

THE RIGHT TO DIE THE END-OF-LIFE STAGE IN BRAZIL, ARGENTINA AND COLOMBIA*

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RESUMO:

Este artigo trata do direito de morrer no Brasil, na Colômbia e na Argentina, sistemas que, cada um a seu modo, asseguraram a dignidade no fim da vida por decisões judiciais. No Brasil, a ortotanásia foi garantida por uma resolução do Conselho Federal de Medicina, validada pela Justiça Federal em sentença proferida em ação civil pública com efeito *erga omnes* proposta pelo Ministério Público Federal. Na Colômbia, a Corte Constitucional assegurou o direito à eutanásia, com critérios médicos estabelecidos pelo Ministério da Saúde. Na Argentina, a Suprema Corte também assegurou o direito à ortotanásia, ainda que se tenha utilizado a expressão eutanásia para definir o fim de vida com assistência médica.

Palavras-chave: Autonomia, direito de morrer, fim de vida, eutanásia, ortotanásia, distanásia, suspensão de esforço terapêutico.

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ABSTRACT:

This article is about the *Right to Die* in Brazil, Colombia and Argentina, with judicial solution for that bioethics dilemma. In Brazil, The Federal Council of Medicine undertook the effort to regulate the suspension of therapeutic efforts (orthotanasia) as an ethical priority for the professional practice of physicians. The *Right to Die* is regulated, albeit in a restrained way, by a judicial decision judged against that resolution. This means the decision is valid in the entire national territory and has the force of a federal act. The Colombian Constitutional Court secured the right to euthanasia for patients with incurable and terminal diseases that generate intense pain, providing that this final procedure must be authorized by the patient's free, informed and unequivocal consent. The Argentinian Supreme Court ruled the right to die with dignity based on the ethical principle of autonomy or self-determination.

Keywords: Autonomy, right to die, end-of-life, euthanasia, orthotanasia, disthanasia, withdrawal medical assistance.

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1. Introduction

In *Illness as metaphor* – an essay in which Susan Sontag (1933-2004) gathered distinct cognitive and emotional perceptions that lead to diseases –, it is evident that the illness-metaphor is already another metaphor in itself: it is the metaphor of an always inopportune death, i.e. (*id est*) a *mors intempestiva*. The fact that the expression “morte tempestiva” [meaning a “timely death”] is not used in Portuguese bears witness to such metaphor. Jacques Pohier points out that the same occurred in the French language, which only kept the Latin adjective *intempestivus*, but not its opposite, *tempestivus*, in the sense of arriving at a desired time. Therefore, *mors tempestiva* would be: death arriving at the right moment, in the right measure.¹ “It happens as if as human beings, we were willing to do anything to avoid recognizing death as a normal and natural event; as if such recognition caused an exceedingly severe wound in the image we seek to cultivate of ourselves and of the human condition. This wound deeply ‘disenchants’ us”.²

If in the recent past, people avoided speaking about death, even if by metaphors, it is certain that one never spoke as much about dying as in recent decades. Not because life lost its primacy for medicine, law, philosophy and religion, but because after we set standards of human dignity based on the reflections that emerged from World War II, and introduced the concept of human rights in the universal mind frame of individual rights guarantees, postmodernity as put forward by Bioethics has allowed us to reflect seriously on

¹ POHIER, Jacques. *A morte oportuna*: o direito de cada um decidir o fim da sua vida. Tradução de Gemeniano Cascais Franco. Editorial Notícias: Lisboa, 1999, p. 11.

² *Idem*, p. 26.

death and dying.³

In spite of the philosophical controversy around the expression 'postmodernity', we consider the period of renewal and innovation of the past four decades as such. This period brought to the scene not only the opportunity, but also the need to expand the discussion on the right to life in order to include the right to a dignified death, which is also a fundamental right. We can say the foremost right postmodernity has rescued is the right to autonomy, i.e. (id est) to self-determination; the right to determine one's own dying is a mere consequence of this rescue. "The antagonism between technical and human values, which characterized medicine in the early decades of the 20th century, is disappearing. The explicit acknowledgment of the human capacity to decide about one's biological destiny started to occupy its due place in modern democratic and pluralist societies".⁴

If anyone can take a man's life – if no one can take a man's death, because all paths lead us to it ⁽⁵⁾ –, then a question must be answered: – Is there a fundamental right to immortality? If the answer is yes, then the State must create mechanisms against death. If the answer is no, then we must see death as the only certainty of human consciousness. In this case, living and dying will be instants of one and the same right: the right to *autonomy*.

The word *autonomy*, from Greek *autos* (from oneself) and *nomos* (rule, authority or law) was incorporated to biomedicine in the 1970s – we take the

³ DWORKIN, Ronald. *Justice for Hedgehogs*, Massachusetts: Harvard University Press: 2011, p. 332.

⁴ CECCHETTO, Sergio. *Curar o cuidar: Bioética en el confín de la vida humana*. Buenos Aires: Ad-Hoc, 1999, p. 93-4.

⁵ SÊNECA, *Sobre a brevidade da vida [On the shortness of life]*. Tradução, notas e introdução de William Li. Nova Alexandria: São Paulo, 1993.

Belmont Report as a reference –, meaning an empowerment to make decisions regarding biomedical issues. A person with full autonomy has the powers and guarantees of a State. In other words, he or she has self-determination.

The *Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*), issued at the *Federal Register* on April 18, 1979,⁶ results from the work of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The Commission was created in 1974 “with the aim of undertaking a full research and study to identify the basic ethical principles that should guide human experimentation in behavioral and biomedical sciences”.⁷

Tom L. Beauchamp, a member of the Commission, reported that a proposal of moral principles to be observed in biomedical research emerged during the seminar held on February 13-16, 1976 at the Smithsonian Institution’s Belmont Conference, in Maryland. Three core principles were originally put forward: respect for persons and beneficence, proposed by H. Tristram Engelhardt,⁸ and justice, proposed by Beauchamp.⁹

In the draft report of June 3, 1976 for the Commission’s 19th Meeting – held on June 11-13, 1976, the principle of respect for persons was rather

⁶ The *Belmont Report*’s first version was published in late 1978: *National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (Washington, DC: DHEW Publication OS 78-0012).

⁷ BEAUCHAMP, Tom L., CHILDRESS, James F. *Principles of Biomedical Ethics*. 7th ed. New York: Oxford University Press, 2002.

⁸ The principle of *respect for persons* emerged from the following proposal by H. Tristram Engelhardt: “*Respect for persons as free moral agents, concern to support the best interests of human subjects in research, intent to assure that the use of human subjects of experimentation will on the sum redound to the benefit of society*”.

⁹ BEAUCHAMP, Tom L. The origins and evolution of the Belmont Report. In: Childress, James F. Meslin, Eric M. and Shapiro, Harold T. (Eds.), *Belmont revisited: Ethical principles for research with human subjects*. Washington, DC: Georgetown University Press, 2005, p. 12-25.

“surprisingly” treated as principle of *autonomy*, and the new concept was approved by the Commission.¹⁰

In the search for a formula to specify the meaning of each of these principles, Michael Yesley – also member of the Commission – presented a schema of individual guidelines in which the principle of *respect for persons* applied to guidelines of informed consent; the principle of *beneficence* applied to the guidelines of risk-benefit assessment; and the principle of *justice* applied to the guidelines of selection of subjects.¹¹

As a guideline for informed consent, the principle of *respect to persons* was not originally conceived as an instrument of protection against risks, but as a guarantee of *autonomy and personal dignity*. As such, it was meant to include the dignity of individuals incapable of making autonomous decisions, which needed the informed consent of legal representatives.

As we know nowadays, the Belmont Report not only influenced biomedical research relations, but also had an impact on the relations between health professionals and patients. These relations had been previously built based on a paternalistic model and were affected not only by the *principle of autonomy*, but also by all other principles (beneficence and justice), including the *non-maleficence* principle (*primus non nocere; first, do no harm*), which was incorporated to the other principles by the influence of Beauchamp and Childress’ book, *Principles of Biomedical Ethics*, written simultaneously with the Commission’s work.

The *principle of autonomy* had a direct effect on the previous physician-

¹⁰ BEAUCHAMP, Tom L., *idem*.

¹¹ BEAUCHAMP, Tom L., *ibidem*.

patient relations, which were built based on a paternalistic model. In Brazil, this transformation is not yet fully consolidated, but a rapid substitution of paternalism for free and informed consent is in full course.

One speaks nowadays of *empowerment health*; in other words, one speaks of the patient who conquered the power to make decisions in regard to his or her health and life. Thus, a passive subject has become a holder of a right. On their turn, from active subjects, physicians have become holders of an obligation. Physicians have thus ceased to be fully sovereign to make clinical decisions and became counselors of a frank dialogue with their patients.

Brazil's legislation recognizes respect for patient's autonomy, for instance, in article 15 of the Civil Code: "No person can be forced to submit to medical treatment or surgical intervention in case of life threat".¹²

According to the Constitution, this article must be read in the following way: No person – not even in case of life threat – will be forced to undergo a treatment or surgical intervention, in respect for his or her autonomy.

Autonomy does not dismiss a person's capacity to express it. There are situations in which a patient becomes incapable of making instant decisions, e.g. in states of unconsciousness in general, which justify resorting to *living wills* and *advance directives* as instruments to express a future wish, a prospective autonomy, with one's refusal or acceptance of general medical treatments.

These *living wills* – a term that does not meet with widespread acceptance among strict advocates of the Roman Civil-Law tradition – are used in cases of terminal care, whereas *advance directives* are used in cases of

¹² BRASIL, Código Civil (Civil Code). Lei nº 10.406, de 10 de Janeiro de 2002.

medical treatments in general, when a recovery is expected. Thus, both terms are contiguous and it is not necessary to distinguish among them.¹³ We adopt *advance directives*, which can materialize in at least four different ways: by written public notice at a registry office; by written statement in private document, at best with notarized signature; by declaring to one's assistant physician, with a written report on the medical record and the patient's signature; or, if the patient is incapable, with two witnesses. In any case, a personal attorney can be appointed to make decisions not provided for in the directives. The Civil Code also allows appointing a curator for an ailing person:

Article 1,780. At request of the ill or physically disabled person, or if none of the persons mentioned by article 1,768 are capable of doing so, a curator can be assigned to manage his or her dealings or property as a whole or in part.

The fourth alternative relates to the patient who did not anticipate directives but declared to friends and relatives his or her rejection to therapeutic efforts in cases of permanent vegetative state or terminal disease: it is the testimonial justification of this will. However, this option demands long judicial processes, as in the *Karen Quinlan*, *Nancy Cruzan* and *Terri Schiavo* cases. As a matter of fact, in the *Terri Schiavo* case, a point of emphasis regarded the supremacy of the *right to live*, whereas the case actually indicated the need to debate *the right to die*, i.e. (id est) the autonomous right to deliberate about the time and place of one's own death. Similar processes are already in course in Brazil.

The right to live does not antagonize the right to die, but includes, in

¹³ GONZÁLES, Miguel Angel Sanchez. Um novo testamento: testamentos vitais e diretivas antecipadas. In: Bastos EF, Sousa AH, coordenadores. *Família e jurisdição*. Belo Horizonte: Del Rey, 2005.

truth, two dimensions of one single right. “All interest in disease and death is only another expression of interest in life” (Thomas Mann, *The Magic Mountain*).

The right to live has actually been considered by the Catholic Church in the *Declaration on Euthanasia*: “(...) some people speak of a ‘right to die’, which is an expression that does not mean the right to procure death either by one's own hand or by means of someone else, as one pleases, but rather the right to die peacefully with human and Christian dignity”.¹⁴

Also in the *Declaration on Euthanasia*, Pope John Paul II affirmed:

When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the physician has no reason to reproach himself with failing to help the person in danger.¹⁵

However, the permissibility of refusing extraordinary treatment measures was already mentioned in the speeches of Pope Pius XII since February 24, 1957:

Natural reason and Christian morality say that man (...) has the right and the duty, in case of grave illness, to take the measures necessary to conserve life and health. (...) But usually the obligation is limited to the use of ordinary means (according to the circumstances of person, place, era and culture), that is to say, means which impose no extraordinary burden on either oneself or another. A more severe obligation would be too heavy for most men, and would render the acquisition of more important higher goods too difficult. Life, health, all temporal activity, are, after all, subordinate to spiritual ends.¹⁶

Brazil's legal system guarantees the right to live and, within its apparent

¹⁴ VATICANO, Sagrada Congregação para a Doutrina da Fé, *Declaração sobre a Eutanásia*, 5 Maio de 1980.

¹⁵ VATICANO, Sagrada Congregação para a Doutrina da Fé, *Declaração sobre a Eutanásia*, 5 Maio de 1980.

¹⁶ PAPA PIO XII. Allocuzione del 24/02/1957. *Acta Apostolicae Sedis* 1957; 49:147.

contradiction, does not formally recognize the right to die. As a consequence of this fact, juridical doctrine has mistakenly stated that such a right does not exist. Living life autonomously is a “potestative” right, which can be exercised without the acquiescence of others; no one needs another person’s license to live his or her own life.

This reasoning does not preclude a reassessment of the right to live, which, as a “potestative” right, can only be renounced by its holder. If it could not be renounced, it would not be a right but a duty: the duty to live. As a duty to live, it would have different juridical consequences *vis-à-vis* the presently known consequences, ranging from punishment of suicide attempts to the prohibition of radical sports and risky activities in general. This could lead to a mechanization of life beyond life, with the imposition of unhuman and degrading treatments to ill persons, known as dysthanasia or therapeutic obstinacy.

2. The (absence of) individual freedom in the “Ancient City”

The notion of individual liberty was not a result of the ancient State. Fustel de Coulanges (1830-1889) (*The Ancient City: A Study on the Religion, Laws, and Institutions of Greece and Rome*. 1874 edition) pointed out that religion – which stood at the origin of the State – and the State – which, on its turn, sustained religion – supported each other mutually and formed one single body. These two interlinked powers constituted a superhuman force that subdued both body and soul. It is a basic mistake to believe that man in the *Ancient City* was free. Man did not even have a slight conception of freedom and did not judge himself capable of holding rights before the city and its gods.

And even with the change in the system of government, from monarchy to aristocracy and to democracy, man had not yet attained true freedom, that is, individual freedom. Nothing in man was independent. His body belonged to the State and was meant to defend it. In the *Ancient City*, man never stopped being a slave of the State.

In such historical context, death was demarcated by the supreme hand of the State, which neither accepted interferences in its resolves, nor recognized the right to die. In Greece, for instance, “an individual could not kill himself without the community’s previous consent, given that suicide was a blow against the community structure. Suicide was politically or judicially condemned. Customary burial practices were denied to an individual who committed clandestine suicide, while one’s hand was amputated from the corpse and buried apart. On its turn, the State had the power to disallow or authorize a suicide, as well as to induce it. Socrates, for instance, was forced to ingest poison in 399 (b.C.)”.¹⁷

Christianity replaced ancient politics and introduced the notion, inherited from Judaism, of life as a sacred gift received from God, and did not recognize an individual’s right to decide about his or her own death, as living and dying only depended on God. Thus, “Christianity’s emphasis on life’s sanctity is part of the Hebrew heritage. Christianity ascribed immortality to the human person, whose life’s singularity on Earth starts precisely at birth”.¹⁸

¹⁷ SILVA, Marcimedes Martins da. *Suicídio – Trama da comunicação*. Dissertação de Mestrado, 1992, Psicologia Social, PUC-SP. (On line). Available from: <http://www.avesso.net/suicidio.htm>. Accessed 8 June 2015.

¹⁸ SILVA, Mário Tavares da. *Eutanásia: alguns aspectos morais*, Lisboa: AAFDL, 2011, p. 62-3.

For Canon Law, we are not owners but trustees of the life God has bestowed on us; thus, we cannot dispose of it. In this line of reasoning, the Council of Arles (452) established suicide as the most serious of all sins. The Council of Orléans (533) forbade religious funeral for suicides. The Council of Braga (561) established the absence of funeral rites. The Council of Toledo (693) ruled on excommunication in case of failed suicide attempts. The Decree of Gratien (1140) prohibited obsequies and burial in ecclesiastic cemeteries. The Synod of Nîmes (1248) reinforced restrictions for funerals of suicidal individuals.¹⁹

Based on these foundations, Saint Thomas Aquinas (1225–1274) followed the footsteps of Saint Augustine at the Synod of Nîmes (1248) and reaffirmed that a suicidal – even a furious madman – would not be buried in Christian lands. In the 20th century, on its turn, the issue was categorized in the Code of Canon Law by Pope Benedict XV in 1918 and suicidal individuals were punished with the denial of obsequies and ecclesiastic graves (*Canon, 1240*), which is still observed in the Jewish religion. However, the Catholic ban was revoked by the 1983 Code of Canon Law (*Canon 1183 to 1185*), edited by Pope John Paul II.

In Brazil, as in most countries with a Catholic tradition, helping another person commit suicide is a crime punishable with a sentence of 2 to 6 years of prison. Depending on the victim's reason, age and resistance capacity, it is a qualified crime with a sentence of 4 to 12 years. There is not a juridical category of physician-assisted suicide.

¹⁹ DURKHEIM, Emile. *O suicídio: estudo sociológico*. Tradução de Luz Cary, Margarida Garrido e J. Vasconcelos Esteves, 2ed. Lisboa: Editorial Presença/Martins Fontes, 1977.

The Brazilian legislation does not include the category of *homicide at the victim's request*, as in the cases of Germany and Portugal, which are two paradigmatic systems for Brazil. In both countries, homicide at the victim's request is punished by a symbolic penalty if compared to traditional suicide. In Portugal, a person who kills after a serious, instant and express request of the victim is punished with a sentence of 1 month to 3 years (CP, article 134) while qualified homicide can result in 25 years of prison (CP, articles 131 and 132). In Germany, a person who kills at the victim's request is punished with 6 months to 5 years of prison (StGB, paragraphs 211 and 216), whereas qualified homicide can be punished with life imprisonment.

Therefore, rejection to the right to decide about one's own death is based on religious values, and also on the State view of ancient civilization. Christianity removed the State's supremacy over man and propagated the separation between State and religion. Christ himself taught that his kingdom was not from this world and added: "Render unto Caesar the things that are Caesar's, and unto God the things that are God's". Traditionally cited as a symbol of distributive justice, this expression was actually uttered in another context. Caesar was still the supreme pontiff, the chief and the leading institution of Roman religion, the guardian and interpreter of beliefs who held cult and dogma in his hands. With these words, Christ broke through the previous alliance that linked earthly and divine realms, proclaiming that religion was no longer the State, and that obedience to Caesar was no longer the same thing as obedience to God.²⁰

²⁰ COULANGES, Fustel de. *A Cidade Antiga*. Estudo sobre o culto, o direito, as instituições da Grécia e de Roma (1864). Tradução de Jonas Camargo Leite e Eduardo Fonseca. São Paulo: Hemus, RVMD, Brasília, V. 9, nº 1, p. 01-20, Jan-Jun, 2015

Even if for Judaism and Christianity, only God can decide on death and dying, secular States certainly cannot adopt religious positions to limit individual freedom. Yet, these are the issues that reach our days and stand at the basis of the universal discussions regarding the right to die and the ways of exercising and expressing it.

3. History of Resolution CFM 1,805/2006

In Brazil, the end-of-life issue has appeared in several act projects both at the House of Representatives and at the Senate. So far, technical inaccuracies and *confusio linguarum* have prevented us from reaching a humanized solution for the end-of-life issue.

As a contradiction, it is necessary to point out that approximately 56 thousand persons are killed in Brazil each year and that no effective policies have been implemented to tackle this “Vietnam War” of our days.

In such context, the Federal Council of Medicine undertook the effort to regulate the suspension of therapeutic efforts (orthotanasia) as an ethical priority for the professional practice of physicians, and issued Resolution CFM 1,805/2006 on November 6, 2006:

DECIDES:

Article 1. A physician is allowed to restrict or suspend procedures and treatments that prolong the life of an ill person in the terminal stage of a serious and incurable disease, provided that the physician is respecting the will of the patient or his/her legal representative.

Article 2. The ill person will continue receiving all necessary care in order to alleviate the symptoms that produce suffering. The provision of comprehensive care will be secured, along with physical, psychic, social and spiritual comfort, including the right to discharge.

According to this resolution, a physician is allowed to restrict or suspend procedures and treatments that may prolong a patient's life at the terminal stage of serious and incurable diseases, while securing the necessary care to alleviate the symptoms that produce suffering, from the perspective of comprehensive care, provided that the physician is respecting the will of the patient or of his/her legal representative.

This resolution was the result of a long process that lasted over 2 years, starting with the public presentation of the project and leading to a series of conferences that included professionals of several areas, among them medicine, philosophy and law in the final week of August 2006. The resolution was issued on November 28, 2006.

4. The civil suit of the Federal Prosecutor's Office

On May 9, 2007, the Federal District's Regional Prosecutor for Citizen Rights filed a public suit against the Federal Council of Medicine and requested the resolution's abrogation. On October 23, 2007, the 14th Federal Court of the Federal District granted a preliminary injunction to suspend the effects of Resolution CFM 1,805/2006.

The public suit was dealt with according to the regular procedures. At the end, the federal Public Prosecutor's Office, represented by another Public Prosecutor, concluded that its proposal was mistaken and that:

- 1) The Federal Council of Medicine had the competence to issue Resolution CFM 1,805/2006, which does not regard criminal law, but, instead, medical ethics and disciplinary consequences in case of non-compliance;
- 2) Orthotanasia is not a homicide when interpreted in the light of the Criminal Code under the Federal Constitution;
- 3) Resolution CFM 1,805/2006 did not determine any significant modification in the daily routine of physicians assisting terminal patients; therefore, it did

not lead to any harmful effect described in the public suit;

4) Resolution CFM 1,805/2006 encourages physicians to describe adopted and not adopted procedures with precision in relation to terminal patients, to increase transparency regarding procedures and the possibility of further control of medical activities.

On December 1st, 2010, the same Federal Judge of the 14th Court rejected the civil suit and revoked the preliminary injunction.

The sentence was judged. Resolution 1,805/2006 is now in effect and led to a unique situation in the world: the right to a dignified death, orthotanasia or suspension of therapeutic efforts was recognized in our juridical system by a federal judge's sentence with an *erga omnes* effect. This means the decision is valid in the entire national territory and has the force of a federal act approved by the National Congress (House of Representatives and Senate).

Differently from paradigmatic decisions of the US Supreme Court – or of Italy's Supreme Court of Cassation in the Eluana Englaro case, which only benefitted persons mentioned in their relatives' requests –, the Brazilian decision accepted and protected a right for all Brazilian citizens who request the right not to undergo therapeutic efforts.

The new Code of Medical Ethics, which is also a resolution of the Council and entered into effect in 2010, repeated the same orientation:

A physician is forbidden to:

Article 41. Abbreviate a patient's life, even at the request of the patient or his / her legal representative.

Single paragraph. In cases of incurable and terminal diseases, the physician must provide all available palliative care without trying useless or obstinate diagnostic or therapeutic actions. Physicians must always consider the patient's express will or, in cases of patient's inability, the will of his/her legal representative.

5. Advance directives

The same process repeated itself when the Federal Council of Medicine approved Resolution CFM 1,995/12, which institutes advance directives. Advance directives are defined as the patient's previously expressed wish regarding the provision of care and treatments he or she wants or not to receive in case of becoming incapable of freely and autonomously expressing one's will.

Article 1. Defines advance directives as the set of wishes previously and expressly manifested by the patient regarding the provision of care and treatment he or she wishes or not to receive in case of becoming incapable of freely and autonomously expressing his or her will.

Article 2. When deciding about the type of care and treatment for a patient incapable of communicating or expressing his or her will in a free and independent way, the physician shall consider the patient's advance directives.

Paragraph 1. If the patient has appointed a representative to this end, his or her information will be considered by the physician.

Paragraph 2. The physician will not consider advance directives of a patient's or legal representative's wish if they disagree, in the physician's evaluation, with the Code of Medical Ethics' precepts.

Paragraph 3. A patient's advance directives will prevail over any other non-medical opinion, including the wishes of relatives.

Paragraph 4. The physician will report in the medical record in case of advance directives directly communicated by the patient to him or her.

Paragraph 5. If the advance directives of a patient's wish are not known, if no representative has been assigned and no relatives are available, or in case of lack of consensus among relatives, the physician will resort to the Bioethics Committee of the institution, or, in its absence, to the hospital's Commission of Medical Ethics, or to the Regional and Federal Council of Medicine, to substantiate his or her decision regarding ethical conflicts, whenever he or she evaluates that such measure is necessary and convenient.

The Federal Public Prosecutor's Office presented a new public suit challenging Resolution CFM 1,995/2012. Again, the Judiciary ruled that this regulation does not contain any illegal or unconstitutional aspect. The decision now has an *erga omnes* effect.

6. FINAL REMARKS

Brazil is not the only country where the *Right to Die* is regulated, albeit in a restrained way, by a judicial decision. In Colombia, the first legally

authorized euthanasia took place on July 3, 2015 after a Constitutional Court decision with *erga omnes* effect.

In Canada the Supreme Court recently struck down a ban on helping patients to die; its ruling will take effect next year.

In Argentina, Supreme Court allowed doctors to withdraw the patient life-sustaining treatment on July 7, 2015. The right to refuse treatment applies equally to withholding therapy that might be offered, such as cardiopulmonary resuscitation, and to withdrawing therapy that is already underway, such as artificial hydration, nutrition, and ventilation.

The Argentinian Supreme Court ruled the right to die with dignity based on the ethical principle of autonomy or self-determination. The patient has the right to choose, including where the deathbed will be placed, and to be left alone with family at that time. The Argentinian patient died from “natural causes”, just four hours after de judicial decision.

But was in Colombia, the first Colombian patient and, also, the first Latin American citizen to have the right to euthanasia.

The first sentence of Colombia’s Constitutional Court (C-239, of 1997) held that the fundamental right to live with dignity also implies the fundamental right to die with dignity. On December 15, 2014, the Constitutional Court secured the right to euthanasia for patients with incurable and terminal diseases that generate intense pain, providing that this final procedure must be authorized by the patient’s free, informed and unequivocal consent.

The Colombia’s Constitutional Court determined that the Ministry of Health should regulate this right while observing the following criteria:

Prevalence of patient's autonomy: subjects responsible for securing the right to euthanasia must analyze the cases considering always the patient's wish. Only in objective and impartial situations can it be possible to contradict a patient's expressed wish.

Swiftness: the right to die with dignity cannot be temporarily suspended, thus imposing excessive anguish to the patient. This right must be swift, quick and without excessive ritualism that could set the patient apart from enjoying this right.

Opportunity: in connection with swiftness, opportunity implies that the patient's wish must be immediately fulfilled without excessive prolongation of suffering, to the point of allowing death with the pain one intended to avoid.

Impartiality: Health professionals must be neutral when applying procedures aimed at fulfilling the right to dignified death. They cannot impose their personal views in terms of ethical, moral or religious contents as an attempt to deny this right. A physician who claims a consciousness objection in connection with these values is not obliged to implement euthanasia, but must appoint another professional to take it to effect.

On April 20, 2015, Resolution 1216/2015 of the Ministry of Health and Social Welfare regulated the right to die with dignity. The right was formally secured to a patient with advanced cancer of the throat, who died on July 3, 2015, and became a relevant step so that other countries and, particularly, Brazil, may also secure the right to a dignified death.