



End-of-life practices: a bioethical analysis of Brazilian Legislative projects, 1981-2020

Práticas de fim de vida: análise bioética dos projetos do Poder Legislativo brasileiro, 1981-2020


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Abstract

Voluntary active euthanasia (VAE) and assisted suicide (AS) constitute end-of-life practices that aim to minimize the suffering of people with incurable diseases, preserving their human dignity in the face of death. However, taboos and controversies still surround them. This study aims to investigate the legal-normative status of these practices in Brazil via a qualitative documentary research with data from the Federal Legislative Power websites from 1981 and 2020. The dialectical hermeneutic proposal of this study discusses the path of political decisions on VAE, AS (and their relations with orthothanasia and palliative care), and the practical effects of their values and moral constructions on people's self-determination in the dying process and in society.

Keywords: Assisted Suicide; Voluntary Active Euthanasia; Palliative Care at the End of Life; Social Values; Bioethics.

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Resumo

Eutanásia voluntária ativa (EVA) e suicídio assistido (SA) são práticas de fim de vida que, embora permeadas de tabus e controvérsias, visam minimizar o sofrimento das pessoas com doenças incuráveis, preservando sua dignidade humana diante da morte. Neste artigo, objetivamos investigar a situação jurídico-normativa dessas práticas no Brasil, por meio de uma pesquisa documental qualitativa que buscou dados do período de 1981 a 2020 nos sites do Poder Legislativo Federal. Com base na proposta hermenêutica dialética, discutimos o percurso das decisões políticas sobre EVA, SA (e suas relações com a ortotanásia e cuidados paliativos) e os efeitos práticos de suas construções valorativas e morais para a autodeterminação das pessoas tanto no processo de morte quanto na sociedade.

Palavras-chave: Eutanásia Ativa Voluntária; Suicídio Assistido; Cuidados Paliativos na Terminalidade da Vida; Valores Sociais; Bioética.

Introduction

The human action called “euthanasia,” a praxis understood since antiquity in its etymological meaning of “good death” (i.e., without pain and suffering) lies among the crucial issues of human finitude (Siqueira-Batista; Schramm, 2005, p. 112). However, the term has undergone a semantic evolution over the centuries. From Thomas More and Francis Bacon in the 17th century onward, it acquired a meaning that refers to the act of ending the life of a person living with a disease to acquiring a pejorative connotation for many societies in the 20th century and representing a mere euphemism for the voluntarily provoked painless suppression of the life of those who endure or might endure unbearable suffering (Pessini; Barchifontaine, 2012).

Stefan Kühl (2002), investigating the relationship between German racial hygienists and American eugenicists, stated that the International Society for Racial Hygiene (founded in 1907 by the American-led international eugenics movement) held international meetings in 1911 (Dresden) and 1912 (London) in which scientists presented their studies on eugenics and discussed its impacts on legislation and social practices, the practical application of eugenic principles, and the promotion of their ideals. These meetings ceased with World War I but “the foundation for transnational cooperation had been laid”¹ and “the German racial hygiene movement followed the development of the American eugenics movement closely” (Kühl, 2002, p. 15), which culminated in Nazi eugenicist science and its application, creating the “eugenic murder” program in World War II.

In mid-1939, a planning group in Nazi Germany organized an operation to exterminate children and young people up to the age of 17 years who had severe physical or mental disabilities, called the “Euthanasia Program.” At least 5,000 children were killed in the name of “eugenic” ideals (Azevedo, 2014, p. 667). Thus, Nazism undoubtedly distorted the meaning of “euthanasia,” just as “the expression *dignified death* was used to legitimize many eugenic homicides” (Dadalto, 2019, p. 2), generating

¹ Prior to 1933, the leadership of American eugenics in the International Society for Racial Hygiene notably contributed to the German eugenics movement with ideas and financial resources (Kühl, 2002).

diverse connotations that aided the development of preconceptions and suspended the debate for almost 20 years due to the association of its program to exterminate vulnerable people by “euthanasia.”

With the end of World War II, the meaning of euthanasia was gradually demystified, and the debate was reignited in the 1960s. According to Diniz and Costa (2004, p. 124), “because it is one of the priority themes for intellectual production in Bioethics, the theme of euthanasia is full of argumentative subtleties that seek to differentiate euthanasia as the exercise of a fundamental right from the extermination practiced by Nazi medicine” (free translation). Thus, the debate resurfaces due to questions on the interruption of futile treatment (dysthanasia), rather than about euthanasia. The dissemination of critical ideas about dysthanasia stemmed from the technological development in health from the 1960s and 1970s.

The incorporation and/or development of new life support care technologies (such as mechanical ventilators) “[...] has enabled significant progress in curing diseases and extending life. However, it is necessary to consider possible harms of prolonging the life of sick people” (Mendes et al., 2020, p. 79812; free translation) for a “dignified death” (Dadalto, 2019). This fact evoked important analyses on the finitude of life, such as on distinguishing voluntary active euthanasia, orthothanasia, and dysthanasia. Moreover, “the possibility of maintaining the functioning of vital organs by technical means, generating liminal states between life and death [...] conferred a new status to medical interventions in [patients’] final moments and opened questions and debates about the potentialities and limits in the use of these technologies” (Alonso; Villarejo; Brage, 2017, p. 1032; free translation), contributing to at least partially rupturing “[...] the taboo our culture has always established around themes related to death” (Gracia, 1990, p.32; free translation). Thus, the advent of intensive care units with the most sophisticated hard technologies (keeping patients alive) has contributed to the debate on euthanasia; understood, in this context, as “turning machines off.” It is essential to highlight that, in Brazil, turning off such devices is currently not considered as euthanasia according to CFM Resolution 1805/2006 in its specific situations.

At the end of the 20th century, according to Berlinguer (2010), “everyday” bioethical issues, i.e., those that “happen every day and should no longer be happening,” included people at the end of their lives suffering during their death process. This juncture gave rise to the first Brazilian legislative proposal on euthanasia: PL 4662/1981. Although paternalistic, its provision “enabling physicians” to “turn the devices off” of persons in a “terminal coma” fostered the debate between the relation between death, suffering, and care technologies. Intensive care units, heart transplants, life support techniques, among others, unsurprisingly constitute some of the agents of this thanatological “revolution,” without which the meaning of the current debate on euthanasia would be lost (Gracia, 1990, p. 28).

However, the ideal of “[...] orthothanasia, which can be demarcated as death in its right time” (Siqueira-Batista; Schramm, 2005, p. 114) emerged in Brazil to mischaracterize the pejorative connotation given to the fight against “therapeutic obstinacy” (or dysthanasia) and defend proportional treatments and expected benefits. Thus, the remedy for dysthanasia—death postponed by “[...] disproportionate treatments” (Siqueira-Batista; Schramm, 2005, p. 114) that, rather than bringing acceptable solutions to people living with sickness, thus causes more suffering—exclusively refers to orthothanasia. Thus, orthothanasia advocates, who tend to philosophically associate it with palliative care, began to define both practices as “substitutes” for the “abbreviation of the dying process (euthanasia)” (Siqueira-Batista; Schramm, 2005, p. 114) and assisted suicide. Thus, the practice of end-of-life—supposed to offer an option to a dignified death—became the only alternative, limiting people’s autonomy. However, a possible definition of what “death at the right time” and “therapeutic proportionality” constitute remains debatable, pressuring the debate on other options for end-of-life practices such as voluntary active euthanasia (VAE) and assisted suicide (AS), which some countries have decriminalized or legalized.

In a more recent definition, “euthanasia can be understood as the use or abstention of procedures that can hasten or cause the death of incurable patients to free them from the extreme suffering that assails them” (Lepargneur, 2009, p. 3; free translation). The lexical delimitation of the terms referring to the bioethics of the end of life show that

the modalities currently used to classify euthanasia would be based on the “‘act itself’ and the ‘consent of patients’” (Siqueira-Batista; Schramm, 2005, p. 113). The act can be classified as active—the deliberate, humanitarian act of causing death without suffering—and passive euthanasia – by deliberately omitting a medical action that would guarantee survival. Patients’ consent can be classified as voluntary—in response to patients’ expressed will—or involuntary euthanasia—performed against patients’ (can thus be equated with “homicide” as it shortens life against the will of persons or without their knowledge). Finally, AS occurs when a person rationally capable of deciding requests the help of another individual to obtain their death, the latter of which intentionally assists them during the act or provides them with the means to carry it out (Siqueira-Batista; Schramm, 2005). It is necessary to differentiate VAE from AS—the objects of this study—since, in the former, it is the healthcare provider who performs the act; whereas, in the latter, it is the person themselves who performs the action to die.

Brazil neither legitimizes such practices nor has engaged in a vivid debate about it, leading us to ask: what do its legislative representatives think and propose? This research aimed to investigate the legal-normative status and the panorama of discussions about VAE and AS in the Brazilian legislative power since understanding end-of-life practices is essential to insert them in the public debate and envision their decriminalization to favor good-quality dying processes and ensure human dignity.

Methodology

The operationalization steps proposed by Minayo (2014) were followed in this qualitative documentary research.

In the first stage, when analytical categories were elaborated, we conducted a search for information in documents concerning the bills related to end-of-life practices on the websites of the National Congress, the Federal Senate, and the Chamber of Deputies, from 1981 onward (as it marks the latest results for

which digitized information is available online). Bills, requests, proposals for plebiscites and public hearings, and plenary debates up to September 6, 2020, constituted the framework of the proposed discussions, totaling 193 documents that contained 15 bills on euthanasia, AS, and Orthothanasia—the end-of-life practices that constitute the objects of this research (Charts 1, 2, and 3). Specific projects on palliative care without direct relation to the aforementioned practices were excluded. Next, the analytical categories were elaborated. Thematic categories were created by horizontally and vertically reading the texts. They included the object of this study: “end-of-life practices (euthanasia and assisted suicide)—between the right to life and the right to die with dignity”².

To sort and classify the data, the collected information was stored and organized on Atlas.ti 9.0 (a software for qualitative research). The quotes that represented their authors’ opinions were chosen and identified by the letter D (“document”) together with their registration number.

The analysis and the hermeneutic-dialectical interpretation of this study evaluated the course of political decisions that involved people’s freedom and possibilities of choice in the face of suffering and death. Thus, the time frame chosen for the documentary search (1981-2020) encompassed legislative practice changes due to the new legal order founded with the 1988 Constitution of the Federative Republic of Brazil (CRFB/1988). Moreover, for data analysis and interpretation, the theoretical framework adopted was everyday bioethics, as it seeks to reconnect the links between ethics and health-disease issues that affect populations (Berlinguer, 2010), and responsibility bioethics, for laying the foundations for moral deliberation processes in the face of ethical problems (Gracia, 2010; Pose, 2011).

Legislative proposals presented in the Brazilian National Congress

Analysis showed that most justifications against decriminalizing VAE and/or AS mention the defense of the principle “of the inviolability

² Only one thematic category stemming from the exploratory phase of this research and its horizontal/transverse reading (Minayo, 2014) of the bills was chosen since this study only shows the portion of its results that is in line with the objective of this text.

of the right to life,” according to Art. 5 of the Brazilian Constitution. However, legislators see this fundamental constitutional principle in an absolute way: a universal norm that admits no exceptions to the detriment of the “principle of the dignity of the human person” (Brasil, 2020), which would encompass the right to die with dignity. Thus, a legislative trend predominantly contrary to VAE/AS was established based on the 1988 Brazilian Constitution, as per the rapporteur’s vote, approved in the opinion of the Commission for the Constitution and Justice: “[...] between the guarantees and individual rights enshrined in our Political Charter³ is the inviolability of the right to life. Any attempt to shorten or exterminate it encounters an insurmountable obstacle in the constitutional text” (D45).

Based on this framework, The bills on end-of-life practices (regarding VAE/SA) that passed through the federal legislature process sought to further criminalize such practices, proposing to redefine them as heinous crimes⁴. Instead of adapting the reception of the then in force 1940 Penal Code to the current Constitution—as the latter fails to openly prohibit VAE in specific situations—they sought to retrocede such understanding, distorting the fundamental rights of freedom and human dignity to more remote times.

Regarding the proposals presented in the Chamber and Senate since 1981 before and after the CRFB/1988, the aforementioned documentation shows the concrete presence of information related to the theme by congressmen, making it possible to explain conflicts of values so the debate on the VAE/AS necessarily “[...] involves the conflict between two values essential to the national legal system: life in its biological sense and the right to a dignified existence” (Júnior; Goulart, 2022, p. 204; free translation) and the right to “a dignified death, understood as the possibility that the individual with a life-threatening disease may choose how they wish to die” (Dadalto, 2019, p. 8; free translation).

The first was PL 4662/1981 (Chamber), which would enable “the attending physician to turn off the devices of a patient in a state of terminal coma or to omit a medication that would uselessly prolong a vegetative life without the possibility of recovering suffering living conditions, in common agreement with the relatives” (D45). Its author, physician and federal deputy Inocêncio Oliveira (PDS-PE) resubmitted it with the same content under PL 732/1983, which was again dismissed after the opinion of the Commission for the Constitution and Justice found it “unconstitutional.” The bill deemed that, “in the area of criminal law, the bill seeks to make a criminal conduct, which is to allow the death of someone, into an atypical conduct” (D119). Thus, the author argued that “the project aims only to regulate a fact that professionals have often faced, causing problems to the [medical] class, hospitals, and family members” (D45). and that “from the point of view of ‘the physician, the professional’ must fight to preserve health, prolong life, and shorten suffering but ‘must have the right to decide on the uselessness of prolonging a vegetative life’ that has no possibility of recovering their sufferable living conditions” (D45). In other words, vesting medicine with the right to decide on “a vegetative life” in “common agreement with relatives.” The “patient” would not even be treated as such, but as a mere body, reinforcing the medicalization of the process of death and dying.

These proposals also show that several projects manifested much more the corporate interests that reflect a continuous interference and domination over the human body than a defense of the right to a dignified death the VAE/AS could provide. Almost a decade later, under the aegis of the 1988 Constitution, Deputy Gilvam Borges (PRN-AP) presented PL 1989/1991, which provided “for the practice of euthanasia in the circumstances it specifies.” His justification was that, at the time, “medicine could [already] safely predict the incurability of certain diseases [...] and avoid suffering for patients and

³ Reference to the 1967 Brazilian Constitution, in force at the time.

⁴ Heinous crimes violate the fundamental principles of the Brazilian Constitution (Brasil, 2020). Law no. 8.072, of 07/25/1990, which addresses heinous crimes, regulates Item XLIII of Article 5 of the Constitution, establishing the list of crimes, typified in the Penal Code, and their penalties. The authors of the criminalist bills intend to include euthanasia, assisted suicide, and abortion in the list of these crimes.

their families” (D15). Thus, “the family of the terminally ill patient diagnosed with the total impossibility of recovery of neuro-cerebral functions may ask a physician to adopt euthanasia” or, “when the request is made by the patient, they will be submitted to a medical board for evaluation of the condition” (D15). In any case, the decision-making power over the dying process is also decentered from the subject, who remains alienated from their own self-determination. Likewise, the report of the Social Security and Family Commission and the Commission for the Constitution and Justice invoked the principle of the “inviolability of life” to dismiss this proposal, claiming that “in view, therefore, of this constitutional principle and even with an express manifestation of the will of the patient or his relatives, euthanasia must continue to be typified in the Penal Code as ‘killing someone,’ repudiating the exclusion of criminality that is intended to be attributed to it” (D15).

By way of comparison, the first two bills by Deputy Inocêncio proposed a unilateral medical decision-making process on “patients in terminal coma,” whereas PL 1989/1991 provided for proof of the “impossibility of recovery of neuro-cerebral functions” and the participation of family members. However, both disregarded the free will of the person who suffers since they failed to provide for the respect for self-determination, thus centering proposals on the supposed “[...] legitimacy of disposing of any person’s life” instead of “centering” the debate on the possibility “of the sick person [...] asking and obtaining euthanasia” (Pessini; Barchifontaine, 2012, p. 409; free translation). Still, the debate on the subject and these bills were dismissed based solely on an interpretation of the principle of the inviolability of life as absolute. Such interpretation can hide illegitimate intentions, such as the agenda that opposes abortion under any situation since, as Diego Gracia (2011, p. 110) states, if “health and life are intrinsic values [...], they are also instrumental values when they are allocated to the service of other things” (free translation).

While we consider the progress of these bills in the Chamber of Deputies to favor the decriminalization

of euthanasia, we highlight their conceptual inconsistencies in classifying end-of-life practices. The Draft Legislative Decree no. 244/1993, presented by Congressman Gilvam as an initiative to call for a plebiscite on euthanasia, proposed that “those qualified to vote will say whether or not euthanasia is an appropriate way to shorten the suffering of terminal patients” (D2). It was dismissed for the same reasons as the previous ones.

Over the years, the then deputy was elected Senator and resubmitted his project, PLS 125/1996, calling on his peers to analyze the issue with the following words:

Mr. President, Ladies and Gentlemen of the Senate, you bring to the session of this House an important and, in a way, quite controversial subject since it confronts some dogmas and values that are deeply rooted in society, especially in religious segments. As a Federal Deputy, I presented a bill and I am reintroducing it at this moment. This bill authorizes the practice of painless death in the cases it specifies and provides other measures: euthanasia (Brasil, 1996, p.8420; free translation).

Despite his eloquence, the senator acknowledged having “no hope that the bill will succeed since it was never put to a vote,” whereas congressmen stated that “no one wants to discuss euthanasia due to its electoral damage” (Gianello; Winck, 2017, p. 11; free translation).

However, some initiatives—although problematic—served to debate end-of-life practices. However, all were dismissed without any dialogue with society to share and improve them following science and bioethics. Then, the most conservative phase of the National Congress on the subject began, with most bills aiming to criminalize end-of-life practices and reap people’s already limited self-determination instead of, in the light of the new Constitution, strengthening the “[...] use of the principle of human dignity as a basis for questioning the possibility of standardizing euthanasia in the country” (Santos; Urnauer, 2023, p. 154) and “[...] the need to recognize the existence of the right to a dignified death, in all its extension, in Brazil” (Dadalto, 2019, p. 1; free translation).

Chart 1 – Bills proposing the legalization of euthanasia from 1981 to 1996

Project/Authorship/Party and Status	Syllabus
PL 4662/1981 Deputy Inocêncio Oliveira (PDS-PE). Dismissed.	Enables the attending physician to turn off the devices of a patient in a state of terminal coma or to omit a medication that would uselessly prolong a vegetative life without the possibility of recovering suffering living conditions, in common agreement with the relatives.
PL 732/1983 Deputy Inocêncio Oliveira (PDS-PE). Dismissed.	Same content as PL 4662/1981. "Authorizing euthanasia."
PL 1989/1991 Deputy Gilvam Borges (PRN-AP). Dismissed.	Provides for euthanasia under specified circumstances.
PDC 244/1993 Deputado Gilvam Borges (PMDB-AP). Dismissed.	Calls for a plebiscite on euthanasia.
PLS 125/1996 Deputado Gilvam Borges (PMDB-AP). Dismissed.	Authorizes the practice of painless death in the cases it specifies and provides for other measures.

Source: Authors' own elaboration

Euthanasia and assisted suicide: heinous crimes or the right to a dignified death?

Among numerous challenges, we seek to focus the dialogue on legislative proposals that propose to qualify euthanasia and/or AS as heinous crimes by interpreting such practices as “privileged homicides” despite the Brazilian Penal Code failing to expressly mention them, evincing a political dispute that has intensified the criminalization of end-of-life practices.

In this context, many legislators have inverted the construction of values to build distorted ideas in favor of their particular interests using historical remnants directed to a conservative and punitive ideology that contradicts the development of self-determination and responsibility in human freedom. They expose the very reasons that motivate them since coercion and persuasion would maintain a “more severe penal treatment to sanction offenders in a more appropriate way and discourage their practice” (D31). In fact, these political actors fear the further development of values connected to the basic structure of human beings and aim to oppose other political groups that represent proposals to “decriminalize” orthoethanasia.

Although we have shown some of the motivations behind the bills that seek to criminalize such

practices by arguing to act in “defense of life,” we must add that the justifications in these bills express prejudices and devaluations, showing “hatred” and “resentment,” as per a representative comment of the bills against decriminalization: “as they seriously attack the inviolability of the right to life, such monstrous and heinous crimes are, in turn, deserving of harsher penal treatment to punish offenders more appropriately and discourage their practice” (D49).

In an attempt to identify the alleged offenders, we find that criminalization initiatives blatantly disrespect healthcare providers as they constitute the exact target subjects of legislative proposals. Despite the universality of the law, healthcare providers (especially physicians, but not exclusively) are subjected to criminalization. Proponents assume that these professionals commit crimes necessitating a stricter law that puts their practices under “state control.” However, theirs are not the only practices to be controlled. Some political “representatives” even aim to silence the voices of society and of those who may dare to truly represent them. The objective of deeming VAE/AS as a heinous crime follows the intention to interdict the public debate on the subject. Thus, they intend to block the need for dialogue and prevent any proposal contrary to conservative political and social interests.

The first criminalist legislative proposition features these intentions since, presenting a bill of their authorship, its proponent clearly explained the motivation for transforming such end-of-life practices into a heinous crime:

[...] The sick and the elderly, against whom there is no one to defend the practice of euthanasia, [...] not only do not have the physical conditions to defend themselves but are psychologically weakened by illness and dependence so that, even when they can still state their will and consent to the practice of euthanasia, it is not possible to know whether they do so with full lucidity or whether, moved by suffering, have lost their innate instinct for preservation. Thus, as Professor Ives Gandra da Silva Martins says in his *Fundamento Natural do Direito Natural à Vida* (Foundation of the Natural Right to Life): ‘abortion and euthanasia are violations of the natural right to life, mainly because they are exercised against those who cannot for themselves.’ It is indispensable, therefore, to make explicit the heinous nature of such crimes, prohibiting the presentation of any proposition that intends to decriminalize or legalize them (D63).

As can be seen, an attempt is made to interdict the debate using arguments of authority and prohibiting the offer of any contrary position since it would legislatively “recognize” that such practices would violate the fundamental principles and clauses of the 1988 Constitution, modifiable only by the Constituent Assembly. This is the political intention of the first proposal—PL 190/1994 (dismissed) by Deputy Osmânio Pereira (PSDB-MG)—which aimed to “define euthanasia as a heinous crime [...] and prohibit the presentation of propositions that aim to legalize or decriminalize them.” It also argued that “it is indispensable to make explicit the heinous nature of such crimes [abortion and euthanasia], as well as the unconstitutionality of any laws or provisions that establish exceptions to their prohibition or aim, directly or indirectly,

at their legalization or decriminalization” (D63). Such proposal would not only stop the dialogue, discussions, and the scientific and bioethical debate on the problem from any possible advance toward building progressive values, but they could also be read as to oppress freedom of expression. Deputy Osmânio presented two more projects (PL 999/1995 and 5058/2005) to make euthanasia and the voluntary interruption of pregnancies a heinous crime, failing in his attempts up to his last term in 2006. However, the currently proposed projects followed a design that resembled his by following conservative and punitive bases.

Deputy Dr. Talmir (PV-SP) acted on several fronts to deepen criminalization. In 2007, he presented PL 2283/2007 (dismissed) to equate the euthanasia with “assisted suicide,” considering both practices a heinous crime under the Penal Code. Based on the constitutional principle of the right to life, he argued that “it is the duty of the State [...] to guarantee to all” this right, before which “the sick and the elderly should deserve special protection given their condition of fragility. However, there are those who defend the practice of euthanasia for these unprotected people [...]. It is indispensable, therefore, that the heinous nature of this crime be made explicit, as well as that any actions in this direction be legally prohibited” (D63).

Then, taking advantage of the public commotion in which he stated that “the death of Eluana Englaro, an Italian woman, [...] shocked the Christian world,” Deputy Dr. Talmir presented PL 5008/2009 to “prohibit the suspension of care of patients in a Persistent Vegetative State” (D56). On the other hand, he entered the dispute to regulate orthothanasia in the face of the controversy surrounding the Resolution of the Federal Council of Medicine and its judicialization. For this, he presented PL 6544/2009, on the “care for terminally ill patients,” forming two groups of projects that are currently under process in the National Congress: (1) addresses the decriminalization of orthothanasia and (2) intends to classify euthanasia and AS as heinous crimes.

Chart 2 – Projects that address the decriminalization of orthothanasia and reject euthanasia

Project/Authorship/Party and Status	Syllabus
PLS 116/2000. Sen. Gerson Camata (MDB-ES). Attached to PL 6715/2009.	Excludes orthothanasia from illegality. (Amend the Penal Code).
PL 3002/2008. Deputy Hugo Leal (PSC-RJ) and Otávio Leite (PSDB-RJ). Attached to PL 6715/2009.	Regulates orthothanasia in the Brazilian national territory.
PL 5008/2009. Deputy Dr. Talmir (PV-SP). Attached to PL 3002/2008.	Prohibits the suspension of care for patients in a persistent vegetative state.
PL 6544/2009. Deputy Dr. Talmir (PV-SP) and Miguel Martini (PHS-SP). Attached to PL 3002/2008.	Provides for the care of terminally ill patients.
PL 6715/2009. Sen. Gerson Camata (PMDB/ES). In progress, substitutes PLS 116/2000, PL 3002/2008, PL 5008/2009, and PL 6544/2009.	Amend Decree-Law no. 2.848 of 7/12/1940 (Penal Code) to remove orthothanasia from illegality.

Source: Authors' own elaboration

Chart 3 – Projects that aim to classify euthanasia and SA as heinous crimes

Project/Authorship/Party and Status	Syllabus
PLP 190/1994. Deputy Osmânio Pereira (PSDB-MG). Dismissed.	It provides for the inviolability of the right to life guaranteed by Article 5, the interpretation of the paragraph 7 of Article 226 of the Federal Constitution, and other provisions.
PL 999/1995. Deputy Osmânio Pereira (PSDB-MG). Dismissed.	It provides for the inviolability of the right to life, defines euthanasia and the voluntary termination of pregnancy as heinous crimes under any circumstance, interprets paragraph 7 of art. 226 of the Federal Constitution, and makes other provisions.
PL 5058/2005. Deputy Osmânio Pereira (PSDB-MG). Dismissed.	Regulates art. 226, paragraph 7 of the Federal Constitution, providing for the inviolability of the right to life, defining euthanasia and the voluntary interruption of pregnancy under any circumstance as heinous crimes
PL 2283/2007. Deputy Dr. Talmir (PV-SP). Dismissed.	Equates euthanasia to the crime of inducing, instigating, or assisting suicide and considers it a heinous crime.
PL 3207/2008. Deputy Miguel Martini (PHS-MG). In progress; attached to PL 4703/1998 by Deputy Francisco Silva (PPB-RJ) which "constitutes the practice of abortion as a heinous crime" under any circumstance.	It includes inducing, instigating, or assisting suicide (euthanasia) and induced abortion in crimes considered heinous.

Source: Authors' own elaboration

The set of projects in the first group was attached to PL 6715/2009 (substitutive) to "bring together the various propositions into a single one" and "provide for the care due to patients in the terminal phase of illness" (D112). The rapporteur of the substitute states: "by analyzing the four projects that are being

processed together, it is possible to verify great harmony between them. They are all opposed to any allusion to euthanasia." On the other hand, they associate orthothanasia with palliative care and base it on the concepts of ordinary and extraordinary care. This substitute bill also defends the decriminalization

of orthothanasia as provided for in PL 6544/2009 by Deputy Dr. Talmir, which is transcribed in Art. 4 of the rapporteur's "substitute" as "if there is a favorable manifestation of the patient in the terminal phase of their illness or, if that is impossible, of their family or legal representative, it is allowed [...] the limitation or suspension by the physician of disproportionate or extraordinary procedures and treatments designed to artificially prolong life" (D110). It adds that "the request for limitation or suspension of the procedures [...] will be presented by the attending physician to the specialized medical board for analysis and ratification or not of the conduct," which may meet individuals' free will or fail to do so. This apparent advance, in fact, "runs the risk of undermining personal autonomy, which is precisely the fundamental value that is trampled on [...]" (Berlinguer, 2010, p. 9; free translation) by medicalizing the process of dying and death and failing to admit that "euthanasia, whether passive or active, should be the result of a free and informed process and, therefore, understood as a fundamental right supported by the ethical principles of autonomy and dignity" (Diniz; Costa, 2004, p. 125). Unsurprisingly, in this field—in which "the 'right to know' is affirmed [...] as an expression of personal autonomy," denying the information and decision-making power of suffering persons produces a formula in which "[...] treating people as a thing means violating their personal autonomy and personal freedom" (Berlinguer, 2010, p. 25, 35; free translation).

On the other hand, the group of bills that treat end-of-life practices as a heinous crime are being processed together (attached) with anti-abortion proposals; two bills directly related to euthanasia and AS (in addition to those already dismissed) refer to PL 4703/1998 by Deputy Francisco Silva (PPB-RJ) and PL 3207/2008 by Deputy Miguel Martini (PHS-MG). The former characterizes abortion under any circumstance as a heinous crime. Its author justifies such proposal by the "journalistic articles frequently published in the media, which report that the practice of illegal abortion is widespread in this country, in addition to registering several cases of euthanasia" (D31). The latter aims to typify the "inducement, instigation, or assistance to suicide" as a heinous crime, equating it to euthanasia.

In short, the analyzed projects seek to criminalize euthanasia and AS, showing similar arguments and a conservative political agenda addressing customs and morals. In these cases, the approval of the classification of these practices as a heinous crime would block the debate in society since it would prohibit the proposals for popular plebiscite on the subject and the Brazilian society to offer its opinion on how to solve these problems. Thus, such neoconservative movement focuses on an "agenda of customs," and it is strongly led by religious groups, presenting legislative proposals that attack the prevailing moral pluralism and seek to approve laws to reestablish a single morality and legitimize their ideals of conception of life and death by the State.

Final considerations

The 1980s and 1990s produced (although limited) proposals to regulate euthanasia and failed initiatives toward plebiscites on the subject. The focus of the debate in the following decades shifted from euthanasia to orthothanasia, with bills attempting to "decriminalize" the latter. Disputes arose around the delimitation of orthothanasia—limiting medical practice on its permission to interrupt treatments/procedures to terminally ill patients, the main subjects of the debate, which barely received any attention from such proposals since they deemed that peoples' self-determination, when mentioned, should be secondary to the legal security of professionals.

Such initiatives (and the scarce public debates) have generated reactions in other political groups that have culminated in radical neoconservative forces in recent years, including among religious leaders, who almost exclusively concern themselves with what has come to be called "agendas of customs." The matters in progress the "conservative bench" have pushed include the anti-abortion agenda and the criminalization of VAE/AS (proposed as heinous crimes). In short, the background of actions from the political forces that oppose the right to a dignified death involves controlling individual freedoms and preventing moral and cultural progress in society.

We had to question these evidently political disputes, finding that the conflicts are based in the paradox within interpretations of constitutional

principles on the inviolability of life and human dignity. Those who oppose any change toward greater freedom to decide concrete cases usually deem the principle of the inviolability of human life as unquestionable, considering the value of life as superior and absolute regardless of context and consequences in detriment to human dignity, detaching the right to life from the right to a dignified death, opposing the legal interpretation that decriminalized euthanasia in Colombia, for example, which finds that the right to a dignified life implies the right to a dignified death (Colombia, 2015).

This evinces the conflicts of values between the actors who have the legislative power of “representation” as they seek to base them on an ethic of conviction by using constitutional principles they interpret according to their own morals. The focus of this research on the discussions of the Brazilian legislature showed, with Berlinguer, that political institutions consist of people with particular morals and interests, generating spaces of tension represented by the conflicts and problems of the ethos (Lima; Verdi, 2012).

As for the issue at hand, “there remains a paradoxical situation in the legal reality [...] which clearly transpires, on the one hand, the value of individual freedom and self-determination and, on the other hand, the value of the absolute protection of one’s life, even against one’s own will or regardless of the quality of life the person desires” (Gianello; Winck, 2017, p. 12; free translation). Conservative political forces prevailing in this reality would tend to criminalize end-of-life practices, including orthothanasia and other palliative care actions, such as palliative sedation.

A long way toward any regulation of practices such as VAE/AS would certainly remain, even under a favorable political environment with participatory democracy open to public debate. In fact, these constitute the basic conditions for building morally legitimate social values as obtaining regulation requires including the moral pluralism of society and the diversity of ideas to the debate due to the need of analyzing the aspects that make up the complexity of human life. Any law and technical-scientific criterion adopted to legitimize these practices must encompass the needs and evolution of social

morality, guaranteeing the right to autonomy of people to decide about their own death and to obtain the right to State assistance to die with dignity.

Legalizing and regulating VAE/AS would, rather than imposing an obligation on anyone, only ensure the right to decide and the necessary support of health services since, as Berlinguer states, “[...] regarding personal autonomy, the decisions about one’s own destiny must also include, in a secular way, that of being able to choose whether or not to continue to be cured, whether to live or die” (Berlinguer, 2010, p. 61; free translation). In short, this right to choose based on the person’s self-determination gives meaning to and “the definition of a death as ‘good’ or ‘dignified’” (Alonso, 2012, p. 191-192) to the daily care of people at the end of their lives.

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