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RESEARCH

Health workers' feelings and perceptions about euthanasia

Amanda Aparecida Alves Silva [1], *Fernanda Kelly Mendes Pestana* [1], *Fernanda Cardoso Rocha* [2], *Bruna Roberta Meira Rios* [3], *Artur Almeida Aquino* [4], *João Fabio Gonçalves Sobrinho* [4], *Joyce Micaelle Alves* [5], *Álvaro Parrela Piris* [4]

1. Departamento de Psicologia, Faculdade de Saúde Ibituruna (Fasi), Montes Claros/MG, Brasil. **2.** Programa de Pós-Graduação Stricto Sensu em Cuidados Primários em Saúde, Universidade Estadual de Montes Claros (Unimontes), Montes Claros/MG, Brasil. **3.** Departamento de Enfermagem, Fasi, Montes Claros/MG, Brasil. **4.** Departamento de Enfermagem, Faculdades Unidas do Norte (Funorte), Montes Claros/MG, Brasil. **5.** Departamento de Enfermagem, Unimontes, Montes Claros/MG, Brasil.

Abstract

Euthanasia, which originally means "good death" or "painless death", is a practice aimed at relieving suffering and ending the pain of the terminally ill patient. This study was designed to understand Intensive Care Unit health workers' feelings and perceptions about euthanasia. This is a retrospective, descriptive and qualitative analysis research conducted with 23 workers at the University Hospital of Montes Claros/MG, Brazil, through structured interviews interpreted from content analysis. The interviewees demonstrated prior knowledge of euthanasia, and their discourses evidenced perceptions of social, moral, ethical and technical aspects. Euthanasia is a matter of great complexity, much discussed worldwide. It is necessary to explore the legalization issue, as well as the impacts of implementing such practice on the life of the sick patient, as well as for society as a whole.
Keywords: Euthanasia. Death. Palliative care. Health personnel.

Resumo

Percepção de profissionais da saúde sobre eutanásia

Em sua origem, a palavra "eutanásia" significa "boa morte" ou "morte sem dor", prática que visa aliviar o sofrimento e cessar a dor do paciente em estado terminal. Este estudo teve como objetivo compreender os sentimentos e as percepções dos profissionais que atuam em unidade de terapia intensiva sobre o tema. Trata-se de pesquisa de caráter retrospectivo, descritivo e de análise qualitativa realizada com 23 profissionais do hospital universitário de Montes Claros/MG, por meio de entrevistas estruturadas, interpretadas a partir da análise de conteúdo. Os profissionais demonstraram conhecimento prévio sobre eutanásia e evidenciaram em seus discursos percepções de aspectos sociais, morais, éticos e técnicos. A eutanásia é questão complexa, muito discutida mundialmente. Portanto, é necessário explorar a problemática de legalização, bem como os impactos dessa decisão na vida do enfermo e na sociedade como um todo.
Palavras-chave: Eutanásia. Morte. Cuidados paliativos. Pessoal de saúde.

Resumen

Percepción de la eutanasia por parte de los profesionales sanitarios

En su origen, la palabra "eutanasia" significa "buena muerte" o "muerte sin dolor", práctica que pretende aliviar el sufrimiento y poner fin al dolor del paciente terminal. Este estudio tuvo como objetivo comprender los sentimientos y percepciones de los profesionales que trabajan en la unidad de cuidados intensivos sobre el tema. Se trata de un análisis retrospectivo, descriptivo y cualitativo, realizado con 23 profesionales del Hospital Universitario Montes Claros/MG, Brasil, mediante entrevistas estructuradas interpretadas a partir del análisis de contenido. Los profesionales demostraron conocimientos previos sobre la eutanasia y mostraron en sus discursos percepciones de los aspectos sociales, morales, éticos y técnicos. La eutanasia es un tema complejo, muy discutido en todo el mundo. Por lo tanto, es necesario explorar la cuestión de la legalización, así como las repercusiones de esta decisión en la vida del paciente y de la sociedad en su conjunto.
Palabras clave: Eutanasia. Muerte. Cuidados paliativos. Personal de salud.

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The topic of euthanasia has been much discussed today, causing endless questionings in the academic and professional world and dividing opinions amongst those who have been studying the practice for a long time. This stems from its connection with one of the most delicate subjects in human perception: death [1].

The concept of euthanasia comes from the Greek "*eu"* (good) and "*thanatos"* (death) – "good death", "death without pain", "death without suffering" [2] –, and the term was used for the first time by Francis Bacon in 1623, in his book "*Historia vitae et mortis*" [3]. There are some types of euthanasia, and it is essential to distinguish them. While *natural* euthanasia refers to death without external interference, *provoked* euthanasia demands human action with the purpose of ending the patient's distress and anguish, ending his/her life directly or indirectly. In addition, provoked euthanasia is subdivided into autonomous, when the patient commits suicide, and heteronymous, when another person cooperates for the cessation of life [1].

There is also *solutive* euthanasia, which assists the patient in several aspects, such as psychological, physical and moral, without using any means to shorten life, while *resolutive* euthanasia brings the patient's death forward, at his request and with his permission and the consent of third parties. Resolutive euthanasia is further divided into three types: liberating euthanasia, which aims to end patient suffering; eugenic euthanasia, which provides painless death for deformed patients with contagious or chronic diseases, aiming to improve human nature; and economic euthanasia, which includes the mentally ill, the elderly and the disabled in order to release relatives and society from the "burden" of their care [1]. However, it is emphasized that human rights reject these forms of euthanasia, which therefore should not, under any circumstances, be used.

Euthanasia can also be characterized as *active* and *passive*. In active euthanasia, attempts are made to reduce distress with interventions that help patient death, and in passive euthanasia, treatment is given up. Passive euthanasia is further divided into direct euthanasia, which brings patient death forward, and indirect euthanasia, considered as pure euthanasia, which does not intend to advance death, only to reduce suffering [1].

Conversely, dysthanasia extends death, using technologies to prevent it, even if this brings pain. This practice can even be considered as bodily injury to the patient or illegal constraint [4]. Orthothanasia, on the other hand, differs from euthanasia in only one point: in the way that suffering is relieved. Orthothanasia suspends treatments that artificially prolong the life of the terminally ill, applying only palliative care to avoid pain [5]. Since in many cases the patient only remains alive due to these treatments, the practice of orthothanasia allows the patient to spontaneously die, without shortening or prolonging life [5].

A few countries today have already legalized euthanasia. The Netherlands was the pioneer, having passed the law that regulates it in 2001, which came into force the following year. As it is a controversial topic, after legalization there were claims and protests, but surveys indicated that a significant portion of the Dutch population (approximately 90%) accepted the practice [6]. In Belgium, euthanasia was legalized in May 2002, coming into force in the same year [6], and in 2014 the country became the first to approve this practice in children, promulgating a law that allows it without limiting age in cases of terminal illness with constant and unbearable suffering [7].

However, even without restricting patient age, Belgian law does not cover everyone, as it requires the ability to discern and ask in writing [7]. Thus, children with alterations in consciousness, without cognitive or motor skills, with intellectual deficits, who are very young, and/or newborns are not covered [7]. Even considering the heated debate involving several professional areas, a survey showed that 75% of Belgians approved the measure, although there were reservations about its possible consequences in society [8].

Also in Belgium, patients in disease stages other than terminal are allowed to request euthanasia, as long as a third doctor supports the decision, confirming the patient's condition. In addition, the case must be examined by a special committee, who will check whether all legal conditions are being met [6].

In Brazil, the Federal Council of Medicine (CFM) provides, in Resolution CFM 1.995/2012 [9], on advance directives of will (ADW), which record the patient's will and preferences in case of illness and is unable to manifest them [10]. Through this instrument, the person can communicate how he wishes to be treated in the event that he is unable to

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make decisions, especially in circumstances of death. However, the resolution does not allow euthanasia [9].

Method

This study seeks to understand the feelings and perceptions about euthanasia of intensive care unit (ICU) workers of a teaching hospital in Montes Claros, Minas Gerais, Brasil. This is a retrospective, descriptive research with a qualitative approach, whose data were collected in interviews. Health workers with theoretical training at technical and higher levels were selected for the study, including doctors, nurses, nursing technicians and physiotherapists. Those who did not wish to participate and those who were not present on the days on which the interview was conducted were excluded for various reasons, such as shift changes, vacations, sick leave and/or maternity leave.

From the main sample targeted, corresponding to the number of technical and higher-level professionals in the surveyed unit (n=36), 23 participants (63.9%) were included. The research had significant adherence and, although qualitative, was characterized by data saturation among the results obtained. The invitations and interviews were carried out in the workplace, presenting the project and the objectives and explaining the form of confidentiality used. The interviews were conducted individually in the meeting and medical report delivery room.

This study followed the precepts of Resolution 466/2012 of the National Health Council (CNS) [11]. To guarantee the confidentiality of information, the researchers took a bouquet with several types of artificial flowers at the time of the interview so that the interviewee could select one of them to be a code name. The informed consent form was signed by all participants.

A structured interview script composed of seven open questions was used to collect the information. This questionnaire was validated by a pre-test, adapting it for later administration. After collection, the data were transcribed and evaluated qualitatively using the content analysis method [12], identifying themes present in the responses and guiding their interpretation in literary bases on the proposed theme. This study can contribute to a greater understanding of intensive care workers' feelings and perceptions on the topic of euthanasia, as well as stimulating the academic community's interest in the subject.

Results and discussion

The categories of analysis developed and presented below are consistent with the pre-established objectives of this research: perception and freedom of choice; workers' understanding of euthanasia; applicability of euthanasia in the ethical and medical sphere; and moral and social aspects of euthanasia.

Perception and freedom of choice

According to Favarim [1], it is essential to analyze the suffering and anguish experienced by the terminal patient, as he has the right to die with total dignity and respect. For some, this condition is related to procedures that alleviate pain and provide some quality and comfort in the remaining life span. However, in other senses, dignity would involve choosing to die before experiencing extreme conditions, before suffering intensifies for both the family and the patient. Therefore, in the process of discussing euthanasia, one must first consider the patient's well-being, wishes, desires, feelings and opinion.

As for the patient's freedom of choice in deciding for or against euthanasia, the interviewees presented similar perceptions. One of them stresses: "*a person, to make a statement like this, that he wants to die, even more in this situation, such person is not in a healthy mental state. I do not think someone that is well would ask to have their life interrupted*" (Anthurium). Another interviewee opines: "*this is a little frustrating, because you really think about the patient, but at that moment he has no condition to decide about his life; in my opinion, he doesn't. A person who asks for this is not open to having other attempts to relieve the pain*" (Sunflower). According to the statements, it is possible to observe that the interviewees consider that, even with terminal illness and experiencing a lot of suffering, patients are not psychologically prepared to decide to shorten their own lives, even if it were allowed.

Another interviewee expresses the opposite, putting himself in favor of the patient's unrestricted right to autonomy: "*I think that if it's legal, if the*

patient and the family want it, we have to follow the patients and family's wish, if it is a legal thing, I am in favor of euthanasia. Because for me, what prevails is what the patient wants; if this is what he wants, then we will follow his will" (Orchid).

The care and concern for life so as not to harm the patient's health is noteworthy. However, his autonomy, his right to choose, to accept or not to accept certain treatments, must be respected, allowing his participation in the decision-making process and empowering him, treating him with total integrity and dignity [13]. As Meireles and Magalhães affirm, *the autonomy to die faces strong moral resistance. Life, due to the common social feeling, extremely influenced by religious morality, is taken to be an inalienable and unavailable asset* [14].

Workers' understanding of euthanasia

Euthanasia implies shortening the life of a terminally ill patient who suffers unbearable pain [15]. At first, its practice, performed by a specialist, encompassed only patients with incurable disease. Over time, it acquired a more specific sense, of promoting the death of an individual who has a disabling, incurable or terminal illness and is suffering [16]. Most interviewees in this study demonstrated knowledge and understanding of the concept of euthanasia, as can be seen:

"The concept I have is when the health worker collaborates in order to interrupt the patient's vital process in some way. It would be the most simplified, although I understand that there are several ways, several scenarios, several contexts in which this can happen" (Desert Rose).

"Concerning euthanasia, I know a little from reading, a little from what I have already discussed, I know the etymology of the word, 'eu' for good, 'thanatos', death (good death), a pleasant death" (Lisianthus).

"Euthanasia is a method in which the person consciously asks to relieve pain, so that people in the health area do something that really takes his life. In a more peaceful way, but which takes his life. And he wants to have the right to choose the time when he will die" (Sunflower).

However, two respondents were unable to address the theme or indicate its meaning. One of them stated: "*I know very little about euthanasia, because it is not a very discussed subject, within the Intensive Care Unit* (*ICU) among us, staff, so I cannot tell you what euthanasia clearly is*" (Orchid).

Another participant reported an experience in the hemodialysis unit of another hospital, who believes that it is a form of euthanasia in practice: "*The patient did not want to undergo the treatment anymore, then he said to the doctor: 'you please discharge me, I shall die at home, I don't want to come here anymore'. He didn't say 'you kill me', but he said 'doctor, you discharge me from here, don't say I don't want to do the treatment, but you discharge me because I don't want to do the treatment anymore'. Then the doctor said he could not discharge him, but the patient died because he was off treatment for six days. When he decided to come, halfway through he didn't resist. Sort of... I think this can fit, because he abandoned the treatment, he said he didn't want to do it and asked the doctor to be discharged, this was a recent case that happened in hemodialysis*" (Dahlia).

Note that the case reported by the interviewee is a form of passive euthanasia. It is emphasized that in Brazil, medical conduct in terminal cases, serious illnesses, without prognosis or incurable is still restricted, due to the complexity and the lack of position on euthanasia. However, the fact that euthanasia is not admitted does not imply denying care to the patient or letting him die in an unnecessarily painful way. There are ways to provide the patient with more comfort and pain relief, offering palliative care and waiting for the patient's life to end naturally. This practice is known as orthothanasia [4]. For some professionals, orthothanasia is the most correct option to care for and comfort the patient in this state:

"I do not believe in euthanasia, second, there are medications that relieve pain, so, not in order to prolong it, but to [give] *comfort"* (Jasmine).

"The path of palliative care is also a path of a relieved death, a good death, a death without necessarily interfering with the patient's autonomy and taking his life" (Lisianthus).

"A way to relieve, I can already quote the term orthothanasia, which would be the same thing as

palliative care and we try to promote comfort for the patient until the end of life" (Cistus).

However, there are those who consider that "*palliative care, when* [the patient] *is in suffering does not always work, so for me, death is what will totally relieve the patient's suffering*" (Orchid). Orthothanasia has been widely defended because it is not considered a way to bring death forward, but to allow it naturally, reducing suffering as much as possible. The criterion used by those who practice it is based on objective aspects, not only emotional and sentimental ones, complying with the law. Therefore, it aims to protect the integrity and dignity of the terminally ill who, due to the pain experienced, does not wish to continue to live or is unable to do so with quality. Its legitimacy and usefulness are legally recognized, and its practice is permitted in Brazil [5].

The Code of Medical Ethics, established in Resolution CFM 2.217/2018, states in its article 41 that it is forbidden for the doctor to *shorten the patient's life, even at his or his legal representative's request* [17]. However, it is noted in the sole paragraph of the same article that, in *cases of incurable and terminal illness, the doctor must offer all available palliative care without undertaking useless or obstinate diagnostic or therapeutic actions, always taking into consideration the patient's expressed will or, if impossible, that of his legal representative* [17].

It is also worth mentioning that the Federal Council of Medicine, supported by Resolution CFM 1.805/2006 [18], allows to restrict or cease procedures and treatments that extend the life of the terminally ill patient with severe and chronic illness, as long as the person's or his legal representative's will is respected. Therefore, it is clear that contradictions and disagreements around euthanasia still persist, marking a moment of normative transition in which its authorization or prohibition is discussed for various reasons and means, considering the difficulty in dealing with extremely delicate issues.

Applicability of euthanasia in the ethical and medical sphere

This category sought to identify the interviewee's view when a patient with a serious or terminal illness asks the medical team to be euthanized. In their remarks, many of the interviewees consider that it is not the duty of the doctor or anyone else to take the patient's life, even if he is in a situation of great suffering. In this sense, it was possible to relate points of view for and against punishing the professional who performed euthanasia. Opinions were compelling:

"I think that nobody has the right to shorten someone else's life. I do not judge whether anyone has done this, but I would not particularly do it; but if he does it, he has to respond to the law, ethically" (Daisy).

"I think I am against it. I think that for us to end the life cycle… I think we don't have that right, I think we have to do whatever is within my reach, regardless of what disorder it is, whether it has a prognosis or not" (Red Rose).

"I think that as soon as he connives with family members, if all family members are in favor, I think he should not be punished, indeed" (Tulip).

"I think a lot of people are dead on the ICU, while a lot of living people are dying on the street. So many people are trapped in there, without any expectation; living, not quite, suffering on a bed, and nothing is done" (Purple Evergreen).

As a result, ethical issues involving euthanasia require profound reasoning, encompassing arguments for and against it that seek to explain or justify the practice in situations such as patients that are terminally ill but conscious, or in a vegetative state without any prospect of improvement, or even children in a serious condition. Therefore, it is possible to explore that the safe discernment of human beings concerning euthanasia is extremely linked to the notion that killing is something that must be challenged and banned by society [19].

Considering the posture and position of the participants during the interviews, the researchers postulate that, despite the effort to offer an adequate environment, perhaps the interviewees felt inhibited, withdrawn or uncomfortable to express their opinions. However, one of the participants showed less inhibition when discussing the topic:

"I think we have to stop treating families that do not take good care of their relatives… Then there is confusion, where we keep treating the family to

avoid lawsuits. So there is openness to a lot, many people who could stop suffering here – were it not for the unnecessary interventions that will not improve, that will just delay suffering, they will not bring life, many people would not be suffering here today. In this case, euthanasia would not even be necessary, but today unfortunately [in] *our society, because of lawsuits, there are many opportunistic people, and we sometimes treat the family who is out of bed rather than the patient in bed… Because there are so many threats, because we are forced to treat the patient, but not the patient, the family, because there is no prognosis"* (Purple Evergreen).

Moral and social aspects of euthanasia

The practice of euthanasia is intrinsically linked to the social value attributed to human life and to the morality related to the act of killing. In the interviews, the influence of religious aspects on the response of interviewees against it was clear:

"I, as a Christian, I do not agree, even though the case is critical and, medicinally speaking, it is hopeless, I believe that God is the one who determines the time" (Gaillardia).

"No. I will make it very clear that I am a Kardecist, a Kardecist Spiritist, my religion already preaches that. Euthanasia, unfortunately, or fortunately, it has a very large religious base, and I do not believe it is the way to relieve pain" (Sunflower).

"Privately speaking, I am against it, for ethical and religious reasons. I do not believe that the interruption of life depends on us, human being" (Jasmine).

The moral position of each interviewee fluctuates according to his closeness to the belief in the principle of the sacredness of life, which impels to safeguard human life as sacred, as sanctified by God. For those who believe in this principle, human attitudes are not morally defined by themselves and their social and ecological consequences, but because of what would have been defined *a priori* as correct by God, being thus regulated heteronomously [20]. Personal values depend on each one's background, on experiences with family, school, and friends and in the course of professional practice. In some cases, the most expressive values in a subject come from beliefs previously acquired from parents and family [20].

The interviews also showed workers in favor of euthanasia and those who took a stand according to each case:

"Euthanasia could be legalized as long as it had a form of strict control by the units where it would be applied (…). *There would have to be training and specialized people to discuss this subject, with the possibility of protocol, for definitions of very specific protocols on performing euthanasia"* (Cistus).

"I think that in some cases, I think it could favor the patient, because we see a lot of suffering, because we really wouldn't need the patient to go through. (…) *I believe, in my opinion,* [that] *it varies from case to case"* (Calla Lily).

The reflection on euthanasia does not intend to approve or defend death, only to encourage society and health workers to think and admit that their loved ones or patients can experience a more peaceful death and without so much unnecessary suffering. It is necessary to admit that the sick person not only has the right to life and the best efforts to promote and restore it, but also to a good death, when dying is imminent. If accepting the request for euthanasia made by a patient that is terminally ill and suffering indescribable pain is a crime, one must reflect: Wouldn't it be equally criminal to force this patient to drag himself along a life immersed in anguish and pain [21]? Would that be the mark of our "humanity"?

Final considerations

A controversial issue that is widely discussed worldwide, euthanasia is allowed in some countries. There is great interest and curiosity on the subject on the part of patients and family members, and that is why one should continue to explore the issue. It should be noted that it is an illegal practice in Brazil, but as a hypothetical basis, this study aimed to know the opinion of intensive care unit health workers of a university hospital in Montes Claros, Minas Gerais, Brazil.

The discourse of the interviewed professionals shows divergent opinions, sometimes favorable and sometimes contrary. However, it must be borne in mind that favorable opinions may have been curbed

by the fact that the practice is considered a crime in the country. It is presumed, therefore, that if the law and religious morality that characterize society already constrain the discussion on euthanasia, especially in the work environment, one can only imagine how badly any member of the team responsible for the procedure would feel. These adverse circumstances prevent accurately knowing workers' opinion on the subject.

However, it cannot be denied that there are several perceptions and positions about the legalization of euthanasia in Brazil and worldwide. There are those who defend the regulation, considering the patient's feelings and will at the end of life; there are those who take their position according to the casuistry, which would require a thorough examination of each case; and, finally, those who value methods that help relieve pain and suffering so that death can take its natural course, without, however, allowing one person to take another's life. All of these positions point to an unequivocal truth: the discussion refers to a concern of today's society and the debate is open.

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Participation of the authors

Amanda Aparecida Alves Silva and Fernanda Kelly Mendes Pestana designed the project, collected the data and, with Bruna Roberta Meira Rios, Artur Almeida Aquino, João Fabio Gonçalves Sobrinho and Joyce Micaelle Alves, discussed the findings and wrote the manuscript. Fernanda Cardoso Rocha helped supervise the work, analyzed the results and collaborated with writing, revising and adapting the text to standards. Álvaro Parrela Piris supervised the project.

Correspondence

Fernanda Cardoso Rocha – Rua São Roberto, 55, Todos os Santos CEP 39400-121. Montes Claros/MG, Brasil.

Amanda Aparecida Alves Silva – Graduate – mandinha9.dinha@gmail.com
0000-0002-9825-2112

Fernanda Kelly Mendes Pestana – Graduate – fernanda.k15@hotmail.com
0000-0003-0697-145X

Fernanda Cardoso Rocha – Master's student – nandac.rocha@hotmail.com
0000-0001-6381-2063

Bruna Roberta Meira Rios – Graduate (specialist) – brunameirarios@gmail.com
0000-0002-7715-2921

Artur Almeida Aquino – Graduate – enfarturaquino@gmail.com
0000-0003-2196-6202

João Fabio Gonçalves Sobrinho – Graduate – joao3832@hotmail.com
0000-0003-2598-0108

Joyce Micaelle Alves – Graduate – joyce.alves25@yahoo.com.br
0000-0002-2339-3607

Álvaro Parrela Piris – Master – alvaroparrela@yahoo.com.br
0000-0002-7151-5015

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