


Violation of the human rights of patients at risk of suicide attempt in Brazil


Violação dos direitos humanos dos pacientes com tentativa de suicídio no Brasil

Luana Lima^a

 <https://orcid.org/0000-0002-6277-6547>


E-mail: luanalima.sc@outlook.com

Laura dos Santos Boeira^b

 <https://orcid.org/0000-0001-8450-0907>


E-mail: laura@veredas.org

Aline Albuquerque^a

 <https://orcid.org/0000-0002-5568-0790>

E-mail: alineoliveira@hotmail.com

Thatiana Ayres Marques^a

 <https://orcid.org/0000-0003-3518-6418>

E-mail: athatiana7@gmail.com

^aUniversidade de Brasília. Faculdade de Ciências da Saúde. Núcleo de Estudos e Pesquisas em Bioética – Cátedra Unesco de Bioética. Brasília, DF, Brasil

^bPontifícia Universidade Católica do Rio Grande do Sul, Programa de Pós-Graduação em Psicologia, Porto Alegre, RS, Brasil

Abstract

Suicide is a serious public health problem worldwide. This study's starting point is the theoretical-normative framework based on human rights standards applicable to the patients in the context of health care. The objective was to investigate the violation of the human rights of patients at risk of suicide. A total of 11 semi-structured interviews were conducted with health professionals, patients, and family members in four Brazilian state capitals. This study is a qualitative empirical research anchored by the hermeneutic-dialectic method. The professionals' difficulty in dealing with the subject was identified, especially by the reproduction of stigmatizing, moral, religious, paternalistic, and/or hyper vigilant behaviours. The violation of the human rights of patients was observed, compromising the care offered, the continuity of treatment, the protagonism, privacy, and the decision-making capacity of the patient, in addition to increasing the vulnerability and the risk of new attempts. Among the interviewees, there was no consensus regarding the awareness of violations on the part of professionals. The protection of these patients depends on the adoption of training measures for health teams, awareness and information processes for the society, and the creation of specific policies and legislation to broaden the understanding of human rights and suicide prevention.

Keywords: Suicide; Human Rights; Patients.

Correspondence

Luana Lima

Universidade de Brasília. Programa de Pós-graduação em Bioética – Cátedra UNESCO Bioética/ Faculdade de Ciências da Saúde. Campus Universitário Darcy Ribeiro, Brasília – DF. CEP: 70910-900

Resumo

O suicídio é um grave problema de saúde pública mundial. Este estudo parte de um referencial teórico-normativo fundamentado nas normas de direitos humanos aplicáveis aos pacientes, no contexto dos cuidados em saúde. Objetivou-se investigar a violação dos direitos humanos dos pacientes em risco de suicídio. Foram realizadas 11 entrevistas semiestruturadas com profissionais da saúde, pacientes e familiares em quatro capitais brasileiras. Trata-se de uma pesquisa empírica qualitativa apoiada no método hermenêutico-dialético. Foi identificada a dificuldade dos profissionais em lidar com a temática, especialmente através da reprodução de condutas estigmatizantes, morais, religiosas, paternalistas e/ou hipervigilantes. Observou-se a violação dos direitos humanos dos pacientes, comprometendo o cuidado ofertado, a continuidade do tratamento, o protagonismo, a privacidade e a capacidade decisional do paciente, além do aumento da vulnerabilidade e do risco de novas tentativas. Entre os entrevistados, não houve consenso a respeito da conscientização das violações por parte dos profissionais. A proteção desses pacientes pressupõe a adoção de medidas de capacitação das equipes de saúde, processos de sensibilização e de informação para a sociedade, assim como a criação de políticas e legislações específicas, de modo a ampliar o entendimento sobre direitos humanos e prevenção do suicídio.

Palavras-chave: Suicídio; Direitos Humanos; Paciente.

Introduction

Suicide is a global public health and human rights issue. Approximately 80% of suicides occur in low- and middle-income countries, with high rates among vulnerable and marginalized groups (WHO, 2019). Young and old people are among the age groups at increased risk of suicide (WHO, 2013), requiring more attention and protection from the State. Between the years 2010 and 2016, the suicide rate increased by 6% in the Americas (WHO, 2019), and Brazil occupies, in absolute numbers, the eighth position in the world rank as the fourth Latin American country with the highest growth in numbers between the years 2000 and 2012 (WHO, 2014).

In 2013, the Mental Health Action Plan (WHO, 2013) was launched with the objective of decreasing the suicide rate by the year 2020. Signed by Brazil, the Action Plan called for changes in health care, emphasizing the need to expand specialized services and improve the quality of services provided to patients at risk of suicide. The plan included recommendations for States to adopt human rights-based strategies for suicide prevention, indicating that mental health should become a political priority.

The human rights framework proves to be a powerful instrument for reflection on the condition of patients with a history of suicide attempts by bringing together a set of ethical and legal norms that establish obligations for States. Thus, considering the importance of human rights for the reflection and prescription about the health care of patients at risk of suicide and attempted suicide, in this research we chose the theoretical-normative framework called Human Rights of Patients (HRP). Human Rights of Patients are a tool for analyzing ethical and legal issues that emerge from the clinical encounter and are being developed by researchers in the Patient Rights Observatory of the Bioethics Graduate Program at the Universidade de Brasília, based on studies by Albuquerque (2016), Cohen and Ezer (2013). The HRP aspect is grounded on international human rights standards applied to health care. The initial assumption is that human rights consist of ethical and legal standards capable of guiding the prescription of health professionals' behaviors. Thus, HRP constitute an ethical reference for all

players who interact in health care by combining the bioethical language with the language of human rights to provide rational arguments that can be used in the process of analysis and deliberation of issues emerging from health care.

As such, HRP are constituted by the following principles and rights: the right to life; the right not to be subjected to torture or to cruel, inhumane or degrading treatment or punishment; the right to freedom and personal security; respect for private life; the right to information; the right not to be discriminated against; and the right to health (Albuquerque et al., 2019). These rights derive from human dignity and are based on the logic of care (Mol, 2008), which is permeated by the interaction between patients and health professionals. This should consider, above all, the well-being, comfort and dignity of patients.

Human Rights of Patients contradict the logic of consumption, which reduces health care to an asset operation, viewing patients as consumers, giving them choices even when such choices may be unsafe and increase the risks of damage to their health. Thus, we can conclude that the framework of HRP is associated with the values that underlie the Brazilian Unified Health System (SUS), which highlights their relevance to the context of health care in Brazil.

In addition, the theoretical corpus of HRP includes the category of increased vulnerability, which understands that some patients, mainly due to personal or social factors, are more likely to suffer violations in health care. The rights of these patients must be ensured through State and non-State mechanisms aimed at mitigating the obstacles arising from the specific condition that increases their fragility. On the other hand, the recognition of particular vulnerability should not lead to the adoption of measures either paternalistic or overly restrictive of rights; on the contrary, it is necessary to encourage these patients to develop their abilities and functionalities so they can take an active role in their health care (Marques, 2019).

Health care for people who access services due to a suicide attempt has been described in the literature as moralistic and lacking understanding, information and reception to suffering patients.

Reisdorfer and other authors (2015), Araújo de Freitas and Martins Borges (2017) show that demands for patient care in cases of self-violence, such as suicide attempts, are interpreted as obstacles in the work performed in hospital emergencies, causing indifference, indignation and nonconformity among professionals. Suicide attempts are commonly understood as a way of getting attention. Through interviews with professionals, Lima (2020) detects that the dimension of appeal is understood as manipulation, theatricality and exhibitionism. Still in this research, the act is also described as moral or psychological weakness, triggering “differentiated care” based on rude approaches out of obligation and with possible sanctions.

Botega (2015) applied the Suicidal Behavior Assessment Questionnaire to 317 nurses and showed, among other things, that 39% believe that “people who want to kill themselves do not attempt to”, and that 85% consider that “life is a gift from God and no one can take it”, manifesting the reproduction of myths and the religious perspective in the perception of the phenomenon.

In the context of patients with attempt and risk of suicide, the application of the HRP aims to promote their dignified treatment, the culture of human rights in health services, the awareness of professionals involved in the health care process and the improvement of the quality of services offered. Given the importance of applying the perspective of human rights to health care for patients with attempt and risk of suicide in Brazil, this study aims to analyze the perceptions of health professionals, family members and patients regarding human rights violations of people at risk of suicide when they are under health care.

Methodological path

This study is part of the research conducted by the Patients’ Rights Observatory (2017), of Bioethics Graduate Program, which resulted in the “Human Rights Report on Patients at Risk of Suicide in Brazil”. Approved by the Research Ethics Committee of Centro Universitário de Brasília (69672017.4.0000.0023), data collection took place between August and September 2017, in four Brazilian state capitals: Salvador,

Brasília, Goiânia and Porto Alegre. Semi-structured interviews were conducted with 11 participants: seven health professionals - psychologists, nurses and occupational therapists -, two patients and two family members, to analyze the violation of human rights of patients with attempted suicide in the context of health care. It is reported that the health professionals interviewed have experience in patient care for patients at risk of suicide, performing activities in public and private services.

Sampling was structured for convenience, ruled by the “snowball” method, which is useful for researching groups that are difficult to access, also recommended when studying delicate and/or intimate issues, requiring key persons to recognize and locate informants (Vinuto, 2014). The interviews were conducted privately in workplaces or private places chosen by the research participants. It should be noted that the sociodemographic profile of the participants will not be considered in this research.

The analysis of the interviews adopted Minayo's hermeneutic-dialectic framework (2014), which is built on the critical understanding of the study of social reality, working in detail with phrases, words, concatenation of ideas, general meaning of the text, etc. expressed by the research participants, with the purpose of weaving together narratives, highlighting the experiences, their contradictions and wealth.

After collecting and transcribing the data, these were categorized according to the prevalent themes enunciated by the participants, summarized in a dialectical way, which means the use of reinterpretation of the findings focused on understanding the conflicts inherent in the interpretive process and reordered into analytical axes (Gomes et al., 2005).

Results and discussion

Based on content collected in the interviews, the data were categorized into four main axes:

(1) Violation of human rights of patients - concerns the analysis of human rights violations of patients with risk and attempt of suicide, particularly in a hospital setting.

(2) Effects of human rights violations on patients who have attempted suicide - concern the beliefs

of health professionals about the direct or indirect impacts of violations on the mental health of patients who have attempted suicide.

(3) Awareness of practices of violation of human rights by professionals, family members and patients - implies awareness of the occurrence of violations.

(4) Strategies to ensure the human rights of patients with attempted suicide - they include measures to confront and prevent the occurrence of human rights violations of such patients in a clinical setting.

Violation of human rights of patients

Based on the framework of the HRP, the violations of the following rights will be discussed: the right not to be discriminated against; the right not to be subjected to torture, degrading or inhumane treatment; the right to health; the right to information and the right to life. Such rights are provided for in international documents and were ratified by Brazil.

The right not to be discriminated against

Discrimination is defined as “any distinction, exclusion, restriction or preference, in any area of public or private life, the purpose or effect of which is to nullify or restrict the recognition, enjoyment or exercise, on an equal basis, of one or more human rights” (OAS, 2013, p. 3). It should be noted that the Universal Declaration of Human Rights (UN, 1948) reinforces every person is equal before the law, without distinction, and is entitled to the equal protection of the law without discrimination. In health care, discrimination can occur in access to services or in patient care received (WHO, 2005).

When analyzing the content of the interviews, it was found that professionals mention several situations of discrimination against patients at risk of suicide.

“A doctor said to a patient: ‘You came to disturb my shift! You don’t want to kill yourself. [...] Next time, go to the Lacerda Elevator and throw yourself from the top, that’s a sure shot (PROFo2).

The doctor's response constitutes incitement to suicide, a crime in Brazil, in addition to supporting

the myth of the “failed” act of suicide as a way of getting attention.

Discrimination against a person who attempted suicide is expressed both through accusatory speech and moral judgment and acts of negligence. One professional mentioned a recent case of hospitalization in which patient had been ignored for more than 24 hours:

“Dear, our priority here are those who want to live!” (PROFo1).

A “sanctity of life” perspective seems to authorize this kind of conduct, without any penalty or institutional sanction, but with all kinds of damage to the patient in a situation of increased vulnerability.

“At the end of the shift, another doctor came: ‘You again? Didn’t I tell you to go home?’ ‘That’s a problem for church, go look for a church, girl.’ (PROFo2).

These findings are connected with the perspective that the subject who attempts or consummates the suicidal act removes the agency of his life from the health institution, confronting the power and knowledge of these institutions and professionals (Lima, 2020). From interviews with doctors, nurses and nursing technicians responsible for first patient care after a suicide attempt, Lima (2020) detected feelings of affront and professional inadequacy, triggering offers of patient care at a minimum level, jokes, provocations, negligence, direct or indirect offense, hostility, sanctions or even pedagogical and encouraging messages.

The repercussions and violations were also reported by Vidal and Gontijo (2013) from the perspective of the patients, who reported significant difficulty in being listened to by the teams. The reports mentioned situations of discrimination and negative attitudes from the whole team; expressions of suffering were named as hysterical outbursts, treated with discredit, neglect, hostility and lack of humaneness, especially in cases where there was no risk of death.

The right not to be subjected to torture or degrading or inhumane treatment

The International Covenant on Civil and Political Rights states that no one may be subjected to torture, cruel, inhumane or degrading treatment or punishment, highlighting the prohibition of subjecting a person, without his or her free consent, to medical or scientific experiments (Brasil, 1992). In health care, inhumane treatment causes intense physical or psychological suffering, and degrading treatment implies provoking feelings of fear, anguish or humiliation in a patient (Albuquerque, 2016).

When examining interviews with health professionals, humiliating treatment that inflicted pain on patients was identified:

“Are you going to lavage the patient? So use the large-bore tube. Not because the lavage will be more effective, but because the person will somehow feel punished, hurt.” (PROFo3).

In patient care for people who have attempted suicide, degrading or inhumane treatment is not restricted to delayed or denied care, but concerns, above all, moral “revenge” against those who have subverted the medical, religious and scientific order (Carvalho, 2014):

“If a thief is admitted with a gunshot wound, they may even think: ‘I shouldn’t save you’, but they don’t say anything, because there the thief will say: ‘For God’s sake, doctor, save me!’ [...] assigning or confirming medical power, medical knowledge. A person who attempts suicide, which is a violent death and the very peak of suffering, is not welcomed precisely because in that setting she foregoes medical knowledge. So he is a person who should be neglected.” (PROFo2).

This idea of neglect is ratified by a patient with a history of several attempts, who shared the experiences of violent treatments and responses:

"I've heard it said a lot of times: I'm going to prepare the mad woman's medication! Oh, you want to die? Why don't you kill yourself? Instead of being a nuisance for me!" (PACo1).

Another interviewee also emphasized that many of the actions of health professionals are based on the pharmacological approach, understanding their tasks, duties and responsibilities to be restricted to the physical body, as explained:

"A patient who attempted suicide [...] was eight months pregnant. [...] Only she did not die, but the baby died [...] She was extremely chastised. They did not want to bring her food. At the time, because she had serum going in both her arms, she had to be fed, but they refused to: "She is going to go hungry." (PROFo2).

The right to health

The right to health, in HRP, is linked above all to the quality and safety of health care. Therefore, the State must guarantee the right to health with access to adequate, quality Specialized Health Services (United Nations Human Rights Office, 2019). Every person the right to health and to be treated with dignity and respect when accessing health services.

The stigma regarding patients who have attempted suicide can compromise professional care, with serious consequences for the patient's health, such as the exclusion of procedure or treatment.

"In my last suicide attempt [...] the doctor refused to see me. She said that if I wanted to die, I would, but I wasn't going to disturb the end of her shift. She took the bag and left. She didn't see me." (PACo1).

Conversely with the discharge given by the professionals, reports also include delayed patient care justified on the grounds of it being a "favor", in addition to cases of non-referral to specialized services. The logic of network is weakened by a lack of knowledge of professionals and / or by a neglect of the system, in such a way as to cause harmful effects for patients at risk of suicide:

"Not ensuring referral for users in the mental health network is very complicated. Today I did two screenings of people [...] one is in their 17th attempt and the other is their 5th attempt. [...] Many of these attempts could have been avoided if they had been under monitoring" (PROFo4).

Commonly, patients are discharged from the emergency room without undergoing psychiatric evaluation or being referred to specialized services (Vidal; Gontijo, 2013). Such missed opportunities to institute and / or continue treatment are related to the negative evolution of patient care and therapeutic intervention; the growing feeling of helplessness; new attempts, which can become even more serious; and the discouragement to search for help again (Tavares, 2013; Silva; Sougey; Silva, 2015).

The right to information and the right to life

The right to information is fundamental to human beings, preserves their dignity and encompasses the rights of a person to receive adequate information about their health care, the treatment they should have, and it ensures the preservation of their life (UN, 2017; Albuquerque, 2016). The right to life is provided for in several international human rights documents (UN, 1948), and therefore must be guaranteed by the State.

Some professionals reported being provided inadequate information, especially regarding the registration of the case in the medical record. The effects of the stigma and taboo on the topic of suicide can result in family members and teams changing the correct record of the situation to characterize what happened in socially acceptable terms.

"Family members who sometimes ask teams to change the record - for example, if a person jumps from a building and survives with multiple fractures, the record will say admission of a polytraumatized patient" (PROFo4).

A properly noted medical record, with no alterations and free of prejudice, as a patient's right, allows the planning of health care, especially with the goal of preventing new suicide attempts.

This conduct aims at responsible hospital management, but it also includes information such as referral to specialized psychosocial care services. The same logic refers to (non-) notification, of a compulsory nature. Failure to provide these conducts eliminates the possibility of integrated, effective and quality treatment and reduces care and the rights to information and life.

“Imagine the case of a person who has taken medication with alcohol and overdoses [...] if you report [the suicide attempt] as only an ‘overdose’, you don’t allow that person to seek care for the suicide attempt, you help feed a secret, and that’s a stressor. Therefore, there is a great correlation between stress and new suicide attempts”(PROFo4).

The right to privacy

Health professionals have the duty to maintain the confidentiality of patients’ personal data, must respect their bodily privacy and cannot deprive them of living with their families and society. In addition, the patient’s right to self-determination implies the right to make decisions about their own body and health (Marques, 2019).

One of the interviewees mentioned the difficulty for teams to maintain privacy about the information about the suicide attempt and risk in the patient’s medical record. Another professional described a case of violation of privacy when the unconscious patient was exposed to people moving around in the health service:

“She was exposed naked, not only in front of the professionals, there were male nurses in that shift, but also in front of other people who were in the emergency room at that place”(PROFo6).

The aforementioned case denounces the objectification of the body, without an integrated look at the subject, her needs, suffering and increased vulnerability.

The right to freedom

It is necessary to respect the health care laws which guarantee the autonomy and freedom of patients.

Involuntary hospitalization and patient retention should be avoided, and if it is necessary, it must comply with international human rights standards, and should occur for the shortest possible time, in the less restrictive manner. From the perspective of HRP, it is essential to seek alternative treatments that do not restrict the patient’s freedom, allowing them to participate in decision-making (WHO, 2005).

Depriving a patient or preventing them from accessing the external environment violates their right to freedom. A emblematic case was reported by a person whose sister was hospitalized after a suicide attempt and the hospital denied visits and communication between them. At that moment, the patient was subjected to excessive physical and chemical restraint, without any need or therapeutic justification:

“She couldn’t even talk, she couldn’t even talk, the state she was in, because they tied her up... they tied her up, they gave her an injection...” (FAMo1).

Effects of human rights violations on patients with attempted suicide

In view of the human rights of patients, which include the rights not to be discriminated against, not to be subjected to degrading or inhumane treatment, to health, information, life, privacy and freedom, the professionals pointed out by consensus that violations of the aforementioned rights would represent a reproduction of violence and negligence that can aggravate the suffering of patients, including encouraging new suicide attempts and also potentiating the suffering of family members.

“I call it the iatrogeny of words. Which is exactly when the patient comes back, comes to the outpatient clinic and says: ‘If even the doctor says that I have to die, that I have to throw myself from the top of the elevator, it is because I really have to die, it is because I am worthless.’” (PROFo2).

The risk that is pointed out is when a patient avoids seeking health services and professionals in order to reduce the harmful effects of the moral judgment to which they are subjected:

“People prefer to stay away from any kind of patient care as a form of protection. Sometimes they can’t help it, so they seek these services and they will go through new violence. Or they stay away from these services, which will make things worse, right?! [...] Somehow it will intensify the illness.” (PROFo3).

The professionals brought up the issue of the violation of human rights of patients articulated with violations of other rights, recognizing the overlapping vulnerabilities that can negatively impact and compromise the survival of these people:

“Suicidal behavior is quite complex and many factors influence the constitution of risk: social, cultural, psychological and biological factors [...] and many of them can be considered as a violation of human rights. Some examples: having been a victim of physical, sexual, psychological violence or neglect in childhood, unemployment, deprivation of freedom, being a victim of prejudice (homophobia, racism) etc.” (PROFo5).

Many of these issues are demarcated by professionals as invisible political agendas.

Awareness of practices of human rights violations by professionals, families and patients

The interviewees differ on the awareness and sensitivity regarding violations of HRP - the right not to be discriminated against, not to be subjected to degrading or inhumane treatment, the right to health, information, life, privacy, freedom - of health professionals. Those who consider that professionals cannot recognize them list the following factors: (1) there is no consensus on the meaning of what the right to health consists of; (2) those who violate it do so out of ignorance; (3) professionals do not have the opportunity to discuss human rights in the work setting, either due to lack of time, the inexistence of this guideline or even because the phenomenon is not perceived as being multidimensional; (4) health services are guided by productivity, which causes the quantitative production of procedures to be above the quality of care.

“Very few people in health care discuss human rights, access to health itself. The right to health as a human right is not a consensual paradigm among the teams. This involves from the person having the right to be a protagonist in their treatment and the situation of social control, to even basic day-to-day issues when they access health services.” (PROFo4).

The interviewees who defend that there is awareness declare that the violating professionals do so in a consensual manner, understanding that they can violate the rights of patients because of the attempted suicide, an act that seems to break the “covenant of the living”.

“I believe that professionals still feel, they believe that they have the right to violate rights because that person who attempts against their own life goes against other principles that they believe are professional, personal, I don’t know, moral, ethical principles... it seems that this entitles them to this type of violation.” (PROFo3).

Those who adopt this second perspective argue that patients and family members may not always know their rights, but they recognize this violation and do not complain for fear of reprisal or of new violations.

“I think they understand, but [...] people in Brazil still believe, even with so much clarification about what the SUS is [...], they still believe that because they are receiving free health care, even if they feel violated by it, because this may after all be good quality health care, they prefer to stay silent.” (PROFo3).

The analysis of the interviews allowed corroborating previous findings, which stated that due to the understanding of the suicide attempt as an act imbued with intentionality, resulting from a choice, this patient is categorized as one who does not need care (Vidal; Gontijo, 2013). The denial or subversion of care reflects the prejudice and misinformation about suicide attempts as a call for help (Vidal; Gontijo, 2013), reveals ignorance about the ambivalence between the desire to live and to die and the attempt as the main risk factor for suicide (WHO, 2014).

Strategies to ensure the human rights of patients with attempted suicide

Regarding strategies in public policy, some professionals highlighted as a primary need the development of actions and plans for suicide prevention. It should be noted that when this study was conducted, the National Policy for Prevention of Self-Harm and Suicide, published in April 2019, did not yet exist (Brasil, 2019).

Another need highlighted was to strengthen the health care network in order to ensure more dignified conditions of care and referral of patients, safeguarding links for continuation in health services. Regarding intersectoral articulation, one interviewee brought up the importance of discussing the architecture and urban planning of cities in order to identify places of risk for suicide, create protection strategies and offer information on support services to people in distress.

Regarding qualification and training strategies for health professionals, most of the interviewees considered it essential to implement ongoing education and training processes for professionals on the topic of suicide and its determinants, in addition to the topic of human rights:

“Training is still very medical-centered on the suicide attempt, on the mental disorder, and we do not have any basic discussions on the social determinants surrounding these issues. People do not kill themselves because they have a disorder, but because they broke up a relationship, were/are unemployed, because they have no life prospects, because they went bankrupt.” (PROF04).

The dynamics of the work separated from the issue and all its complexity reflect a technical and ethical instrumental unpreparedness to deal with the patients in question, which is a reflection of the social taboo on the subject (Lima, 2020).

Some professionals identified training as a significant but insufficient measure. For them, this measure conveys information to improve the operationalization of the technique, however it may be unsatisfactory regarding ethical aspects, which must be addressed through awareness-raising processes.

“I often say that working in this field is not about just knowing, but about being available. Because you are called on to be flexible, to demystify and deconstructing, right?!” (PROF04).

The importance of education actions was reinforced not only aimed at undergraduate and graduate health courses, but also to target public safety professionals who respond to suicide incidents, in addition to media professionals:

“Because disclosing information also changes the way people have access, the right to information is a human right, let’s say, and people don’t have access [to information] today, because information succumbs to people’s stigma.”(PROF04).

One professional advocates that the lack of a law that provides for the rights of patients in the country prevents and/or hinders the adoption of responsible and responsive practices.

Finally, one of the professionals interviewed reflected on the importance of committed and in-depth actions with patients at risk of suicide and their families in the interface with human rights:

“I think that working with people at risk or with a history of suicide attempts, as well as with their families, should help them organize themselves in the search for the guarantee of human rights. Encouraging these people to be protagonists is essential even to overcome the difficulties that led them to be at risk” (PROF05).

Final remarks

The moral condemnation of suicide added to the imperative of life in the hospital setting leads to the (re)production of stigmatizing and tutelary behaviors. Interviews with professionals, patients and family members state, to a greater or lesser extent, the violation of the human rights of patients who attempted suicide. The right not to be discriminated against was subverted based on distrust and delegitimization of the act, accusatory speeches, moral and religious judgment,

prioritization of patient care for people who “want to live” and even incitement to suicide. The right not to be subjected to degrading treatment was invalidated by the recognition of humiliating treatment given to attempters, such as unnecessary infliction of pain as a form of punishment for attempted suicide. The fundamental reason for hospitalization causes professionals to delay or deny patient care, also infringing the right to health.

The rights to information and to life were disrespected by the failure to provide inadequate information, especially with regard to the medical record, thus reducing the possibilities of accessing therapeutic alternatives and, consequently, ways of enhancing quality of life. The right to privacy was also suspended due to the entry in the the medical record and its repercussions, with cracks in confidentiality. Finally, the right to freedom was violated by the prohibition to visit and communicate with the external environment, as well as by physical and chemical restraints during hospitalizations.

The described scenario tends to weaken patients, especially from a decision-making point of view, disrespecting precepts recommended by the HRP, such as their decision-making capacity, autonomy and their protagonism in their health itinerary. Still among the effects of the violations, the accounts stated that violation of the HRP can aggravate the suffering or psychopathological state of patients, even increasing the risk of new attempts. Withdrawing from health services to avoid judgment can further increase the vulnerability of these individuals.

With regard to awareness of the practices of violation of the HRP by professionals, family members and patients, there was no consensus. Interviewees blame the lack of awareness due to a lack of knowledge, a lack of consensus on the meaning of health rights and debate about the work setting, and also due to the scarcity of time and logic of productivism. Other interviewees affirmed awareness of the cases, they consent that the professionals violate rights because they believe that the attempters broke the medical, religious and capitalist ethics first.

The strategies to ensure the human rights of patients with attempted suicide were described by

the need to build a National Suicide Prevention Plan (the National Law was instituted on April 2019, without a corresponding plan), the need to strengthen the health care network, especially to ensure more dignified conditions of reception and referral. Intersectoral articulation extrapolated health care, so the revision and construction of urban architecture, and the offer of information to the population by the media, were also recorded. Within the health field, the need for training, awareness and permanent education processes on the topic of suicide and its conditions, in addition to HRP, were pointed out. Education actions also considered public safety agents and undergraduate and graduate health courses.

Finally, a legislative measure is needed to establish the rights of patients in order to guide the conduct of professionals and expressly indicate to patients and their families their rights. Particularly for patients at risk of suicide, due to their condition of increased vulnerability, the existence of a law is crucial as it constitutes a powerful instrument for demanding respectful, dignified treatment.

References

- ALBUQUERQUE, A. *Direitos Humanos dos Pacientes*. Curitiba: Juruá, 2016.
- ALBUQUERQUE, A; BOEIRA, L. S.; LIMA, L., AYRES, T. Os direitos humanos dos pacientes em risco de suicídio no Brasil. *Cadernos Ibero-Americanos de Direito Sanitário*, [S.l.], v. 8, n. 1, p. 26-35, 2019.
- ARAÚJO DE FREIRAS, A. P; MARTINS BORGES, L. Do acolhimento ao encaminhamento: o atendimento às tentativas de suicídio nos contextos hospitalares. *Estudos de Psicologia*, Natal, v. 22, n. 1, p. 50-60, 2017.
- BOTEGA, N. *Crise suicida: avaliação e manejo*. Porto Alegre: Artmed, 2015.
- BRASIL. Lei nº 13.819, de 26 de abril de 2019. Política Nacional de Prevenção da Automutilação e do Suicídio. *Diário Oficial da União*, Brasília, DF, 29 abr. 2019. Disponível em: <http://www.planalto.gov.br/ccivil_03/_Ato2019-2022/2019/Lei/L13819.htm>. Acesso em: 27 fev. 2020

BRASIL. Decreto nº 592, de 6 de julho de 1992. Atos Internacionais. Pacto Internacional sobre Direitos Civis e Políticos. Promulgação. *Diário Oficial da União*, Brasília, DF, 07 jul. 1992. Disponível em: <http://www.planalto.gov.br/ccivil_03/decreto/1990-1994/Do592.htm>. Acesso em: 27 fev. 2020

CARVALHO, S. *A morte pode esperar?* Clínica Psicanalítica do Suicídio. Salvador: Campo Psicanalítico, 2014.

COHEN, J.; EZER, T. Human rights in patient care: a theoretical and practical framework. *Health and Human Rights Journal*, Boston, v. 15, n. 2, p. 7-19, 2013.

GOMES, R. et al. Organização, processamento, análise e interpretação de dados: o desafio da triangulação. In: MINAYO, M. C. S.; ASSIS, S. G.; SOUZA, E. R. (Org.) *Avaliação por Triangulação de Métodos: abordagem de programas sociais*. Rio de Janeiro: Fiocruz, 2005.

LIMA, L. *Deverei velar pelo outro?* Suicídio, estigma e economia dos cuidados. Belo Horizonte: Dialética, 2020.

MARQUES, T. A. *Nise: Aproximações entre os direitos humanos e saúde mental dos pacientes*. 2019. 120 f. Dissertação (Mestrado em Bioética) - Faculdade de Ciências da Saúde, Universidade de Brasília, Brasília, DF, 2019.

MINAYO, M. C. *O desafio do conhecimento: pesquisa qualitativa em saúde*. 14. ed. São Paulo: Hucitec, 2014.

MOL, A. *The logic of care: health and the problem of patient choice*. London: Routledge, 2008.

OAS - ORGANIZAÇÃO DOS ESTADOS AMERICANOS. *Convenção Interamericana contra toda forma de discriminação e intolerância*. Washington, DC: OAS, 2013. Disponível em: <https://www.oas.org/en/sla/dil/docs/inter_american_treaties_A-69_Convencao_Interamericana_discriminacao_intolerancia_POR.pdf>. Acesso em: 25 maio 2021.

OBSERVATÓRIO DIREITOS DOS PACIENTES. *Relatório sobre Direitos Humanos dos Pacientes em Risco de Suicídio*. Brasília, DF: UnB, 2017. Disponível em: <[\[direitos-humanos-dos-pacientes-em-risco-de-suicidio/\]\(#\)>. Acesso em 5 abr. 2020.](https://www.observatoriopaciente.com.br/relatorio-sobre-</p></div><div data-bbox=)

ONU - ORGANIZAÇÃO DAS NAÇÕES UNIDAS. *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. New York: ONU, 2017. Disponível em: <https://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/35/21>. Acesso em: 25 maio 2021

ONU - ORGANIZAÇÃO DAS NAÇÕES UNIDAS. *Declaração Universal dos Direitos Humanos*. Brasília, DF: ONU Brasil, 1948. Disponível em: <<https://brasil.un.org/pt-br/91601-declaracao-universal-dos-direitos-humanos>>. Acesso em 5 abr. 2020.

OMS - ORGANIZAÇÃO MUNDIAL DA SAÚDE. *Livro de recursos da OMS sobre saúde mental, direitos humanos e legislação: Cuidar, sim - excluir, não*. Genebra: OMS, 2005.

OMS - ORGANIZAÇÃO MUNDIAL DA SAÚDE. *Plan de acción sobre salud mental 2013-2020*. Genebra: OMS, 2013.

REISDORFER, N.; ARAUJO, G. M.; HILDEBRANDT, L. M.; GEWEHR, T. R.; NARDINO, J.; LEITE, M. T. Suicídio na voz de profissionais de enfermagem e estratégias de intervenção diante do comportamento suicida. *Revista de Enfermagem da UFSM*, [S. l.], v. 5, n. 2, p. 295-304, 2015.

ROTHES, I.; HENRIQUES, M. Health Professionals Facing Suicidal Patients: What Are Their Clinical Practices? *International Journal Environmental Research and Public Health*, Basel, v. 15, n. 6, p. 1210, 2018. Disponível em: <<https://www.mdpi.com/1660-4601/15/6/1210>>. Acesso em: 5 abr. 2020.

SILVA, T. P. S.; SOUGEY, E. B.; SILVA, J. Estigma social no comportamento suicida: reflexões bioéticas. *Revista Bioética*, Brasília, DF, v. 23, n. 2, p. 419-426, 2015.

CFP - CONSELHO FEDERAL DE PSICOLOGIA. *Suicídio e os desafios para a psicologia*. Brasília, DF: CFP, 2013. Disponível em: <http://newpsi.bvs-psi.org.br/ebooks2010/pt/Acervo_files/suicidio_desafios_psicol.pdf>. Acesso em: 5 abr. 2020.

OHCHR - UNITED NATIONS HUMAN RIGHTS OFFICE. *Open Statement by the Special Rapporteur*

on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Geneva: OHCHR, 2019. Disponível em: < <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/297/58/PDF/G1929758.pdf?OpenElement>>. Acesso em: 5 abr. 2020.

VIDAL, C. E. L.; GONTIJO, E. D. Tentativas de suicídio e o acolhimento nos serviços de urgência: a percepção de quem tenta. *Cadernos de Saúde Coletiva*, Rio de Janeiro, v. 21, n. 2, p. 108-114, 2013.

VINUTO, J. A amostragem em bola de neve na pesquisa qualitativa: um debate em aberto. *Temáticas*, Campinas, v. 22, n. 44, p. 203-220, 2014.

WHO - WORLD HEALTH ORGANIZATION. *Preventing Suicide.* A global imperative. Geneva: WHO, 2014. Disponível em: < <https://www.who.int/publications/item/9789241564779> >. Acesso em: 5 abr. 2020.

WHO - WORLD HEALTH ORGANIZATION. *Suicide in the world.* Global Health Estimates. 2019. Disponível em: <<https://apps.who.int/iris/bitstream/handle/10665/326948/WHO-MSD-MER-19.3-eng.pdf?ua=1>>. Acesso em: 21 maio 2021

WHO - WORLD HEALTH ORGANIZATION. *The European Mental Health Action Plan.* Turkey: WHO, set. 2013. Disponível em: <https://www.euro.who.int/__data/assets/pdf_file/0004/194107/63wd11e_MentalHealth-3.pdf>. Acesso em: 21 maio 2021

Authors' contribution

Lima, Boeira, Albuquerque and Marques contributed to the design of the study, data collection and analysis, drafting and revision of the manuscript.

Received: 08/27/2021

Resubmitted: 12/8/2020; 05/18/2021; 08/27/2021

Approved: 03/02/2022