

## Bioethical principles

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Biomedical ethics (or bioethics), which emerged in the late 1960s, is, according to the definition from Giovanni Berlinguer, “a philosophical discipline that connects science, life, and morality.”

According to Mark Segre, bioethics is “the part of Ethics, the branch of philosophy, which focuses on the issues of human life (and, therefore, of health). Bioethics, which considers life, also deals with death (which is inherent to life).”

In 1979, Tom Beauchamp and James Childress were the first to present the four principles of biomedical ethics: Beneficence, non-maleficence, autonomy, and justice.

Autonomy is the only biomedical ethics principle that is not included in the Hippocratic Oath, written in the fifth century BC.

All principles are equally important, and there is no hierarchy between them.

The Principle of Beneficence leads us to try to maximize benefits and minimize risks and/or harm to patients.

The Hippocratic Oath states, “I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice,” and also “Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice...”

The Brazilian Code of Medical Ethics includes Chapter V - Relations with Patients and Families, which states that the physician shall not: Article 32: Fail to use all available means of diagnosis and treatment that are scientifically recognized and in his or her power in favor of the patient.

The Principle of Non-Maleficence leads us to seek to minimize the risk and/or harm to the patient, as in the Hippocratic axiom “*Primum non nocere*.”

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I will keep them from harm and injustice,” and also “Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice...”

The Brazilian Code of Medical Ethics includes Chapter III - Professional Responsibility, which states that the physician shall not: Article 1: Cause harm to the patient by act or by omission in any way that may be characterized as incompetence, recklessness, or negligence. Paragraph 1: The physician’s responsibility is always personal and cannot be presumed.

The Principle of Autonomy teaches us that, excluding life-threatening situations, it is up to the patient to decide on which diagnostic and therapeutic practices they want to undergo.

Autonomy is an individual’s ability to manage his or her life, and to rely on his or her own means, will, and principles. It is only not relevant, other than the risk of death, if the patient is unable to decide for himself/herself, be it because of a lack of understanding of the problem, an inability to evaluate it properly, or an inability to decide.

We must keep in mind that, although parents are responsible for their children, they are not their owners. Children and adolescents have their own wills and personalities and are therefore entitled to varying degrees of autonomy.

The ability of children and adolescents to face problems are diverse and subjective. This ability varies with maturity and level of understanding. Some children may have greater maturity and understanding than others who are chronologically older. Children and adolescents must have the right to autonomy within the limits of their discernment. The evaluation of the pediatric patient’s sense of judgment is always subjective and may therefore be unfair.

In the physician’s decision-making process when providing care, there are varying degrees of involvement depending on the type of patient.

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In emergency care for a patient in cardiac arrest, the degree of patient involvement is low, and the doctor decides what to do without worrying about getting permission from the patient or legal representative.

When a physician is treating someone who is otherwise healthy and in possession of his or her mental faculties, patient involvement is moderate and the patient has the right to decide on the diagnostic and therapeutic practices, provided there is no risk of death.

When a physician is caring for a terminally patient, patient involvement is high and the patient's will must prevail.

### **In the Brazilian code of medical ethics:**

Chapter I - Fundamental Principles - XXI - In the physician's decision-making process, which is in accordance with his/her conscience and with legal provisions, the physician shall accept their patients' wishes regarding diagnostic and therapeutic procedures, provided that they are appropriate for the case and scientifically recognized.

Chapter IV - Human Rights - The physician shall not: Article 22: Fail to obtain the patient's consent or the consent of the patient's legal representative after explaining the procedure to be performed, except in cases of imminent danger of death.

Chapter IV - Human Rights - The physician shall not: Article 24: Fail to guarantee the patient the right to decide freely regarding his or her person or well-being and to exercise his/her authority.

Chapter IV - Human Rights - The physician shall not: Article 26: Fail to respect the will of any person considered physically and mentally capable who is on a hunger strike, or to force feed this person, and should inform the person about the potential complications of prolonged fasting and treat the person in case of imminent risk of death.

Chapter V - Relations with patients and families - The physician shall not: Article 31: Disregard the right of the patient or of the patient's legal representative to decide freely regarding the implementation of diagnostic or therapeutic practices, except in case of imminent risk of death.

Chapter V - Relations with patients and families - The physician shall not: Article 34: Fail to inform the patient of the diagnosis, prognosis, risks and goals of the treatment unless direct communication may cause harm, in which case the information must be communicated to the patient's legal representative.

Chapter IX - Professional Confidentiality - The physician shall not: Article 74: Break professional confidentiality involving minors, including providing information to parents or legal guardians, provided that the minor has the ability to make decisions and except in cases in which non-disclosure may cause harm to the patient.

Chapter XII - Education and Medical Research - The physician shall not: Article 101: Fail to obtain informed consent from the patient or the patient's legal representative

for research involving human subjects after the necessary explanations about the nature and consequences of the research. Paragraph 1: In cases in which the research subject is a minor, both consent from the patient's legal guardian and informed consent to the extent of the subject's understanding are required.

### **There is concern over the autonomy of the physician:**

Chapter I - Fundamental Principles - VII - The physician shall exercise his/her profession with autonomy and is not required to provide services that go against his/her conscience or to those who they do not wish to treat, except in the case of absence of another physician in an urgent situation or an emergency or when the physician's refusal may harm the patient's health.

Chapter II - Physicians' Rights - It is the physician's right: IV - To refuse to exercise his/her profession in a public or private institution in which working conditions are not adequate or may harm his/her health, the health of the patient, or the health of other professionals. In this case, the physician shall immediately communicate his or her decision to the ethics committee and the Regional Medical Board.

Chapter II - Physicians' Rights - It is the physician's right: IX - To refuse to perform medical acts which, although permitted by law, go against his or her conscience.

Chapter V - Relations with Patients and Families - The physician shall not: Article 36: Abandon any patient under his or her care. §1º - If events occur that, in the physician's opinion, hinder the physician's ability to have a good relationship with the patient or to fully perform his/her professional duties, the physician has the right to deny care, provided that he/she first notifies the patient or legal representative, ensures the continuity of care, and provides all of the necessary information to the physician who assumes responsibility. §2º - With the exception of cases of just cause, once the physician has communicated with the patient or the patient's family, the physician shall not abandon the patient because he/she has a chronic or incurable disease, but shall continue to assist this patient, even if it is to provide palliative care.

The Principle of Justice is the duty to act fairly, to offer more to those who have less and less to those who have more. We should treat unequals unequally.

The Hippocratic Oath states, "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself."

### **In the Brazilian code of medical ethics:**

Chapter III - Professional Responsibility - states that the physician shall not: Article 20: Allow personal interests, political interests, religious beliefs, or any other creed, nor the interests of the physician's employer, supervisor, or public or private institution financing the care in question to interfere in the

physician's choice of the best means of prevention, diagnosis, or treatment that is available and scientifically recognized as being the interest of health the patient or of the society.

Chapter XII - Education and Medical Research - The physician shall not: Article 99. Participate in any kind of experimentation involving human subjects for military purposes, political purposes, ethnic purposes, eugenic purposes, or any other purposes that threaten human dignity.

### **This brings us to the concepts of euthanasia, orthothanasia, and dysthanasia:**

Euthanasia is the practice in which the life of an incurably ill patient is shortened. It is prohibited by Brazilian law and by the Brazilian Code of Medical Ethics.

Orthothanasia is the decision not to artificially prolong the death process beyond what would be the natural process. It is addressed in the Brazilian Code of Medical Ethics.

Dysthanasia is the artificial prolongation of the death process in a way that causes patient suffering, even if the current medical knowledge does not offer the possibility of a cure or improvement to the patient. It is unacceptable therapeutic obstinacy because it is not in the interest of the patient.

Although it is difficult to deal with death (even among physicians and other health care professionals), we must understand that it is an inherent part of life, and we need to be prepared to deal with the inevitable death of a patient in such a way that respects the patient's dignity and avoids unnecessary suffering.

In our daily practice, we are confronted with a number of intensive care beds occupied by patients without the possibility of receiving a cure or improving, or by patients who should be in palliative care units but who take up highly valuable space that could be better used by patients with the potential for recovery.

It is important for us to recognize that, often, the most important thing is to give our patients the possibility of a dignified death. As the psychiatrist Elisabeth Kübler-Ross said, "Dying with dignity is to die with my values, surrounded by the people I love." This can certainly not be achieved in an intensive care unit, where death is lonely and impersonal.

Dr. Daniel Callahan, philosopher and biomedical ethicist, suggests that death be integrated into medical purposes as the final outcome of health care, and should not be considered a failure of medical acts. In a 1977 document, the World Health Organization said that "Inevitably, each human life reaches its end. To ensure that this occurs in a way

that is dignified, caring, and as painless as possible, deserves as much priority as any other."

When we are dealing with a severely ill patient, we may find ourselves in one of two situations. The first is when there is a possibility of recovery, and the second when death is inevitable.

When there is a possibility of the patient's recovery, we must put beneficence above non-maleficence. The preservation of life is more important than the relief of suffering. Therapeutic obstinacy is justified.

When the opposite situation is expected and death proves inevitable, we must give priority to non-maleficence and to the relief of suffering (orthothanasia), thus setting beneficence and the preservation aside. Therapeutic obstinacy becomes unacceptable (dysthanasia).

We must make these decisions while respecting the autonomy of the patient and always trying to act with justice.

The Brazilian Code of Medical Ethics supports this in Chapter V - Relations with Patients and Families, which states that the physician shall not: Article 41: Shorten the patient's life, even at the request or his legal representative. Paragraph 1: In the case of incurable and terminal illness, the physician shall offer all palliative care available without undertaking diagnostic or therapeutic actions that are useless or obstinate, and must always take into account the wishes of the patient or, in their absence, the wishes of the patient's legal representative.

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