to human finitude, it is essential that disciplines from different areas of knowledge, such as medicine, psychology, theology, nursing and so many others, dialogue between with each other. Sharing the knowledge from each area will help health care professionals to provide proper care to patients in their terminal phase of life; furthermore, only an interdisciplinary approach will allow an adequate decision-making in the palliative care setting.[21] At this point, it is important we recall the experience of the American neurosurgeon Dr. Paul Kalanithi, who registered in his book "The Last Breath of Life" the trajectory of his life from the stage "In perfect health I begin" (Part I) to the stage "Do not stop until death" (Part II). In 167 pages, the author allows us to follow his experience to the encounter of death. The epilogue of the book was written by his wife Lucy after Paul's death, and it brings the following teaching: "Paul's decision not to look away from death sums up a force that we do not celebrate enough in our culture against the idea of mortality. Writing this book was an opportunity to teach us to face death with integrity".[22] Returning to the research published by The Economist, we consider it is important to highlight some points regarding the data found in the four countries studied. Despite the existing socio-demographic and cultural differences between them, some similarities should be mentioned. In all 4 countries, interviewed subjects considered the health care initiatives sponsored by government unsatisfactory. They also believed that the government was unprepared or discouraged to promote adequate measures for the care of elderly people or those affected by terminal illnesses. When asked about treatments considered essential for the end-of-life health care, most Japanese, Italians, and Americans preferred therapies that could promote pain reduction and relief from the suffering imposed by diseases. Similarly, when asked about the finiteness of their own lives, subjects expressed an impressive consensus: "live well, as long as possible, provided the dignity of the person is always respected." When discussing the end-of-life planning, the vast majority of people in all countries expressed that death is still considered a "taboo subject", being the biggest obstacle to talk about planning, even considering other issues related to the cultural differences of each people. In relation to DAV registrations, the North Americans were the ones who were more willing to sing the document.

Care at the end of life as perceived by bioethicist Ezequiel Jonathan Emanuel

The prestigious The Medical Journal of Australia published an article by the US oncologist and bioethicist Emanuel entitled "Euthanasia and suicide-assisted: focusing [attention] on data", which arouse great interest among the lay public, and fueled heated debates in academic environments. In summary, the author argues that the focus on the finitude of life should migrate from the defense of euthanasia and assisted suicide to the improvement of palliative care to be provided to terminally ill patients.[23] It is important to note that Emanuel was a professor at the Harvard Medical School until 1998, when he became head of the Bioethics Department at the National Institute of Health (NIH) Clinical Center. In collaboration with his wife Linda Emanuel.[24] Marcia Angell and Edmund Pellegrino, he published in 1998 in the Harvard University Press the book "Regulating how we die". In the chapter "The false promise of beneficent killing", Pellegrino is very assertive in commenting: "It is an injustice to offer these patients [at the terminal stage of life] assisted suicide or euthanasia as options [valid] while so many other possibilities can be provided".[24] As we can see from excerpts from Emanuel's recent article, the teachings of Pellegrino are his mains source of inspiration. He affirms that there are arguments that rarely gain media attention and would be key in providing ethical support for medical decision-making in cases of terminally ill patients. Using data from countries where euthanasia (E) and assisted suicide (AS) are legalized practices, Emanuel argues that "these data mean that the cry to legalize euthanasia and assisted suicide does not help to improve end-of-life care. E and AS do not solve the management of symptoms or improve the practice of palliative care. These interventions are for 1% and not 99% of patients who are dying. We also need to deal with the problem that the vast majority of terminal patients face, that is, how to get relief from symptoms, and how to avoid hospital [hospitalizations] and stay at home in the final weeks of life. Legalizing E and AS would really be secondary when it comes to end-of-life care, a fact defended by few to few [and supported by the media] but not aimed at improving care for the vast majority of end-of-life patients who will continue to suffer.".[23] According to him, the public perception of the supposed need for the practice of E and AS is overly focused on pain. The word "suffering" is also [inappropriately] used in an attempt to broaden [the scope] of the argument about "existential issues." However, existential suffering, as well as pain, can very well be controlled through [adequate] medical care. The author concludes: "Pain is not the primary reason why people seek the E or the AS. Many healthy people believe that pain would be the main reason [patients] would seek [E and AS], however, we have evidence that it is different". According to the author, patients who request and undergo E or AS rarely experience unbearable pain and few of them desire these procedures. Corroborating his conclusion, researchers have evaluated data from patients suffering from cancer or AIDS in the State of Oregon, USA, and have shown that patients who were interested in E or AS did not suffer unbearable pain. The follow-up of patients who had requested and undergone AS showed that less than 33% of them experienced unsatisfactory pain control. Emanuel asks: "if it is not the pain, then what motivates the patients to ask for E and AS?" Probably, in the author's opinion, it would be "depression, loss of hope, life fatigue, loss of control and dignity". The real reasons for requesting AS would be psychological and not primarily physical; therefore, patients would not be relieved by increased doses of morphine, but by a psychotherapeutic approach. In the states of Oregon and Washington, USA, where E is legalized, the reasons for requesting AS were the following: 90% of the patients mentioned the loss of autonomy and 70% the loss of personal dignity. It is interesting to note that depression and hopelessness are usually not considered when opting for AS. Similarly, in the Netherlands, the main legal requirement for the practice of E is "extreme physical or mental suffering," making it difficult to recognize whether or not the determining reasons are dependent on the emotional state. However, many Dutch researchers, when interviewing patients who requested E, recognized that some of them were experiencing uncontrollable pain, although "most were visibly depressed". The North American oncologist highlights the importance of carefully considering psychological suffering. He affirms: "The importance of psycho-existential suffering as a reason for patients to request E and AS indicates that [the justification for such requests] are less palliative and more [similar] to [reported in cases of] conventional suicide". It is known that the main causes of conventional suicide are psychological problems, an underestimated subject by doctors in states where E and AS are legalized. In fact, in the states of Oregon and Washington, for example, less than 4% of the patients who requested AS received any type of psychological assistance. Since psychosocial factors are the main reason for requesting E or AS, it would be reasonable to request a psychiatric follow-up for this patients before any irreversible medical decision is made. The author concludes: "We need to think very differently about why people ask for E or AS. The image that the vast majority of people have of patients squirming in unbearable pain is simply wrong".[23] Another issue that has been widely and fallaciously reported by the media is that death by a single lethal dose, supposedly quick and painless, is a "dignified" way to die. According to Emmanuel, this conclusion is the result of a hasty and untruthful evaluation of reality. On the other hand, he believes there is no medical act that can be considered risk-free, since any procedure can cause adverse events and E and AS are no exceptions. This assertion was confirmed by researchers in a study made in the Netherlands in 2000, in which they showed that 5.5% of the cases of E and AS were accompanied by technical errors that promoted some degree of suffering. Also, in 6.9% of the cases, there were procedure difficulties that culminated in the patient's death. Complications during venipuncture occurred in 4.5% of E and 9.8% of AS cases. These facts suggest that the commonly held view that E and AS are fast and uncomplicated ways to induce a quiet death is misleading.

Final considerations

In short, we must conclude that death, although a taboo subject, must be viewed more naturally in order to spare patients from senseless and prolonged agony, respecting their personal values and beliefs. This would allow them to complete their life cycles with dignity. We agree with Emanuel when he says: "taking into account the evidence now presented the legalization of E and SA appears as a much less attractive alternative". What would then be the main motivation for legalizing interventions that shortened lives of a small minority of patients who are depressed and frightened for having lost their ability to exercise their autonomy of will? Although there is no consensual response, we consider it is essential to conduct a professional exercise based on an aphorism attributed to Hippocrates, although not mentioned in his major work, the "*Corpus Hippocraticum*", and that has been guiding the medical arts for ages: "to heal sometimes, to relieve often and to comfort always".[13] Once again, we recall the perplexity that dominates the daily life of intensive care physicians, so well described by Machado,[10] professionals who have their activities permeated by doubts that occupy the debate on moral issues related to E, dysthanasia, orthothanasia and AS**.** And here, the philosophy of palliative care emerges with vigor, supported by safe clinical practices that have a solid scientific basis and are suitable instruments to offer humanized care to patients suffering from terminal diseases.

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The authors declare no conflict of interest.

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