



Human Dignity, Misthanasia, Public Health and Bioethics in Brazil

Dignidad humana, misthanasia, salud pública y bioética en Brasil



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Abstract

This paper aims to reflect on human dignity and misthanasia in the public health system in Brazil. For this, concepts, document reviews and public data about the condition of the Brazilian population's access to public health were all used. The indicators show the health inequalities in the country, with the north and northeast at a disadvantage both in terms of access to health and the number of available professionals. Thus, the most underserved population tends to continue to be excluded from society and impaired with respect to their human dignity.

Resumen

Este trabajo tiene como objetivo reflexionar sobre la dignidad humana, la salud pública y misthanasia en Brasil. Para esto se utilizaron conceptos, revisión de documentos y datos públicos sobre la condición de acceso de los brasileños a la salud pública. Los indicadores muestran desigualdades en salud en el país, con el norte y el noreste en desventaja tanto en el acceso a la atención médica cuanto en el número de profesionales disponibles. Por lo tanto, la población de los más desatendidos tiende a permanecer excluida de la sociedad y perjudicada con respecto a su dignidad humana.

Key words

Human dignity; misthanasia; public health; bioethics.

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Fechas

Recibido: 16/11/2016. Aceptado: 14/09/2017



1. Introduction

The dignity of the human being is a spiritual and moral value inherent in the person. Every human being is endowed with that amount, constituting the maximum principle of democratic rule of law.

According to the Universal Declaration of Human Rights (ONU, 1948), "all human beings are born free and equal in dignity and rights" and should not be any kind of discrimination, whether of ethnicity, gender, religion, social class, or any other. Dignity cannot be waived or alienated, so that one cannot speak on the pretense of a person to be granted dignity, since the attribute is inherent given the human condition (Sarlet, 2012). In Brazil, the Constitution of 1988 (Brasil, 1988) places, among others, dignity as a fundamental principle in its Article 1: "The Federative Republic of Brazil, formed by the indissoluble union of the states and municipalities and the Federal District, is themselves in democratic rule of law and is founded on: i

Every human being is endowed with that amount, constituting the maximum principle of democratic rule of law

- the sovereignty; ii - citizenship; iii - the dignity of the human person". With a focus on preservation and respect for human dignity, guaranteeing the right to health is indispensable, and with the same degree of importance because it is the protection of life, the most precious of human beings.

While ensuring access to healthcare is only one of beacon standards of the objectives to be achieved by the Brazilian State, it is clear that this goal is far from being reached (Memória, 27 jan. 2016). This ac state fosters social inequality and discrimination of those who are hostages of public health at the expense of those who can take advantage of private health, overlapping the private economic social interests that both interest to a neoliberal hegemonic globalization, fomenting social exclusion, thus leaving the public entities to comply with its constitutional purposes (Pecego & Lima, 2014). The recurring failures reported daily on public health, call attention the numerous premature deaths, said misthanasia, occurred due to lack of resources, neglect of the patient or lack of autonomy of this with the proposed treatments.

This article aims to conduct a reflection on the misthanasia in the Brazilian public health and concepts of human dignity. Thus, literature review was conducted on the proposed themes and researched indicators of infant mortality, access to health and quality of service in different Brazilian regions.

2. Human Dignity

The dignity of the human person and citizenship, among others, are fundamental principles of the democratic and social state of law (3), determining that the public entity to serve the people and not the other way, after all is people who have the power, which through its representatives, create and structure the state of operation at each new constitution Democratic, with fundamental individual and collective rights and guarantees that impose an action and/or state abstention (Pecego & Lima, 2014). The



elected representatives of the people have an obligation to serve him and to always worry about reaching the maximum well-being of society, respecting human and social rights provided in the Constitution.

In the words of Thomas de Aquino (1225-1274): dignity is something absolute, belonging to the essence. All nobility anything to him by reason of his being, the more perfect the way something has to be, the more valuable, noble and worthy will be. For Immanuel Kant, there are two types of values: “when something is above all price, then it has dignity”. Defining this way that being worthy cannot be acquired or bought, establishing a price, but it is something born above the matter of human nature.

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The struggle for the conquest of respect for human dignity was a constant in the fight against injustice and the search for an intrinsic foundation every human being, today, one of the principles mentioned in the judgments given by the courts and judicial chambers, in litigations involving the fundamental rights of individuals (Mendonça & Silva, 2014).

3. Misthanasia

The misthanasia is the early death of a person resulting from human evil, called active or medical malpractice misthanasia called passive misthanasia (Pessini, 02 out. 2015). This is the “short life” of many in social level, by various causes, such as poverty, violence, drugs, hunger, lack of infrastructure and minimum conditions of sanitation, education, among others (8). The misthanasia is the result of human evil, and though this evil was not premeditated, could be avoided. What we see is that, in contrast, is not given due importance in the organization and interest of the government in ensuring quality of life and health citizens, which would ensure the application of the right of human dignity (Almeida, 2010).

The structural relief omission that affects millions of patients during their lifetime and not only in the advanced stages and terminals of their diseases, as well as the absence or precariousness of health care services in specialized hospitals or clinics, makes that the dying process becomes painful and suffering that could supposedly be avoided. According Paterra (2015) should be kept in mind the millions of children suffering victims of various diseases, which is also a kind of infanticide, as the policies of the Federal Government are not aimed at solving the homeless problem, but target only minimize them (Paterra, 2015, p.5).

Among the crimes provided for in the Brazilian Penal Code, the relief omission is one. Art. 135 - “Failure to provide relief to those who will be unable to help themselves or report the public authority that the event may do so where possible” (Brasil, 31 dez, 1940). The Code of Medical Ethics, in its Chapter III, mentions that “it is forbidden to cause medical harm to the patient, by act or omission, be characterized as incompetence, recklessness or negligence”. In Chapter IV, “is sealed to the doctor treating the human



being without civility or consideration, disregarding his dignity or discriminate against him in any way or under any circumstances” (Medicina, 2009, pp.1-17).

Many of the individual needs that should be regulated by society and the State, are still incipient, not providing the necessary support and expected. Unfortunately reported about yourself daily deaths caused by lack of beds in ICUs, lack of support for the treatment of diseases in public hospitals, lack of information to the population and indifference to human. Thus there is the *misthanasia* as another condition that promotes anger, which, hopefully, mobilizing a situation improves for unattended population.

The big problem is the disregard of public power for the dignity of the human person, since it should provide not only a “dignified death”, but life with quality, well-being and health

Interpret the social reality that surrounds *misthanasia* necessarily leads to the realization that there is a deep social inequality, characterized by diverse needs. Such needs go beyond the barrier of physiological and focus both in contributing to the establishment of risk situations. It is expressed primarily in underserved populations, in which there are no adequate conditions for the survival of individuals, or at least to the satisfaction of minimum conditions of well-being in individual and relational level. The human being of the twenty-first century has surpassed the basic considerations of Maslow; it is eager for personal participation, community involvement, responsibility

and management of collective problems, while it assumes a hedonistic position, guided by consumption and disposal.

The relations of domination and power that occur in the various social spheres relegate the underprivileged to a situation of increasingly evident lack of which every human being alone does not feel able to leave. For many, the meaning of life becomes merely survive and even this ends up being denied them, since in many places the health, education, sanitation, hygiene and others are still poor or nonexistent. Public policies are hindered by power games and commonly the underprivileged population is the most widely affected.

Talking about social inequality and needs inherent in certain part of the population means that there is a demographic cut line, below which lies a larger or smaller group, subjected to some kind of exclusion. The big problem is the disregard of public power for the dignity of the human person, since it should provide not only a “dignified death”, but life with quality, well-being and health. Thus, *misthanasia* is related to public health policies and the quality of life that should be part of government planning in pursuit of social justice (Zaganelli et al., 2016). It is not only the result of economic segregation, but also inequalities resulting from differences and inadequacies, injustices, social exploitation, public disengagement with the suffering of the other, poor access to care and basic services, as well as almost total absence of power.

This social neglect will feed on prejudice and stereotypes which, in turn, will serve the power forces in the regulation of relations between groups that face. These groups are potentially vulnerable individuals, often in vulnerable situations, which must have its subjectivity and its preserved cultural context, especially with regard to conditions for the underprivileged minorities, issues involving gender, race, economic status and religious beliefs.



The power relations that dictate who lives and who dies more early, Foucault called thanatopolitics

Social disqualification in which this population is located, creates them a stigmatized condition puts them at risk of social exclusion and ultimately impose an increasing embrittlement, which can lead to different levels of hopelessness, helplessness, poverty and marginality. An accumulation of failures and snuffed out the hopes, it is common to this population as for alcohol and/or drugs, meanwhile seeking to find happiness and escape the feeling of exclusion, and psychological and social suffering. The literature reviewed shows a constant disruption of social ties, when they cease all forms of aid provided by the company.

The marginalized is therefore vulnerable to misthansia; away from all the material and spiritual wealth, their values are not recognized, which results in an exclusion as well as social, cultural. The lack of appropriate welfare policies secretes and difficult to (re)integration, contributing further to the expansion of prejudice to stereotyping and the increase in social inequalities.

To those less privileged citizens, when inserted in a disease process, it is also sealed a prolongation of life for a long time, as this extension is often conditioned the procedures with which the customer or his family is able to afford economically. Thus, live longer those with greater purchasing power; it creates a kind of biological segregation in capitalist domain time.

The power relations that dictate who lives and who dies more early, Foucault called thanatopolitics. It is not the place great inroads into the subject, but we must be clear that the exacerbation of care for the lives of some individuals today, culminates by generating a disregard for the lives of many, imposing unnecessary deaths, and numerically superior. The mass death, victimized by violence may have better livelihoods for the population, from complex forms of power, which involves a large number of institutions.

So, it is killed for the preservation, enhancement and purification of life by providing a split point, from which they separate those who must continue to live those who will soon perish. The thanatopolitics binds to vulnerability, techniques and technologies of power, even leading to doubt whether it would be a mechanism of power or domination.

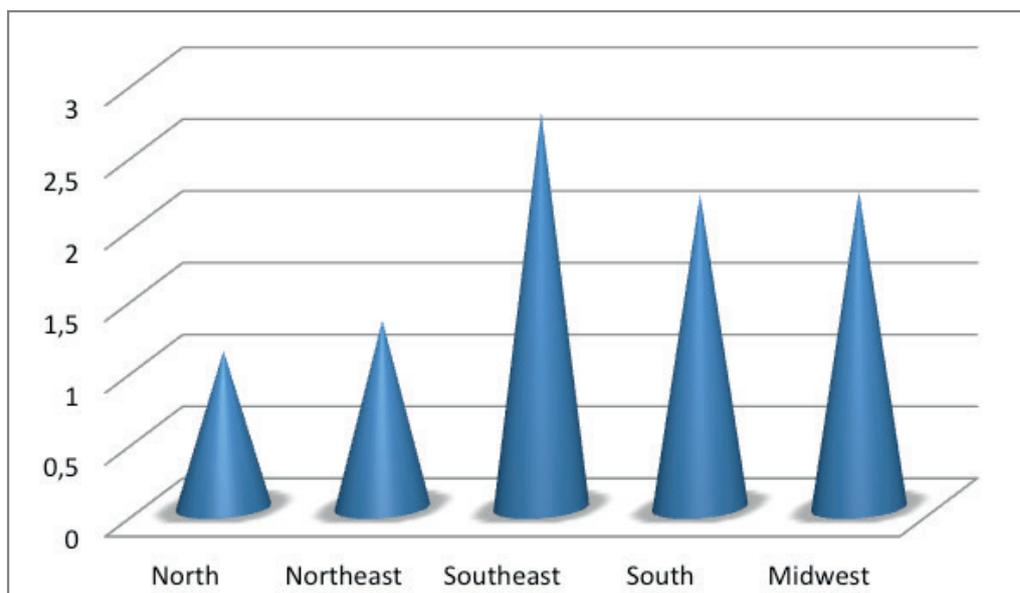
4. Public Health and Health Indicators in Brazil

The evolution of the Brazilian health system, with greater supply of medical jobs and greater demand for health needs, together with the expansion of undergraduate places in medicine, explains the increase in the number of doctors in Brazil over the years. This growth, however, did not benefit the population homogeneously, persisting medical distribution inequalities. The research on Medical Demography in Brazil in 2015 conducted by Scheffer et al. (2015), appears that the regions with the greatest shortages are North (1.09 doctors per 1.000 inhabitants) and Northeast (1.3), the Maranhão State with the smallest proportion of the country, around 0.79 doctor per 1.000 residents. On the other hand, the Southeast region has the highest



number of doctors per 1.000 inhabitants, being around 2.75 (figure 1). The research shows that 60 % of doctors are available to 30 % of the population living in major Brazilian cities, Brazil is the eighth country among forty, with lower rate of doctors per 1.000 (Scheffer, 2015).

Figure 1. Distribution of Doctors in Brazil by Regions/1.000 inhabitants (2015)

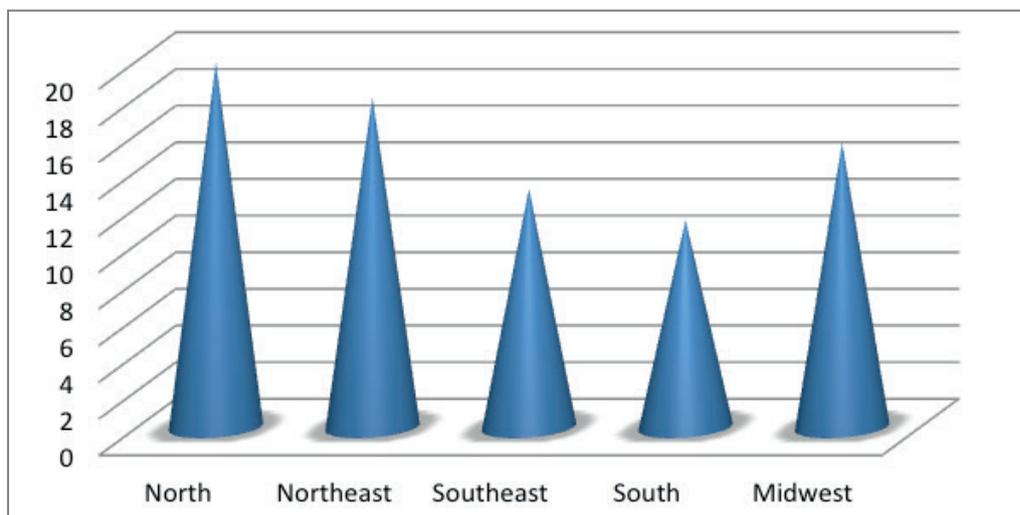


The availability of information supported by valid and reliable data is a precondition for the objective analysis of the health situation, and also for making decisions based on evidence and for programming health actions. The search for measures of health status of the population is a central activity in public health, including systematic recording of mortality data, survival, morbidity, disability, access to services, quality of care, living conditions and environmental factors, others, should thus define the health status of a population (Brasil, 2016).

Looking at infant death rate in Brazil (figure 2), there is a reduction of 26.1 to 15.3 from 2000 up 2011. But when we analyze the regions separately, we notice a difference of 19.9 to 11.3 for 2011. The worst situation is in the North region, which is more lacking in doctors per inhabitant, making this population more vulnerable. The region with the lowest infant mortality rate is the South followed the Southeast, Midwest and Northeast (PIPSA, 2008).



Figure 2. Number of infant deaths (under 1 year) per 1.000 live births (Brazil, 2000-2011)



When we analyze the Brazilian states we found the worst infant mortality rates in Amapá (24.1), Piauí (20.8) and Pará (20.6). Lower rates are found in Santa Catarina (10.8), Rio Grande do Sul (11.1) and São Paulo (11.6).

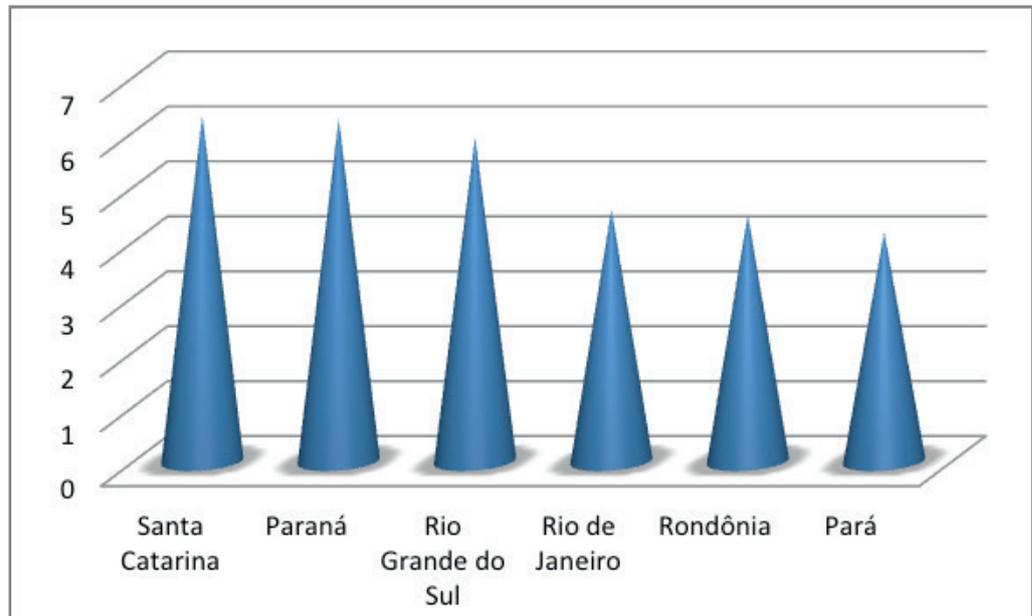
In 2011, life expectancy in Brazil was 74.08 years, which demonstrates the continuity of the strong growth trend of this indicator. It should be noted that the life expectancy at birth in the world in 2011 was 70 years and was 64 years in 1991. The life expectancy of Brazilians has a large gap between the units of the Federation. Thus, the Federal District and Santa Catarina present life expectancy above 76 years. Alagoas already has the worst life expectancy (68.4 years), almost a decade less. On the other hand, it is worth considering that Alagoas was the state that had the highest growth between 2001 and 2011, having been found a gain of 4.5 years in the period. The difference in life expectancy between men and women, who in 1991 was seven years, remained at the same level in 2011 (RIPSA, 2008).

On sanitation and illiteracy rate, according to the Public Health System Data (DATASUS) in 2010, over a million and a half of households had no toilet facilities, with the vast majority in the Northeast. The illiteracy rate was 9.4, and is the northeastern most impaired (Brasil, s.d.)

Checking the Public Health System Performance Index (IDSUS) index this created by the Ministry of Health – which assesses whether the population is getting to be answered in the public network and quality of service in all municipalities, states and at the national level according to scale of 0 to 10– a first assessment, Brazil's score in 2012 is 5.57. In Figure 3 are described referring to the lowest scores Rio de Janeiro states, Rondônia and Pará (respectively 4.58, 4.49, 4.17), and the largest in the South, Santa Catarina, Paraná and Rio Grande do Sul (respectively 6.29; 6.23; 5.90) .



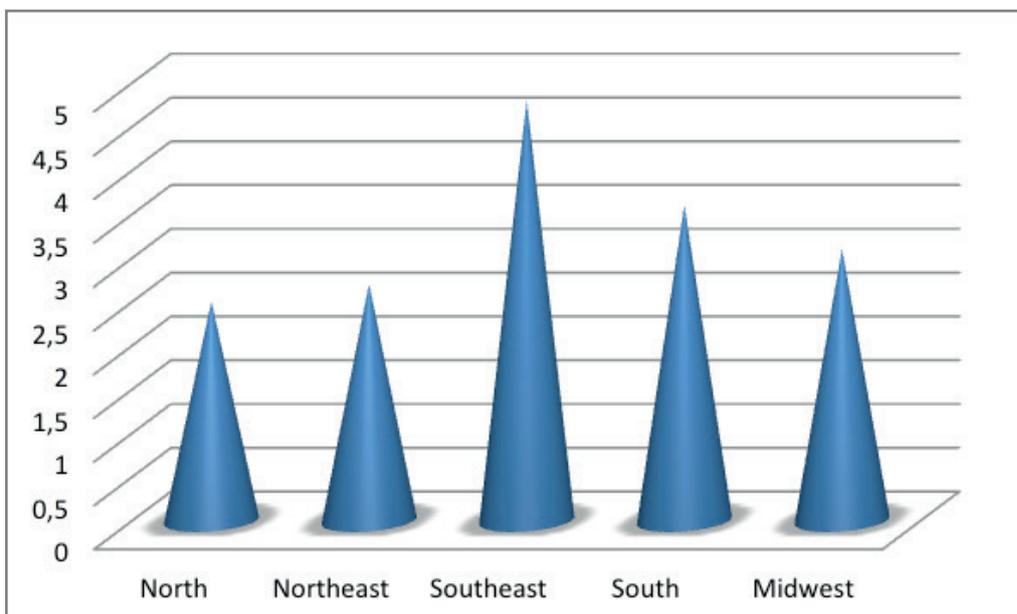
Figure 3. IDSUS score regarding the care and service quality by Federal Unit (2012)



Given that the country suffers from a public system and other private, the latter predominantly composed of health plans, you need to know the data of these two systems to get a complete view of the Brazilian health system performance as a whole. However, considering that the number of medical appointments scheduled by private insurance beneficiaries is available on the National Health Agency only at national level, the technical unit made the comparison to the states only with respect to consultations within the SUS. In 2010, Brazil was 4.0 medical visits per capita, the fourth smallest amount among 29 countries for which data were compiled by the Organization for Economic Cooperation and Development. Between 2002 and 2010, our country experienced an increase of 3.3 to 4.0 in the number of medical visits per capita, the fifth largest proportional growth among the 29 countries mentioned above. That year, there was a large gap between the private health system and the Unified Health System –SUS–. In the first model, there were 5.4 visits per beneficiary, as the SUS 3.6 consultations were recorded. In 2010, it was also uneven geographical distribution of these consultations. In the North, there were 2.5 visits per capita, considering only dependent on the SUS population; already in the Southeast was 4.8 per capita consultations. Northeast, Midwest and South registered respectively 2.7, 3.1 and 3.6 consultations. The states of Amapá, Pará and Piauí had the worst performers, with respectively 2.1, 2.1 and 2.2 consultations per inhabitant dependent SUS population. Already São Paulo, Espírito Santo and Rio de Janeiro made respectively 6.0, 4.2 and 3.8 consultations. Finally, the states of Roraima and Rondônia showed the highest growth in the number of consultations per inhabitant, when considered dependent on the SUS population, more than doubling this number between 2000 and 2010 (Brasil, s.d.).



Figure 4. Number of medical consultations per inhabitant in 2010



5. Conclusions

The dignity of the human person, particularly those who are in a vulnerable situation, dispenses more attention from the government, from existing public policies and others whose creation may be necessary.

The misthanasia phenomenon will remain as a ghost prowling the people who need to have their needs resolved as a priority on the agenda of society and the state. The indices presented corroborate this view, as they clarify needs and point out weaknesses. Thus, a re-evaluation and new implementations in public policies are essential.

The individual at risk of misthanasia is also a victim; we need to establish a deep understanding of social reality and to broaden the understanding of how this vulnerability is made and produced, social or inter-subjectively, while taking into account the power relations.

The indicators show the health inequalities in the country, with the north and northeast at a disadvantage both in access to health as the number of available professionals. The South and Southeast regions are the areas with the highest coverage, which are also the most privileged in relation to income and urban infrastructure. Thus, the most underserved population, tends to continue excluded from society and impaired with respect to their human dignity.



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