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



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Abstract

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

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

CEP/Famema Approval No.166/08



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

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





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

Historical and Symbolic Context

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

Since the ages of Medicine's father, the advances in the care to the terminal individual reinforce such conception by increasing the survival of patients considered terminal. If in the beginning of the 20th century the time for the advent of death, after the finding of a serious disease, was five days, the advances achieved along that century made it possible that today such interval is tenfold greater.² Accordingly, the student of medicine is molded, since early stages, to face death as a great adversary that shall be fought and, if possible, defeated thanks to the best science or competence available³. Such characterization of the professional physician such as the one that defeats death is seen in the next mythical and poetical narrative, in the myth of Asclepius, the Greek god son of Apollo who, during his apprenticeship with centaur Quiron, would have acquired the power of providing life to the dead⁴.

The imperative associated to such representation of physician's role contributes to future professional not receiving in his/her formation pedagogical contents to deal with human terminality. According to Hill⁵, only



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

Here are the first problems: technology advances inserted into medicine permit that life, even in terminal instances, be extended for a considerable time. Added to this is the fact that physician, in his/her formation, receives as a dogma that he/she is the caretaker of that life, which he/she should preserve at any cost, preventing its end. How, within such context, to face the patient's autonomy, in case he/she expresses the wish of dying due to the fact of being restricted to a painful and irrecoverable

situation? At to which extent an individual under such condition has the right to intervene, make an opinion and be heard when the issue is his/her own death? Or, furthermore: until when it is considered ethical to extend or abbreviate a life? Prior to such question, it became necessary to deepen the understanding on the process of dying and death itself. It occurs, then, the definition of the ways of such process: euthanasia, dysthanasia and orthotanasia.

Euthanasia, from the Greek *euthanasia*, is a neologism created in 1623 by the philosopher Francis Bacon. At the time, that word was used to mean a good death. Euthanasia, therefore, is the attitude that provides an easy and no

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

Nevertheless, it is also necessary to deepen the definition of euthanasia, including its several classifications, as well as the basic differences related to euthanasia, regarding agent's execution mode. In orthotanasia, methods to extend a life, which would cease naturally or even to abbreviate it are not used. Euthanasia, in its turn, uses practical means to interrupt life, even when it could be extended. In this sense, it could be divided into *active* and *passive*. The first, happens when death derives from a positive conduct, and the second when gotten from an omitted stand⁹. A very common mistake is the confusion between passive euthanasia and orthotanasia, also known as restricting medical conduct. The former, as well as its active mode, has as finality to promote



death and, secondarily, cease suffering. In the CFM document was suspended by a orthotanasia the wish is not killing but preliminary injunction in 2007, thus increasing preventing the extension of death - when using, its relevance when indicating the inability of often, procedures that dishonor human dignity certain sectors in the society in handling with at the end of life ⁹. the bioethical discussion of issues related to death ¹⁰.

With the purpose of clarifying the controversy on the issue, CFM published Resolution But what is a necessity may calm down with 1805/06, defining that: *At the terminal stage of time, but not be silenced forever. In December serious and incurable illnesses, it is allowed to 2010, after three years of legal discussion, it physician to limit or suspend procedures and was published Judge's decision at the 14th treatments that extend patient's life, assuring Federal Court from the Federal District, him/her the care required to alleviate the revoking the preliminary injunction that symptoms that lead to suffering, in the suspended the resolution ¹¹ and ruling as perspective of a full care, respecting patient or groundless the public civil suit brought by the his/her legal representative's wish ². Federal Public Attorney's Office against the Federal Council of Medicine. It was recognized*

The publication states that it is the physician's that the permission to interrupt the treatment duty to clarify patient or his/her legal at the request of the patient on a terminal representative, the therapeutic modalities situation does not violate the Federal adequate to the case, indicating that a second Constitution and, thus, the resolution was in medical opinion is patient or his/her force again. representative's reserved and acquired right.

Finally, it resolves that the patient shall continue In the Civil Justice realm, it was approved by receiving all assistance for the symptomatic the Federal Senate the Bill No. 6,6715/09, relief, in order to prevent suffering. It is assured which decriminalizes orthotanasia ¹². In that his/her physical, psychic, social and spiritual text, within the scope of palliative care to terminal patient, it is not considered a crime to discharge, if he/she so desires. suspend disproportional and extraordinary means, provided that the inevitable death is

Resolution CFM 1805/06 was not unanimously attested by two physicians. Here, it is also accepted; sectors from the society showed necessary the patient's express consent or, if discomfort and rejection. The argument to reject unable, by his/her legal representative ¹³.

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





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

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

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

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

One realizes, retroactively, the importance of the original document, rescued in

Objectives

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

Materials and methods

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

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



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

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

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

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

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

Results and discussion

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

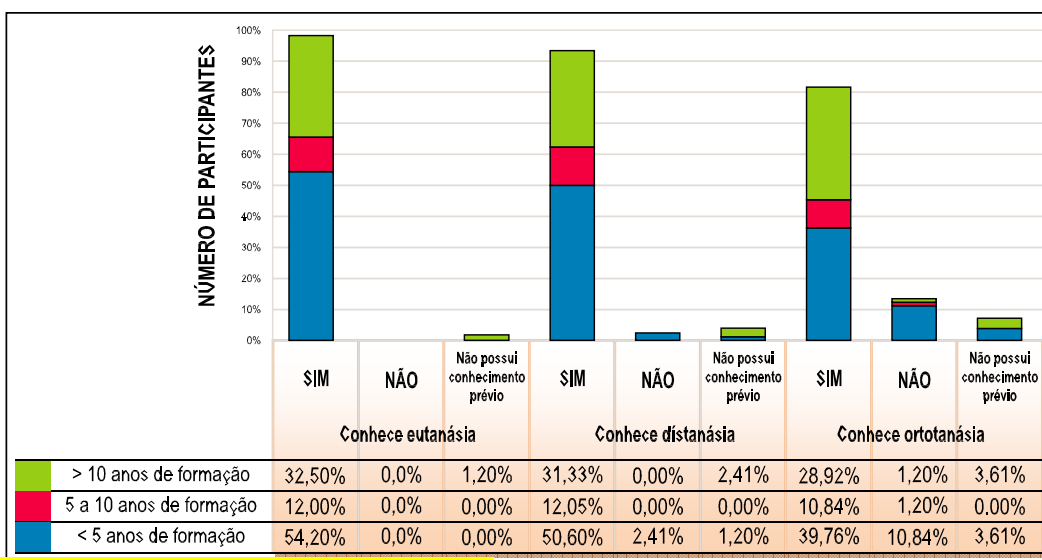
Sex	Nº	%	Time of graduation	Nº	%
Male	50	60.2	Less than 5 years	45	54
Female	33	39.8	From 5 to 10 years	10	12
Total	83	100	More than 10 years	28	34



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

Dysthanasia is correctly known by 94% of the interviewees and orthotanasia by 79.5%. One may suppose that the lack of knowledge about the last two terms derives from their several definitions and inaccuracies¹⁶ and to the fact of been relatively recent.

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



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

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

Failures in understanding may be identified also when participants in the study were able to expose what they understood by orthotanasia, when the

detailed explanation of the concept, previously provided by the questionnaire was not similar to knowledge that they had until then. It was then possible to verify that among the most common terms in the bioethics discussion involving death and the dying process, orthotanasia is the one which generates more conceptual confusion.

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





without prognostic, since in case of the acceptability of orthotanasia in 92.8% non-terminal patient the removal of of interviewees, thus, noticing that treatment would be classified as active professionals consider undeniable the euthanasia. Palliative care appearing in acceptance of death in the time of the second example, are care provided to each one, seeking to avoid unneeded patient in his/her terminal moments, with suffering, abbreviations or the main objective of improving the quality extensions¹⁹. The percentage analysis of life, not interfering in the illness reveals a trend to adopt therapeutics evolution ¹⁷. In other terms, is the multi- that enables the reduction of suffering professional practice aiming at offering to by such patients, including even the terminal patient care involving the euthanasia. In summary, the universal physical, emotional, social and spiritual language is of repudiation to the aspects with the objective of attaining the therapeutic obstinacy. best quality of life possible for him/her and their families ¹⁸. They are examples of Such aversion to dysthanasia and a palliative care, among which: hygiene, favorable attitude to orthotanasia and comfort, symptomatic medications and even to euthanasia occurs because the religious support. studied population understands the dynamics of beneficence and non-

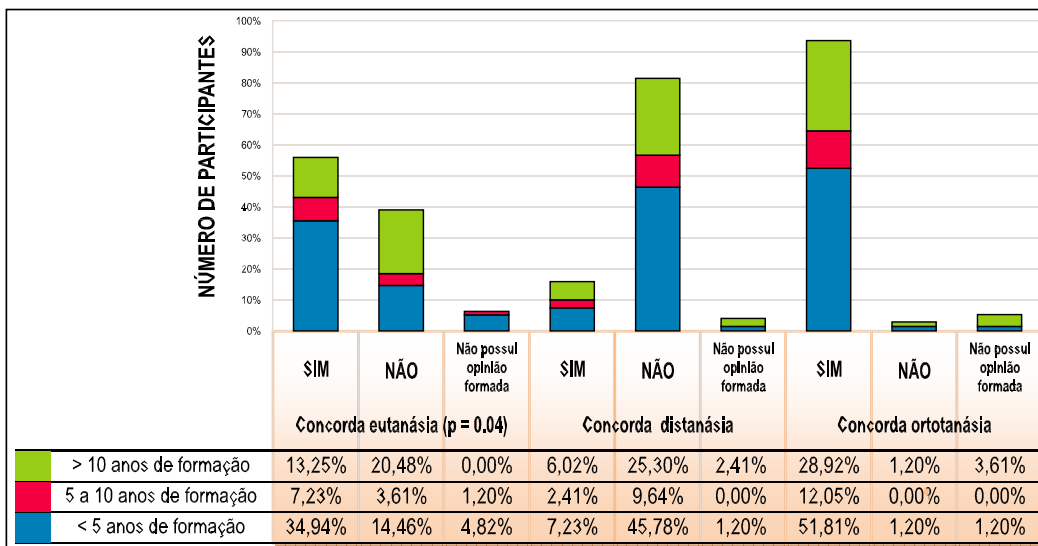
As to agreement regarding the three non-maleficence along an individual's terms, most part of the sample is existence. Under conditions in which the favorable to the practice of euthanasia treatment and the cure are possible, (55.4%). But, when the term is beneficence should overlap non-dysthanasia, 80.7% of the interviewees non-maleficence. In practical terms: salvation were contrary to the practice, noting actions (dialysis, mechanical ventilation, that among the evaluated concepts it is amputations, and transplants) should be the most rejected by the sample. A applied, even if they bring along some justifiable result, bearing in mind the degree of suffering. On the other hand, change in focus of medicine since the when death is inevitable, the cure is no second half of the 20th century, with the more possible and the non-maleficence backward movement of the paternalist principle should prevail. If heroic practice toward respect to autonomy, conducts are established during that whose center of attention is the sick. stage there will be only a temporary and For the latter often it is not relevant to usefulness postponement of the death extend his life time if it is at expense of event, at the cost of suffering. useless suffering. Thus, the answers by professionals who participated in the The understanding and acceptance of study seem to be in consonance with the other ethical principles may also be such trend of medicine, based on the assessed. If is to the patient to decide respect to the patient. and make an opinion on how his/her terminality will be, his/her principle of

Still, in the perspective of such change in behavior, it was verified the





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



NUMBER OF PARTICIPANTS

>10 years of training 5 to 10 years of training

<5 years of training

autonomy shall prevail. Furthermore, the principle of justice is also respected: it is understood that resources with therapeutic obstinacy shall be preserved to individuals with a favorable prognostic. As to the practice, in the evaluated population 8.4% had made euthanasia. It is a considerable figure in view of the reality of the Brazilian laws, which characterizes it as a crime. When inquired on which practices made would characterize euthanasia (in such case practiced or observed), 29 different types of answers were noticed. When organizing them, two nuclei of ideas could be identified. The first one covers answers such as: “use of medication inducing respiratory arrest”, “sedation in high doses”, “administration of a cocktail of drugs with a sedative effect and respiratory depressor”, “M1 on a large scale”, “use of M1 and M2”.

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

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

The first, direct, occurs when the main objective is the postponement of death; the second, indirect, when life is shortened, although the main objective is to promote comfort to the patient - such circumstance occurs when the medication doses used with the purpose of minimizing suffering to the patient anticipates the death, although the intent was only to reduce or suppress suffering⁹. The capacity of some analgesics and sedatives, such as morphine, providing a respiratory depressor effect is already known, when administered in high doses.

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To abolish unbearable pains and it was found that the use of drugs was the anguish, drugs like these are most common. It should be emphasized, administered in large amounts, even however, that the main intention seems not though death is considered as an to have been to alleviate pains and occa- adverse effect. Data seem to reveal that sionally cause death, but rather promote it is precisely due to the fact that it is death to secondarily cease pain, which characterized as a charitable action, with characterizes direct euthanasia.

the purpose of minimizing excruciating pain and suffering, that the practice is accepted with certain tranquility.

The other nucleus of ideas that one may withdraw from the answers to the questionnaire is well represented by these

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

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

Although the practice of double effect euthanasia is justifiable under the mentioned situations and intents, one cannot consider use of each and all a sedative and analgesic medications as exempt of ethical deceit. As seen, it is not the use of the drug that will make the action acceptable in bioethical terms, but the intention that motivates it. When analyzing the responses obtained in surveyed sample, when focused in the practice of euthanasia,

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

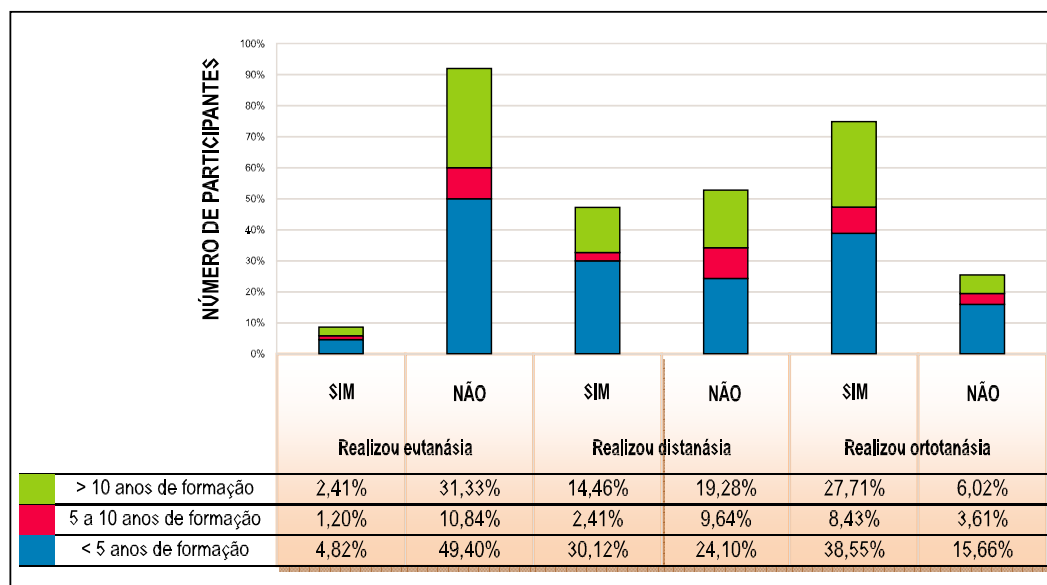
probable that it occurs from the illness ~~São~~ required the omitted artificial assistance. Otherwise, when one stops feeding and hydrating, such actions become, in alliance with basic pathology, the direct causes of death.

When questioned on dysthanasia, 47% of the interviewees affirm that they have done it already. However, of those who did it, 66.7% do not agree with its practice - number that meets the observations in the medical literature ^{23,24}. The causes for the discrepancy between acceptance/realization of dysthanasia are centered in the lack of understanding between the health team and the family; in the adequate communication of professional care-takers and in the less than professional behavior by these, according to the literature ²⁵. These are situations that make the physician to insist in the maintenance of life even when it is not anymore feasible.

Such kind of perseverance occurs due to the bad relationship between the health professional and the family, making it difficult the understanding that everything has already been done in trying to save the patient and that the best thing would be facing death with dignity and less suffering – or also derives from legal pressures, feared by the physicians. Other causes studied are also the request by the patient himself/herself and the uncertainty as to the diagnosis and prognostic ²⁴.

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

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



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

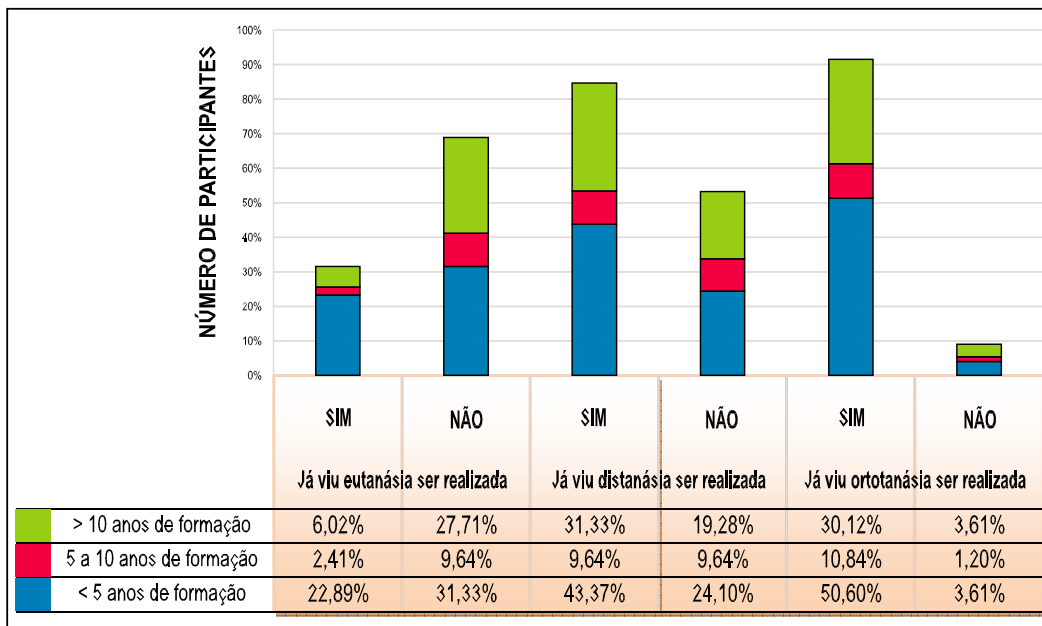


It should be emphasized that, in this case, that, being a controversial issue, no conflicts have been found between acceptance and realization, such as those discussed defensively, there is a resistance in admitting the active practice, especially of euthanasia and dysthanasia, topics discussed with a certain fear since they are not accepted by the morality existing in our society and also, in the case of euthanasia, in the legal dimension.

When questioned IF they had seen as observers (and not as agents) any of the three practices, the number of occurrences was significantly greater, which provides evidences to believe

that, being a controversial issue, discussed defensively, there is a resistance in admitting the active practice, especially of euthanasia and dysthanasia, topics discussed with a certain fear since they are not accepted by the morality existing in our society and also, in the case of euthanasia, in the legal dimension.

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



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

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

by it also did not suffer a significant alteration according to the years of profession of the participating physicians.

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

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

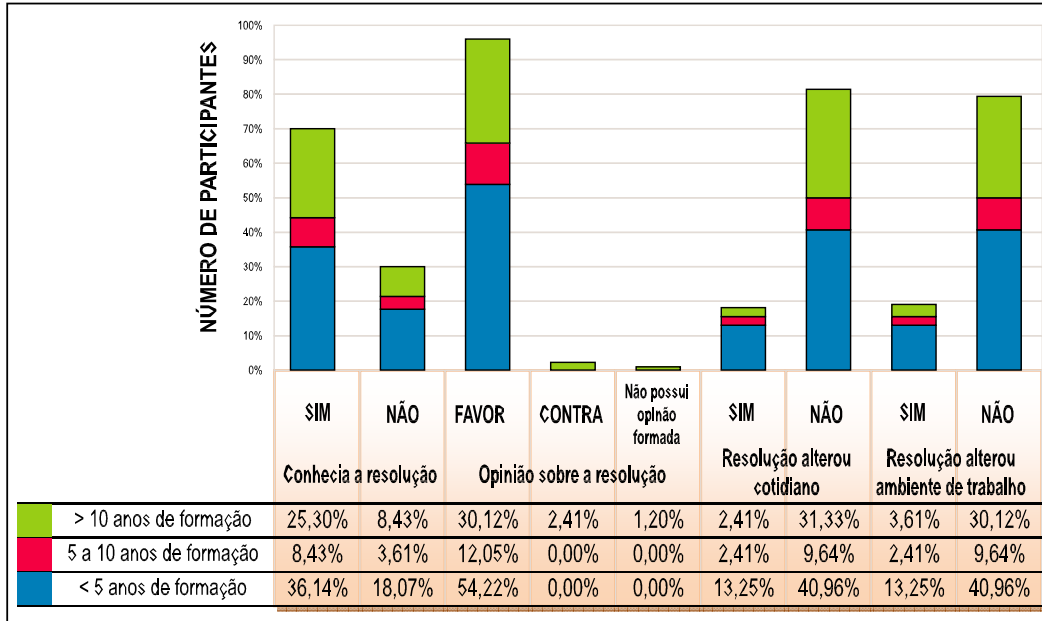
It may be noticed, then, that such results reflect the change of the focus established in medicine. With a more recent formation, it is easier for the newcomers to the profession to accept that even euthanasia may be established for the patient's wellbeing, a perspective seen with a certain preconception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

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

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

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

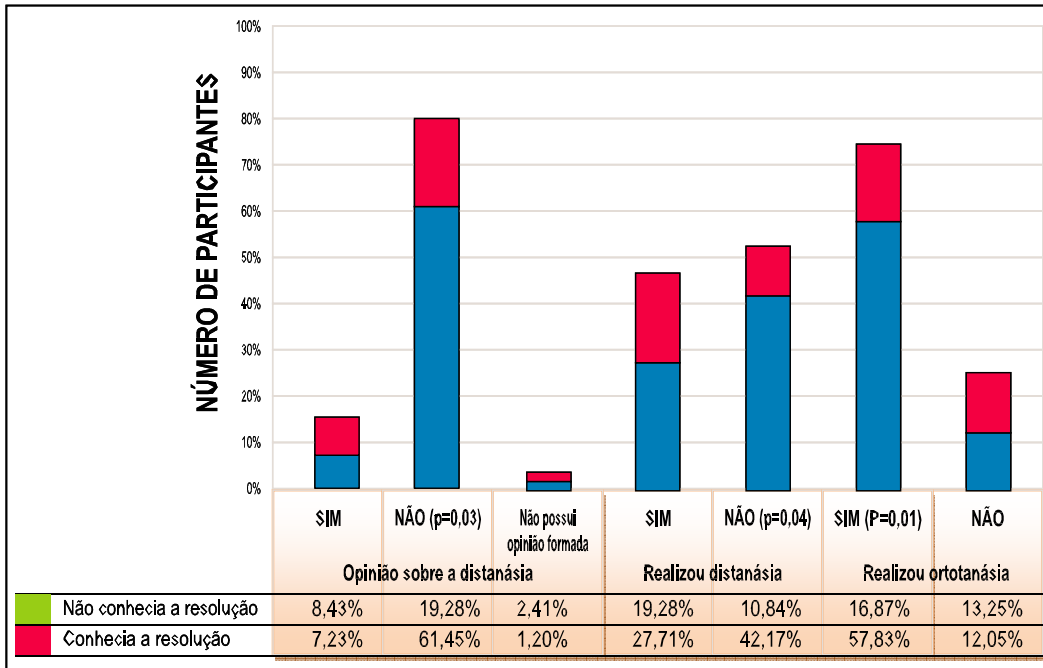
Chart 5 Aspects of Resolution CFM 1.805/06



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

Detailing the answer regarding the It stands out on behalf of the common resolution, it is ascertained that knowing practice of orthotanasia, even before it is a factor related to the non-CFM Resolution, the fact that 56% of acceptance (p=0.03) and non-realization those who did not know the document (p=0.04). That data can be interpreted already practiced orthotanasia. Such considering that the resolution is – situation may occur not only due to the although on a non-ideal way - a form of fact of being considered an ideal of good educating, of taking knowledge to the medical practice, regarding terminality of medical class. Therefore, its knowledge life, but also because that resolution was would imply being aware of said change not the pioneer in dealing with the on the focus of practices related to the subject; several previous publications end of life, which by the stimulus from that consecrate the patient’s right to bioethics started to orient the medical medical restrictive conducts or which, at praxis from the middle of the 20th least, seek to spare the patient from century. As a consequence of the being exposed to situations that were not knowledge and reflection on such desired by him/her. As examples, we process, many professionals became may cite the ‘Cartilha dos Direitos do more critic and contrary to the practice *Paciente*’²⁶, Article 15 of the 2002 Civil of dysthanasia. Finally, it was observed Code²⁷ and the Statute of the Elderly²⁸. that knowing the resolution is directly related to the practice of orthotanasia (p=0.01). Of those who knew it, 82.8% had practiced it and of those who did not know it, 56% had done it.

Chart 6 Impact of CFM Resolution 1.805/06



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

Final considerations

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

autonomy, beneficence, non-maleficence, and maintaining the principle of justice.

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

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



Due to such rather complex picture, and It can be inferred the urgent need of aware of the impossibility of postponing promoting and deepening such a discussion of such importance, entities, discussion, and also disseminating representing the society started subjects related thereto. For this reason, positioning themselves on such topics. it may be defended, with no doubt, CFM Unquestioned is the more and more trivial Resolution 1805/06, whose impact may use of the mentioned terms. It may be be felt in the medical environment and in noticed, however, that they are still the society. Knowing its contents brought unknown by an expressive part of the effective changes in the behavior of the population, and which is worse: there are professionals studied, who expressed physicians that still make confusion when themselves in the practice of their defining them. professional daily life becoming more ethical and in line with the humanitarian values.

Resumo

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

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

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

Resumen

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

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

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

References

1. Juramento de Hipócrates. Conselho Regional de Medicina do Estado de São Paulo [Internet]. 2001 [atualizado 2011; acesso 27 abril 2011]. Disponível: <http://www.cremesp.org.br/?siteAcao=Historia&esc=3>.
2. Conselho Federal de Medicina. Resolução CFM nº 1.805, de 28 de novembro de 2006. Na fase terminal de enfermidades graves e incuráveis é permitido ao médico limitar ou suspender procedimentos e tratamentos que prolonguem a vida do doente, garantindo-lhe os cuidados necessários para aliviar os sintomas que levam ao sofrimento, na perspectiva de uma assistência integral, respeitada a vontade do paciente ou de seu representante legal. Diário Oficial da União. 2006 Nov 28:seção I, p.169.
3. Cedrola JPV, Carvalho GA, Bezerra TS, Siqueira-Batista R. Asclépio, mito e medicina. Revista da Faculdade de Medicina de Teresópolis. 2003;5(supl):47.
4. Siqueira-Batista R, Schramm FR. Eutanásia: pelas veredas da morte e da autonomia. Ciênc Saúde Coletiva. 2004;9(1):31-41.
5. Hill TP. Treating the dying patient. Arch Int Med. 1995;12:1265-96.
6. Schramm FR. Morte e finitude em nossa sociedade: implicações no ensino dos cuidados paliativos. Rev Bras Cancerol. 2002;48(1):17-20.
7. Paciornik R. Dicionário médico. 2ª ed. Rio de Janeiro: Guanabara Koogan; 1975. Eutanásia; p. 244.
8. Pessini L. Distanásia: até quando investir sem agredir? Bioética [Internet]. 1996 [acesso 4 jul 2011];4(1):31-43. Disponível: http://revistabioetica.cfm.org.br/index.php/revista_bioetica/article/view/394/357.
9. Villas-Bôas ME. A ortotanásia e o direito penal brasileiro. Rev Bioética. 2008;1(16):61-83.
10. Villas-Bôas ME. A ortotanásia é legal (ou da Resolução CFM nº 1.805/06 numa visão para juristas). Evocati Revista [Internet]. 2007 [postado em 14 jan 2007; acesso 12 jan 2011];(13). Disponível: http://www.evocati.com.br/evocati/interna.wsp?tmp_page=interna&tmp_codigo=97&tmp_secao=23&tmp_topico=biodireito.
11. Brasil. Justiça Federal. Seção Judiciária do Distrito Federal. Ação civil pública nº 2007.34.00.014809-3, de 1 de dezembro de 2010. Dispõe sobre nova liminar, concedida por juiz federal, que suspende a anterior, conferindo legitimidade à Resolução CFM 1.805/06. JFDF [Internet]. 2011 [acesso 4 jul 2011]. Relator: Roberto Luis Luchi Demo. Disponível: http://www.jfdf.jus.br/destaques/14%20VÁRA_01%2012%202010.pdf.

12. Brasil. Congresso Nacional. Senado Federal. Projeto de Lei nº 6.715/09. Dispõe sobre a regulamentação da ortotanásia no Brasil. Câmara dos Deputados [Internet]. [acesso 8 mar 2011]. Disponível: <http://www.camara.gov.br/sileg/integras/827792.pdf>.
13. Gramuglia E. A ortotanásia. Revista DR!. 2010 Jan-Fev;60:42.
14. Conselho Federal de Medicina. Código de ética médica: resolução CFM nº 1.931/09. Brasília: CFM; 2009.
15. Amorim, RHP. O novo código de ética médica e o direito à morte digna. Jurisway [Internet]. 2010 [acesso 5 julho 2011]. Disponível: http://www.jurisway.org.br/v2/dhall.asp?id_dh=4521.
16. Pessini L. Distanásia: até quando prolongar a vida? 2ª ed. São Paulo: Loyola/Centro Universitário São Camilo; 2006.
17. Torreão L. Aspectos éticos na abordagem do paciente terminal em unidade de terapia intensiva pediátrica [dissertação]. São Paulo: Faculdade de Medicina da Universidade de São Paulo; 2001.
18. Reiriz AB, Scatola RP, Buffon VR. Cuidados paliativos, a terceira via entre eutanásia e distanásia: ortotanásia. Prática Hospitalar. 2006;48:77-82.
19. Pessini L. Eutanásia: por que abreviar a vida? São Paulo: Loyola/Centro Universitário São Camilo; 2004.
20. Horta MP. Eutanásia: problemas éticos da morte e do morrer. Bioética. 1999;7(1):27-34.
21. Pío XII. Discurso del santo padre Pío XII sobre las implicaciones religiosas y morales de la analgesia [Internet]. Vaticano: Libreria Editrice Vaticana; 1957 [acesso 3 julho 2011]. Disponível: http://www.vatican.va/holy_father/pius_xii/speeches/1957/documents/hf_p-xii_spe_19570224_anestesiologia_sp.html.
22. Anjos Filho RN. Anotações sobre a existência de uma excludente constitucional de antijuridicidade. Revista dos Mestrados em Direito Econômico da UFBA. 2001 jan/dez;(9):367-78.
23. Pessini L. Distanásia: algumas reflexões bioéticas a partir da realidade brasileira. Bioética. 2004; 12(1):39-60.
24. Palda VA, Bowman KW, McLean RF, Chapman MG. Futile care: do we provide it? Why? A semistructured, Canada – wide survey of intensive care unit doctors and nurses. J Crit Care. 2005;20(3):207-13.
25. Abbott KH, Sago JG, Breen CM, Abernethy AP, Tulsy JA. Families looking back: one year after discussion of withdrawal or withholding of life-sustaining support. Crit Care Med. 2001;29(1):197-201.
26. Pessini L, Barchifontaine CP. Problemas atuais de bioética. 5ª ed. São Paulo: Loyola/ Centro Universitário São Camilo; 2000. p. 417.
27. Brasil. Código Civil Brasileiro de 2002. São Paulo: Saraiva; 2002.

28. Brasil. Lei nº 10.741, de 1º de outubro de 2003. Dispõe sobre o estatuto do idoso e dá outras providências. Presidência da República [Internet]. [acesso 8 fev 2011]. Disponível: <http://www.planalto.gov.br/ccivil/LEIS/2003?L10.741.htm>.

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Authors participation in article

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



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

- 1) Euthanasia is the attitude that provides an easy and no-suffering death to the person who suffers from an incurable or very suffered illness , by reducing extended suffering, giving him/her a fast and painless death. Conceptually, it needs the practice of some action, which will result in the death.
- () Yes
() No
() Has no previous knowledge on dysthanasia
- If your previous knowledge was not correct, what did you understand by dysthanasia?
- B) Do you agree with the practice of dysthanasia?
() Yes
() No
() I have no opinion on the subject
- A) Did you have previous correct knowledge on what euthanasia was?
() Yes
() No
() Has no previous knowledge on euthanasia
- C) Have you, in your professional life, ever made dysthanasia?
() Yes
() No
- B) If your previous knowledge was not correct, what did you understand by euthanasia?
- D) Have you ever watched the practice of dysthanasia in your work environment?
() Yes
() No
- C) Do you agree with the practice of euthanasia?
() Yes
() No
() I have no opinion on the subject
- E) Have you ever heard of colleagues in the profession who have made or seen the practice of dysthanasia?
() Yes
() No
- D) Have you, in your professional life, ever made euthanasia?
() Yes
() No
- E) If you answered that you have already made euthanasia, what have you made to practice it? (do not answer if in the previous question you Said that you have never made euthanasia)
- F) Have you ever heard of colleagues in the profession who have made or seen the practice of euthanasia?
() Yes
() No
- If you answered Yes (you have already seen colleagues in the profession practicing euthanasia), which was the practice made by them that resulted in euthanasia?
- 2) Dysthanasia, known as synonym of therapeutic obstinacy, would occur when the physician uses every and all resources available to extend the life of a terminal patient. It is the opposite of euthanasia.
- B) Do you agree with the practice of dysthanasia?
() Yes
() No
() Has no previous knowledge on orthotanasia
- If your previous knowledge was not correct, what did you understand by orthotanasia?
- B) Do you agree with the practice of orthotanasia?
() Yes
() No
() Has no previous knowledge on orthotanasia
- A) Did you have previous correct knowledge on what dysthanasia was?
() Yes
() No
() Has no previous knowledge on orthotanasia
- If your previous knowledge was not correct, what did you understand by orthotanasia?
- B) Do you agree with the practice of orthotanasia?
() Yes
() No
() Has no previous knowledge on orthotanasia





- Yes
- No
- I have no opinion on the subject

C) Have you, in your professional life, ever made orthotanasia?

- Yes
- No

D) Have you ever watched the practice of orthotanasia in your work environment?

- Yes
- No

E) Have you ever heard of colleagues in the profession who have made or seen the practice of orthotanasia?

- Yes
- No

4) In November 2006, the Federal Council of Medicine published CFM Resolution 1,805/06 (DOU, Nov. 28, 2006, Section I, p. 169), establishing that in the terminal stage of serious and incurable illnesses the physician is permitted to limit or suspend procedures and treatments prolonging the life of the patient, assuring him/her the necessary care to alleviate the symptoms that

lead to suffering, in the perspective of a full assistance, by respecting the wish of the patient or of his/her legal representative. The resolution also provides the assurance to the patient or his/her representative the legal right to request a second medical opinion..

A) Were you aware of CFM's resolution?

- Yes
- No

B) What is your opinion on CFM Resolution No. 1805/06?

- In favor of
- Against

I have no opinion on the subject

C) Has Resolution CFM 1805/06 changed your working life?

- Yes
- No

D) Has Resolution CFM 1805/06 affected in any way your work environment?

- Yes
- No

