

complications. However, the best way of avoiding confusion and uncertainty among radiologists would be if such a protocol were officially incorporated in the PCPNDT Act.

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References

1. Parmanand Katara v. Union of India and Ors, A.I.R 1998 SC 1703.
2. Rai R. Pvt doc fined 3 lakh for turning away dying man. *The Times of India* [Internet]. 2010 July 23 [cited 2013 Jan 19]. Available from: <http://epaper.timesofindia.com/Default/Layout/Includes/ASCENT/ArtWin.asp?From=Archive&Source=Page&Skin=ASCENT&BaseHref=CAP%2F2010%2F07%2F23&ViewMode=HTML&PageLabel=1&EntityId=Ar00108&AppName=1>

Advance directives, palliative care and clinical bioethics committees

Concerns relating to end-of-life decisions

The topic under discussion at the 10th Brazilian Congress on Bioethics was "Advance directives, palliative care, and clinical bioethics committees," among the most important end-of-life issues. Other than the psychosocial, medical, and ethical aspects of making an end-of-life decision, juridical concerns need to be considered as well. From the point of view of physicians, one of the main difficulties faced by them while making such decisions is determining the appropriate time for the suspension of medical procedures in patients with incurable diseases.

What is right and what is wrong?

In ethical terms, the discussion of the end of life with patients is rooted in the four bioethical principles of autonomy, beneficence, non-maleficence, and justice (1).

In countries that uphold the right to orthoethanasia, designed protocols are followed for this purpose and it is ensured that the practice is backed by complete legal certainty. Hence, the patient's wishes are fulfilled and at the same time, the medical and health institutions participating in the process are protected from any kind of liability (2).

This, however, is not the scenario in Brazil. Although a resolution by the Federal Council of Medicine in 2006 (3) and the revised 2010 Brazilian Code of Medical Ethics (4) lay down guidelines for end-of-life decisions for terminally ill patients or those who are not competent to take a decision, as you stated in your article (5), there is no federal law regulating these matters.

When should doctors stop trying to treat patients? Our current technological skills and biological knowledge have served to make dilemmas regarding death more problematic and have made the choices more difficult (2). More than ever, health actions are ruled by an inclination towards critical care and high-tech medicine.

Once the occurrence of death is deemed irreversible, who is responsible for taking a decision in the case of an unconscious

patient? How would familial ties and economic realities influence this decision? How could such a medical decision be questioned? Each situation is unique, and people have different emotions, reactions and expectations. Even when the informed consent of a family member has been obtained, other family members may have different perceptions and may later argue that they were not consulted. The readiness to have the treatment stopped depends on the relative's personal acceptance of the end of life. As for the patient, he/she has the right not to receive futile treatment. Physicians should respect the wishes of the patient, but not necessarily those of the patient's family.

A document that could help avoid several dilemmas is the "living will" This is like a clinical record that is prepared by patients as proof of their willingness to undergo invasive or painful procedures to prolong their lives in terminal states. The concept of a living will was recognised by the Brazilian Federal Council of Medicine in 2012. The living will is acknowledged in countries such as Spain, Japan, the United States, Portugal, and Uruguay (6).

Medicine today offers a wide range of possibilities by which life can be extended and this raises the question of how to determine the limits to which life should be extended. Protocols for end-of-life issues should be developed and validated, and laws must be framed and enacted. Without clear rules, decision-making becomes more difficult and tends to be coloured by personal views. Consequently, cultural, psychosocial, and religious influences seep in. By helping in the identification of goals and establishment of procedures, laws and protocols help make end-of-life decisions less emotive and more technical. The emphasis of medicine should be concern for the patient with the disease, and not the disease itself. Medicine should be oriented to relieving the suffering of the patient. To fulfil this ideal, legal support is needed.

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References

1. Duffy TP. The medical student and care at the end of life. *Virtual Mentor*. 2013 Aug 1;15(8):672–6. doi: 10.1001/virtualmentor.2013.15.8.medu1-1308.
2. Felix ZC, da Costa SF, Alves AM, de Andrade CG, Duarte MC, de Brito FM. Euthanasia, dysthanasia and orthoethanasia: an integrative review of the literature. *Cien Saude Colet*. 2013 Sep; 18(9):2733–46. Portuguese .
3. Conselho Federal de Medicina (CFM) [Federal Council of Medicine]. Resolution CFM nº 1931/2009. Code of Medical Ethics [Internet]. Brasília: CFM; 2009 Sep 24 [cited 2014 Feb 25]. Portuguese. Available from: http://www.portalmedico.org.br/resolucoes/CFM/2009/1931_2009.pdf
4. Conselho Federal de Medicina (CFM) [Federal Council of Medicine]. Resolution no. 1995/2012. Advance directives [Internet]. Brasília: CFM; 2012 Aug 31 [cited 2014 Feb 25]. Portuguese. Available from: http://www.portalmedico.org.br/resolucoes/CFM/2012/1995_2012.pdf
5. Schlemper BR Jr. The 10th. Brazilian Congress on Bioethics. *Indian J Med Ethics*. 2014 Apr-Jun; 11(2):121–33.
6. Grimberg M, Chehaibar GZ. Living wills [online]. *Arq Bras Cardiol*. 2012 Dec; 99(6):1166. Portuguese.