GUIDE FOR APPLYING A

MINICOURSE

ORTHOTHANASIA

UNRAVELLING THIS ENIGMA!

ANTONIO VALVERDE NEGREIROS JUNIOR
ADILSON PEREIRA

FOA

UniFOA
Centro Universitário de Volta Redonda

MESTRADO
PROFISSIONAL
ENSINO EM CIÊNCIAS
DA SAÚDE E DO MEIO AMBIENTE

SUMMARY

PRESENTATION 03

TARGET AUDIENCE 06

OBJECTIVE OF THE GUIDE FOR THE APPLICATION OF A MINICOURSE ON ORTHOTHANASIA 07

TEACHING THEORY USED AS THE BASIS FOR THE MINI-COURSE 08

MODULES 1, 2 AND 3 09

MODULES 4 AND 5 10

MODULES 6 AND 7 11

MINICOURSE QUESTIONS 13

FINAL THOUGHTS 29

AUTHORS 30

BIBLIOGRAPHICAL REFERENCES 31

PRESENTATION

In 1900, the life expectancy (estimated number of years that an individual can live) of Brazilian citizens was 33.7 years, and it made a significant leap in just over 11 (eleven) decades, reaching 75.4 years in 2014.

According to the Brazilian Institute of Geography and Statistics (IBGE), in a 2020 publication, life expectancy for men went from 72.8 years in 2018 to 73.1 years in 2019, and for women from 79.9 years to 80.1. This increase in life expectancy, which in theory translates into the hope of living longer and with a better quality of life, does not detract from the fact that we are human beings and that we carry with us a limit, an end. Ageing and the consequent longevity lead to the frequency of various types of illness and, consequently, the end of life.

Orthothanasia seeks to use appropriate means to treat a dying person, i.e. it does not anticipate the end, but rather accepts mortality at the right time, providing all the necessary care and regular means for the patient not to suffer, seeking to control pain and other symptoms, as well as taking care of psychological, social and spiritual problems, achieving the best possible quality of life for the patient.

The end of life (usually a serious and irreversible medical condition) can sometimes be accompanied by pain and suffering, and when the quality of life is no longer the same, the individual himself begins to question what is most important to him at that moment and to consider what choices to make when the moment of death comes.

The teaching of orthothanasia is generally included in the context of palliative care and thanatology. The research showed that there is a gap, which we understand as a lack of content applied to the training of doctors and health professionals in relation to the teaching of death and, consequently, of orthothanasia.

According to the research carried out, undergraduate medical courses do not effectively teach doctors how to deal with terminally ill patients or how to manage the situation of death in a humanised way. This is why discussion and teaching about orthothanasia is so important.

The field of orthothanasia, including palliative care, is on a growing trend due to the increase in life expectancy of the world's population and the consequent increase in diseases caused by an ageing population.

Given this panorama, we believe it is unequivocally important that professional training (skills and competences in orthothanasia) be applied to undergraduate medical students so that they can adequately address this social configuration.

The proposal we are presenting here is a Guide for applying a Minicourse on Orthothanasia with seven modules, which begins with research questions for students to study and ends with an assessment to identify what has been learnt, as well as helping the teacher to devise action strategies for developing the teaching and learning process.

In a recent publication from October 2021, the World Health Organisation (WHO) estimates that every year more than 56.8 million people, including 25.7 million in the last year of life, will need Palliative Care and that by 2060 the need for Palliative Care is expected to almost double.

What is a minicourse?

A mini-course is a short event (usually between 2 and 16 hours) that seeks to present and initiate a discussion on a specific subject, with the aim of the student learning more about an area of interest and thus acquiring an overview of the subject covered.

TARGET AUDIENCE

The target audience is undergraduate medical students, more specifically between the 4th and 12th terms, as they have more academic experience.

OBJECTIVE OF THE GUIDE FOR THE APPLICATION OF A MINICOURSE ON ORTHOTHANASIA

The Educational Product Guide for the Application of a Minicourse on Orthothanasia is the result of the research project "TEACHING ORTHOTHANASIA IN MEDICAL GRADUATION: A PROPOSAL FOR DIDACTIVE-PEDAGOGICAL MATERIALS", developed by master's student Antonio Valverde Negreiros Junior, under the guidance of Prof Dr Adilson Pereira, at UniFoa's Professional Master's in Teaching in Health and Environmental Sciences.

This Guide to the Application of a Minicourse on Orthothanasia aims to subsidise the acquisition of basic skills and competences required for the training of 4th to 12th year undergraduate medical students.

TEACHING THEORY USED AS THE BASIS FOR THE MINICOURSE

The basic premise of deciding on a learning theory is the characteristics of the educational process being pursued. Andragogy, defined by Malcolm Knowles (1913-1997) in the 20th century, is an ancient science that studies adult education in order to seek effective learning for the development of skills and knowledge. Adult education should not be taught in the same way that we educate children.

Andragogy enables teaching based on motivation and self-knowledge, as well as making the student's experience a fundamental element. Therefore, in order to encourage adults to learn, it is important to choose relevant content that is related to their area of expertise and day-to-day activities, enabling them to apply their new knowledge to solving real problems.

Malcolm Shepherd Knowles was a researcher and one of the leading adult educators in history. He was very influential in popularising andragogical concepts (1950s to 1970s) and today is considered by many to be the "Father of Andragogy". He is also one of the main figures in the development of the Humanist Theory of Learning. He graduated in Philosophy (1934) from Harvard University, Master's (1949) and Doctorate (1959) from the University of Chicago.

1st MODULE

In class, the teacher will present a problem situation in relation to the topic being studied (orthothanasia). At this point, the students will be introduced to the topic of orthothanasia and the study method to be applied, which will be directed research (out-of-class activity). Two 30-minute lectures will be needed, one to explain the topic of orthothanasia and the other to explain the directed research.

2nd MODULE

In the classroom, the teacher will organise the students into groups, where they will be asked the following questions for research (extra-class activity): 1) How is medical education applied to concepts relating to orthothanasia for undergraduate medical students in Brazil? 2) Death, 3) Objectives of Medicine, 4) Concept: Orthothanasia, differences in relation to Dysthanasia, Mysthanasia, Euthanasia and Assisted Suicide, 5) Palliative Care, 6) Medical understanding of Orthothanasia, 7) Legal understanding of Orthothanasia.

3rd MODULE

Together with the students, the teacher in the classroom will analyse possible sources of information to support the research, such as bibliographical research, the experiences of medical professionals and interviews with health professionals. The suggestion for standardising studies and improving group performance is bibliographical research (out-of-class activity). A 30-minute lecture is required.

4th MODULE

Exploring information. In class, the teacher will ask each student to carry out individual bibliographical research (out-of-class activity) on the questions posed in the second module.

In this proposal, students will be guided by the teacher to carry out their research in parallel via a virtual environment and at a later date this research will be worked on in class (Module Five).

A 30-minute lecture will be required.

5th MODULE

Group discussions and conclusions. At this point the students, organised in groups and supervised by the teacher in the classroom, will discuss the issues they have researched and produce conclusions. This is a scenario where students can be seen helping other students to complement their thoughts on the subject, with the aim of achieving success in the study.

Seven lessons of one hour each will be needed for the discussions and conclusions of the seven questions posed in the second module.

6th MODULE

Generalisation of conclusions and synthesis. The teacher will cross-reference the conclusions presented by the groups of students with the contributions of scientists who have previously studied the subject. In this way, the answers given by the students to the proposed questions will be assessed in class.

Seven lessons of one hour each will be needed to draw conclusions and summarise the seven questions posed.

7th MODULE

Assessment. The teacher will ask the students to submit an individual text describing all the activities carried out, as well as presenting their conclusions on the proposed questions (extra-class activity). A 30-minute lecture is required.

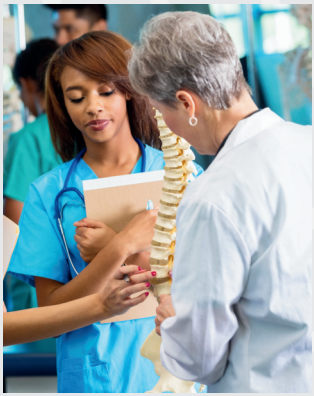
The students' task is not simply to carry out the tasks decided by their teachers, but to actively participate and understand the learning outcomes, assessing their own progress, their responsibility for learning, and engaging with other students to learn collaboratively.

This is the Diagnostic Assessment methodology, which is the result of analysing how much each student has learned, what knowledge they have accumulated and what skills and competences they have developed throughout their learning journey.

According to Luckesi (2002), diagnostic assessment is "an instrument for understanding the stage of learning the student is at, with a view to making sufficient and satisfactory decisions so that they can move forward in their learning process". In this way, "diagnosing" is a dialectical tool, a successive process that provokes action, reflection and interpretation of the events that occur during the learning process, and is an opportunity for teachers to define their stance on the learning process, validating and/or reviewing their pedagogical practice.

To reinforce the above, Rabelo (2009) justifies that diagnostic assessment identifies the reality of the students and makes a prognosis about their individual knowledge, thus helping the teacher to devise action strategies to develop the teaching and learning process.

With the diagnosis, the teacher will be able to determine what needs to be done to solidify the students' strengths and improve their weaknesses. It is this assessment that will serve as a guide for teacher planning, enabling the teacher to adapt their methodologies and propose a plan for pedagogical interventions.



MINICOURSE QUESTIONS

THE TEACHING OF ORTHOTHANASIA IN UNDERGRADUATE MEDICAL COURSES IN BRAZIL

The studies by Poletto, Santin and Bettinelli (2013) showed that the teaching in medical courses is that death is amphemeral, however the subject of death is insufficiently debated throughout professional training, especially the discussion of how to face death. In undergraduate medical courses, the focus is on the importance of preserving life, favouring the use of technologies and treatments with the aim of distancing death, and not on how to face death when the patient is terminally ill.

They also pointed to the need to revise the curricula of undergraduate medical courses and related areas to better address the process of death and dying, as well as palliative care.

Costa, Caldato and Furlaneto (2019), Santos, Menezes and Gradvohl (2013), Ferreira, Nascimento and Sá (2018) , Poletto, Santin and Bettinelli (2013) and Pereira, Rangel and Giffoni (2019), in their work, verified the deficiency of medical education in relation to issues related to death and dying in undergraduate medical courses.

DEATH

Costa, Caldato and Furlaneto (2019) argue in their studies that in the face of advances in medicine and the longevity of individuals, it is necessary to understand the terminality of life (a process that highlights the near, inevitable and expected death), since technology and invasive methods increase longevity, delay the process of death and prolong the subsistence of human beings, without guaranteeing quality of life. In this scenario, patients are often kept alive by therapies that cause more pain than relief and comfort.

According to Santos, Menezes and Gradvohl (2013), just as patients can choose how they will live, they can also choose how they will die, since in the practice of orthothanasia, during the patient's terminal phase, technological or futile medical procedures used as a way of prolonging a painful death are suspended, so that a natural death can occur, with the relief of symptoms that lead to suffering, comprising death with dignity.

These authors also describe that the socio-historical context is one of denial of death and that living with human terminality demands acceptance of death.

Ferreira, Nascimento and Sá (2018) point out that although death is part of the daily lives of health professionals, it can still be considered taboo, since in our society habits, beliefs and knowledge repel death, which is seen as an evil to be overcome, in resistance to a natural and irremediable process.

Poletto, Santin and Bettinelli (2013) pointed out that historically doctors have been trained to preserve life and overcome death, and that there is still an understanding that if there is no treatment to cure the patient, there is nothing more to be done. Even so, the authors emphasise the importance of striving to defend human dignity at the moment of death.

Pereira, Rangel and Giffoni (2019) recorded in their work that the majority of medical undergraduates who took part in a field survey said they did not feel able to deal with death, emphasising the difficulty of facing the end of life, the finiteness of life itself, confirmation of the impossibility of a cure and failures in communication, especially of bad news.

MEDICAL OBJECTIVES

According to Pessini (2001), the objectives of medicine are:
a) Promotion of health and prevention of disease;
b) Relief of pain and suffering;
c) Curing and caring for the sick with so-called curable or incurable diseases;
d) Avoidance of premature death, with the consequent search for a dignified and serene death.

With regard to health promotion and disease prevention, we must not forget that death can only be postponed, never completely overcome, and that illness in general cannot be completely overcome, because it will always end up being replaced by another illness throughout life (Pessini, 2001).

As for the relief of pain and suffering, although they often go hand in hand, they are not the same thing. Pain is linked to physical discomfort, while suffering is linked to a psychological state.

The mental and emotional suffering that accompanies illness is often overlooked, as it is difficult for some doctors to understand that the fear of illness can cause as much suffering as the pain itself (Pessini, 2001).

The healing function of medicine involves healing and caring, since healing can happen in a broader sense, by effectively helping the sick person to live with permanent illnesses (Pessini, 2001).

Reducing premature death (when a person dies before having had the opportunity to experience the most important possibilities that characterise the human life cycle) is one of medicine's first and most important objectives, helping young people to one day become elderly, and the latter to live the rest of their lives with dignity (Pessini, 2001).

CONCEPTS: ORTHOTHANASIA, DIFFERENCES FROM DYSTHANASIA, MYSTHANASIA, EUTHANASIA AND ASSISTED SUICIDE

Orthothanasia, a word that defines the right, correct death, comes from the Greek orthos, which has the meaning of straight, normal, and thanatos, which has the meaning of death (Villas-Bôas, 2005).

According to Junges *et al.* (2010), orthothanasia reflects a desirable death, without artificially prolonging life by using procedures that lead to increased suffering, which modifies the natural process of dying.

According to Araguaia (2015), orthothanasia is the name given to the process by which it is decided not to subject a terminally ill patient to invasive procedures that prolong their death and, at the same time, compromise their quality of life. In this way, orthothanasia focuses on the adoption of palliative procedures, seeking to control pain and other symptoms.

In the view of Reiriz *et al.* (2006), orthothanasia is the non-investment in obstinate, even futile, actions aimed at postponing the death of an individual whose underlying disease insists on progressing, leading to the progressive failure of vital functions.

In this way, to the extent that therapeutic resources can no longer restore health, technical attempts become futile by intensifying efforts to maintain life. It is therefore a concept related to palliative care (Pessini; Bertachini, 2004; Reiriz *et al.*, 2006), i.e. care given to people whose illness cannot be cured.

According to Villas-Bôas (2005), in orthothanasia, the doctor does not interfere at the moment of the lethal outcome, either to anticipate it or to postpone it. It is said that there is no shortening of the vital period, since it is already in inevitable exhaustion. Nor is there any recourse to measures that, without having the power to reverse the terminal condition, would only result in prolonging the process of suffering and dying for the patient and their family. Basic care is maintained.

For Barroso and Velho Martel (2010, p. 240), orthothanasia is "death at its proper time, not fought with extraordinary and disproportionate methods as in dysthanasia, nor hastened by intentional external action, as in euthanasia."

For Borges (2005), orthothanasia is conceptualised as not artificially prolonging the process of dying, beyond what would be the natural process, carried out by the doctor.

According to Lopes, Lima and Santoro (2018), Dysthanasia is characterised by the adoption of excessive therapeutic measures that are not aimed at curing, but at the patient's suffering, by adopting futile and disproportionate measures that constitute inhuman and degrading treatment, by allowing life to be prolonged exclusively in quantitative and not qualitative terms.

Mistanásia (also known as social euthanasia), according to Martin (2004), can be characterised by three situations:
a) The great mass of sick people who, for political, social and economic reasons, don't become patients because they can't enter the medical care system;
b) Patients who manage to become patients and then become victims of medical error;
c) Patients who end up being victims of malpractice for economic, scientific or socio-political reasons.

Euthanasia, according to Lopes, Lima and Santoro (2018), should be understood as the act of taking the life of another person suffering from an incurable disease that causes them unbearable pain and suffering, out of pity and in their own interest. What motivates the perpetrator of euthanasia is compassion towards their neighbour, which differentiates it from simple homicide, which is killing someone.

Euthanasia can also be classified as active or passive, according to Santoro (2010). Active if there is an action for the death event and passive if there is an omission for the death event to happen.

Assisted suicide, in the view of Lopes, Lima and Santoro (2018), is the behaviour in which the individual himself ends his life without the direct intervention of third parties in the conduct that will lead to death, the third party in this case will participate by providing moral or material assistance to carry out the act and for humanitarian reasons.

PALLIATIVE CARE

The World Health Organisation (WHO, 2020, p. 1) defines Palliative Care as follows:

Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illnesses. It prevents and alleviates suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.

Palliative care, recognised by the WHO in 1990, dates back to the initiative of social worker and doctor Cecily Saunders, who founded St. Christopher's Hospice in 1967. Saunders engendered a new vision of patients with diseases that could not be cured, with the aim of controlling symptoms, especially pain. In Brazil, Prof. Dr. Miriam Martelete, an anaesthesiologist at FMUFPA, was the pioneer, founding the Pain Service at Hospital das Clínicas in 1979 and the Palliative Care Service in Porto Alegre in 1983.

MEDICAL UNDERSTANDING

The first (legal) medical understanding of the applicability of Orthothanasia came from the Federal Council of Medicine (CFM), which promoted CFM Resolution No. 1,805 in 2006, assuring medical professionals, in its article 1, that "[...] the doctor is allowed to limit or suspend procedures and treatments that prolong the life of the terminally ill patient with a serious and incurable illness, respecting the will of the person or their legal representative" (CFM, 2006, p. 1).

The CFM, in its explanatory memorandum to CFM Resolution 1,805, stated (Dadalto, 2013, p. 137):

[...] it is important for society to realise that certain therapeutic decisions can only prolong the suffering of human beings until the moment of their death, and it is essential that doctors, patients and family members, who have different interpretations and moral perceptions of the same situation, come to debate human terminality and the process of dying.

It is vital that the doctor recognizes the importance of the need to change the therapeutic approach when faced with a terminally ill patient, for whom the World Health Organization calls for the adoption of palliative care, i.e. an approach focused on the quality of life of both patients and their families in the face of problems associated with life-threatening illnesses. It seeks to prevent and relieve suffering through early recognition, accurate and careful assessment and treatment of pain and other symptoms, whether physical, psychosocial or spiritual.

Following the publication of Resolution 1.805/2006, the CFM, in 2009, using its legal powers, approved the new Code of Medical Ethics, prohibiting the practice of "dysthanasia" and expressly legitimizing "orthothanasia" as ethical conduct.

In fact, in item XXII of its Chapter I, which deals with the Fundamental Principles of Medicine, the 2009 Code of Medical Ethics (p. 31) expressly states that "in irreversible and terminal clinical situations, the doctor shall avoid carrying out unnecessary diagnostic and therapeutic procedures and shall provide patients under his care with all appropriate Palliative Care".

The new Code of Medical Ethics of 2009 (p. 39) emphasized the applicability of Orthothanasia in its article 41, expressly in the sole paragraph of this same normative device.

In cases of incurable and terminal illness, the doctor must offer all available palliative care, without undertaking useless or obstinate diagnostic or therapeutic actions, always taking into account the patient's express wishes or, if impossible, those of their legal representative.

The next Code of Medical Ethics, from 2019, maintained the same determinations and guidelines regarding the applicability of orthothanasia.

Today, in the ethical sphere of the practice of medicine, the medical understanding is one of total rejection of the practice of "dysthanasia" and total approval of the practice of "orthothanasia".

In this way, orthothanasia is an obligation for all doctors (to offer it) and a right for all patients.

LEGAL UNDERSTANDING

With the publication of CFM Resolution No. 1.805/2006, there was an antagonism both in medicine and in the legal world, since it was mistakenly claimed that the crime of homicide would be characterized if a doctor limited or suspended treatment and procedures that would prolong the life of a patient in the terminal stage of an incurable disease, thus causing the patient's death.

Thus, in opposition to CFM Resolution no. 1.805/2006, the Federal Public Prosecutor's Office, on May 9, 2007, filed a Public Civil Action (2007.34.00.014.809-3 - Federal District) against the CFM, requesting the repeal of the aforementioned resolution, arguing that orthothanasia, like euthanasia, would constitute the crime of homicide.

The Federal Court of the Federal District, accepting the request for a preliminary injunction, suspended the validity of CFM Resolution 1.805/2006.

After hearing the CFM, the Federal Public Prosecutor's Office, the plaintiff in the case, acknowledged the error of its decision and requested that its initial claim be dismissed, admitting that the practice of orthothanasia did not constitute the crime of homicide.

Finally, the Federal Court of the Federal District fully accepted the final arguments of the Federal Public Prosecutor's Office, dismissing the proposed action and re-establishing the validity of CFM Resolution No. 1,805/2006, on the following grounds (Distrito Federal, 2010, p. 3):

1) the CFM is competent to issue Resolution No. 1.805/2006, which does not deal with criminal law, but rather with medical ethics and disciplinary consequences;

2) orthothanasia is not a crime of homicide, as interpreted by the Criminal Code in the light of the Federal Constitution;

3) the publication of Resolution No. 1,805/2006 did not lead to any significant changes in the day-to-day lives of doctors who deal with terminally ill patients, and therefore did not generate the harmful effects advocated by the initial petition;

4) Resolution 1.805/2006 should, on the contrary, encourage doctors to describe exactly the procedures they adopt and those they fail to adopt in relation to terminally ill patients, allowing greater transparency and enabling greater control of medical activity;

5) The requests formulated by the Federal Public Prosecutor's Office should not be accepted, because the measures sought will not prove useful, given the arguments developed.

The current Code of Medical Ethics (2019, p. 28) emphasizes the applicability of orthothanasia in its article 41:

> In cases of incurable or terminal illness, the doctor must offer all available palliative care without undertaking useless or obstinate diagnostic or therapeutic actions, always taking into account the patient's express wishes or, if this is impossible, those of their legal representative.

In the light of current national legislation, there is no legal provision preventing the practice of Orthothanasia as a medical treatment, since "no one will be obliged to do or refrain from doing anything except by virtue of the law", as determined by article 5, II, of the Federal Constitution (Brazil, 1988).

In the practice of orthothanasia, there is no intention or action to harm life, so there is no need to consider the hypothesis of the crime of homicide provided for in article 121 of the Penal Code (Brazil, 1940).

Nor does the practice of orthothanasia involve the omission of aid, provided for in Article 4 of the Penal Code (Brazil, 1940), since it involves a patient with an irreversible illness, who has already received the necessary care for his hypothetical recovery, but without success.

Nor does it violate the principle of human dignity, set out in Article 1, III, of the Federal Constitution (Brazil, 1988).

FINAL THOUGHTS

When we talk about orthothanasia, we are not talking about a situation in which the patient is allowed to die due to neglect or lack of care. When we talk about orthothanasia, we are talking about a situation in which the patient has already received treatment, but their death is inevitable. To prolong the patient's life would be to prolong their suffering, to extend their death. Allowing a suffering patient with imminent death to die is not depriving them of their right to life, nor is it offending the unavailability of the right to life, but it is guaranteeing their dignity. Therefore, we should not understand that orthothanasia violates the unavailability of the right to life.

In view of the above, it follows that orthothanasia is a practice that is not only permitted, but in many cases the best way to enforce the principle of human dignity. It should not be confused with euthanasia, nor with dysthanasia. It is the viability of allowing the patient to die naturally, when they are already in a state of irreversible health and inevitable death. It can also be added to Palliative Care, seeking the least discomfort for the patient in their remaining time of life. It's not about killing the patient, but allowing them to die naturally. As in its etymology, orthothanasia is the right way to die.

Only through professional education will it be possible to properly train doctors who are trained in orthothanasia, doctors who, when faced with patients with incurable or terminal illnesses, will be prepared to offer medical care that is comfortable and minimizes suffering and pain.

AUTHORS

ANTONIO VALVERDE NEGREIROS JUNIOR

ADILSON PEREIRA

BIBLIOGRAPHICAL REFERENCES

ARAGUAIA, Mariana. Ortotanásia. Brasil Escola [s. l.], c2015. Disponível em: http://www.brasilescola.com/sociologia/ortotanasia.htm. Acesso em: 27 jan. 2024.

BARROS, Aidil J. da Silveira; LEHFELD, Neide Aparecida de Souza. Fundamentos de Metodologia científica. 3. ed. São Paulo: Pearson Prentice Hall, 2014.

BARROSO, Luís Roberto; VELHO MARTEL, Letícia de Campos. A Morte como ela é: dignidade e autonomia individual no final da vida. Revista da Faculdade de Direito da Universidade Federal de Uberlândia, Uberlândia, v. 38, n. 1, p. 235-274, 2010.

BORGES, Roxana Cardoso Brasileiro. Eutanásia, ortotanásia e distanásia: breves considerações a partir do biodireito brasileiro. Jus Navigandi, Teresina, v. 10, n. 871, p. 1-10, 2005.

BRASIL. [Constituição (1988)]. Constituição da República Federativa do Brasil de 1988. Brasília, DF: Presidência da República, 1988.

BRASIL. Decreto-Lei nº 2.848, de 7 de dezembro de 1940. Código Penal. Rio de Janeiro: Presidência da República, 1940.

5 - BRASIL. Ministério da Educação. Conselho Nacional de Educação. Resolução CNE/CES nº 3, de 3 de novembro de 2022. Altera os Arts. 6o, 12 e 23 da Resolução CNE/CES no 3/2014, que institui as Diretrizes Curriculares Nacionais do Curso de Graduação em Medicina. Brasília, DF: MEC; CNE, 2022.

BRASIL. Ministério da Educação. Conselho Nacional de Educação. Resolução CNE/CES nº 3, de 20 de junho de 2014. Institui Diretrizes Curriculares Nacionais do Curso de Graduação em Medicina e dá outras providências. Brasília, DF: MEC; CNE, 2014.

CAMPOS, Ana Cristina. IBGE: esparança de vida do brasileiro aumento 31,1 anos desde 1940. Agência Brasil, Rio de Janeiro, 26 nov. 2020. Disponível em: https://agenciabrasil.ebc.com.br/geral/noticia/2020-11/ibge-esperanca-de-vida-do-brasileiro-aumentou-311-anos-desde-1940#.Acesso em: 26 jan. 2024.

CASTRO, Andrea Augusta; TAQUETTE, Stella Regina; MARQUES, Natan Iório. Cuidados paliativos: inserção do ensino nas escolas médicas do Brasil. Revista Brasileira de Educação Médica, Brasília, v. 45, n. 2, p. e056 (1-7), 2021. Disponível em: https://doi.org/10.1590/1981-5271v45.2-20200162. Acesso em: 29 jan. 2024.

CONSELHO FEDERAL DE MEDICINA (CFM). Código de Ética Médica: Resolução CFM nº 1.931/09. Brasília, DF: CFM, 2010. Disponível em https://portal.cfm.org.br/images/stories/biblioteca/codigo%20de%20etica%20medica.pdf. Acesso em: 26 jan. 2024.

CONSELHO FEDERAL DE MEDICINA (CFM). Código de Ética Médica: Resolução CFM nº 2.217, de 27 de setembro de 2018 , modificada pelas Resoluções CFM nº 2.222/2018 e 2.226/2019. Brasília, DF: CFM, 2019. Disponível em: https://portal.cfm.org.br/images/PDF/cem2019.pdf. Acesso em: 26 jan. 2024.

1CONSELHO FEDERAL DE MEDICINA (CFM). Resolução CFM nº 1.805/06. Brasília, DF: CFM, 2006. Disponível em: https://sbgg.org.br/wp-content/uploads/2014/10/tratamentos-na-terminalidade-da-vida.pdf. Acesso em: 26 jan. 2024.

COSTA, Tanise Nazaré Maia; CALDATO, Milena Coelho Fernandes; FURLANETO, Ismari Perini. Percepção de formandos de medicina sobre a terminalidade da vida. Revista Bioética, Brasília, v. 27, n. 4, p. 661-673, 2019. Disponível em: https://doi.org/10.1590/1983-80422019274349 Acesso em: 28 jan. 2024.

DADALTO, Luciana. Testamento Vital. 2 ed. Rio de Janeiro: Lumen Juris, 2013.

DISTRITO FEDERAL. Seção Judiciária do Distrito Federal (14. Vara Federal). Processo nº: 2007.34.00.014809-3. Autor: Ministério Público Federal. Réu: Conselho Federal de Medicina. Relator: Juiz Roberto LuisLuchi Demo, 01 de dezembro de 2010. Disponível em: https://www.conjur.com.br/dl/se/sentenca-resolucao-cfm-180596.pdf. Acesso em: 26 jan. 2024.

FERREIRA, Julia Messina Gonzaga; NASCIMENTO, Juliana Luporini; SÁ, Flávio César de. Profissionais de saúde: um ponto de vista sobre a morte e a distanásia. Revista Brasileira de Educação Médica, Brasília, v. 42, n. 3, p. 87-96, 2018. Disponível em:https://doi.org/10.1590/1981-52712015v42n3RB20170134. Acesso em: 27 jan. 2024.

GIL, Antonio Carlos. Como elaborar projeto de pesquisa. 4. ed. São Paulo: Atlas, 2002.

GOLDIM, José Roberto. Eutanásia – Luxemburgo. UFRGS, Rio Grande do Sul, 03 mar. 2014. Disponível em: https://www.ufrgs.br/bioetica/eutalux.html. Acesso em: 26 jan. 2024.

INSTITUTO BRASILEIRO DE GEOGRAFIA (IBGE). Brasil: uma visão geográfica e ambiental do início do século XXI. Rio de Janeiro: IBGE, 2016.

INSTITUTO NACIONAL DE CÂNCER (Brasil). Cuidados paliativos. INCA, Brasília, 16 set. 2022. Disponível em:https://www.gov.br/inca/pt-br/assuntos/gestor-e-profissional-de-saude/controle-do-cancer-do-colo-do-utero/acoes/cuidados-paliativos. Acesso em: 26 jan. 2024.

JUNGES, José Roque *et al.* Reflexões legais e éticas sobre o final da vida: uma discussão sobre a ortotanásia. Revista Bioética, Brasília, v. 18, n. 2, 9 nov. 2010.

KNECHTEL, Maria do Rosário. Metodologia da pesquisa em educação: uma abordagem teórico-prática dialogada. Curitiba: Intersaberes, 2014.

LOPES, Antonio Carlos; LIMA, Carolina Alves de Sou; SANTORO, Luciano de Freitas. Eutanásia, Ortotanásia e Distanásia: aspectos médicos e jurídicos. 3. ed. atual. e ampl. São Paulo: Atheneu, 2018.

.

21 LUCKESI, Cipriano Carlos. Avaliação da aprendizagemescolar. 14. ed. São Paulo: Cortez, 2002.

MARTIN, Leonard. Aprofundando alguns conceitos fundamentais: eutanásia, mistanásia, distanásia, ortotanásia e ética médica brasileira. São Paulo: Loyola, 2004.

MENDES, Karina Dal Sasso; SILVEIRA, Renata Cristina de Campos Pereira; GALVÃO, Cristina Maria. Revisão integrativa: método de pesquisa para a incorporação de evidências na saúde e na enfermagem. Texto Contexto Enferm., Florianópolis, v. 17, n. 4, p. 758-64, 2008. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072008000400018&lng=pt&tlng=pt1. Acesso em: 29 jan. 2024

MOREIRA, Marco Antonio. O mestrado (profissional) em ensino. Revista Brasileira de Pós-Graduação, Brasília, v. 1, n. 1, p. 131-142, jul. 2004.

MORITZ, Rachel Duarte *et al*. Terminalidade e cuidados paliativos na unidade de terapia intensiva. Revista Brasileira de Terapia Intensiva, São Paulo, v. 20, n. 4, p. 422-428, 2008.

OLIVEIRA, Nielmar de. IBGE: expectativa de vida dos brasileiros aumentos mais de 40 anos em 11 décadas. Agência Brasil, Rio de Janeiro, 29 ago. 2016. Disponível em: https://agenciabrasil.ebc.com.br/geral/noticia/2016-08/ibge-expectativa-de-vida-dos-brasileiros-aumentou-mais-de-75-anos-em-11. Acesso em: 26 jan. 2024.

ORGANIZAÇÃO MUNDIAL DA SAÚDE (OMS). Cuidado paliativo. OMS, Genebra, 05 ago. 2020. Disponível em: https://www.who.int/news-room/fact-sheets/detail/palliative-care. Acesso em: 26 jan. 2024.

ORGANIZAÇÃO PAN-AMERICANA DE SAÚDE (OPAS). OMS divulga recursos para lidar com flagrante escassez de serviços de cuidados paliativos de qualidade. OPAS, Genebra, 05 out. 2021. Disponível em: https://www.paho.org/pt/noticias/5-10-2021-oms-divulga-recursos-para-lidar-com-flagrante-escassez-servicos-cuidados. Acesso em: 26 jan. 2024.

PEREIRA, Erika Aguiar Llara; RANGEL, Adriana Belle; GIFFONI, Julia Calixto Guimarães. Identificação do nível de conhecimento em cuidados paliativos na formação médica em uma Escola de Medicina de Goiás. Revista Brasileira de Educação Médica, Brasília, v. 43, n. 4, p. 65-71, 2019. https://doi.org/10.1590/1981-52712015v43n4rb20180116. Acesso em: 26 jan. 2024.

PESSINI, Leo; BERTACHINI, Luciana. Humanização e cuidados paliativos. São Paulo: Loyola, 2004.

PESSINI, Leo. Distanásia: até quando prolongar a vida? São Paulo: Loyola, 2001. (Coleção Bioética em Perspectiva).

PINELI, Paula Pereira *et al.* Cuidado Paliativo e Diretrizes Curriculares: inclusão necessária. Revista Brasileira de Educação Médica, Brasília, v. 40, n. 4, p. 540-546, 2016. Disponível em: https://doi.org/10.1590/1981-52712015v40n4e01182015. Acesso em: 29 jan. 2024.

POLETTO, Sadi; SANTIN, Janaína Rigo; BETTINELLI, Luiz Antonio. Vivência da morte de idosos na percepção de um grupo de médicos: conversas sobre a formação acadêmica. Revista Brasileira de Educação Médica, Brasília, v. 37, n. 2, p. 186-91, 2013. Disponível em: https://www.scielo.br/j/rbem/a/DRxnqX53fkvNTFdvkrdZJBn/?lang=pt#. Acesso em: 29 jan. 2024.

RABELO, Edmar Henrique. Avaliação: novos tempos, novas práticas. 8. ed. Petrópolis, RJ: Vozes, 2009.

REIRIZ, André Borba *et al.* Cuidados paliativos, a terceira via entre eutanásia e distanásia: ortotanásia. Prática Hospitalar, [s. l.], v. 6, n. 48, p. 77-82, 2006.

RIBEIRO, Renato Janine. O mestrado profissional na política atual da Capes. Revista Brasileira de Pós-Graduação, [s. l.], v. 2, n. 4, p. 8-15, 2005.

SANTORO, Luciano de Freitas. Morte Digna: o direito do paciente terminal. Curitiba: Juruá, 2010.

SANTOS, Luís Roberto Gonçalves dos; MENEZES, Mariana Pires; GRADVOHL, Silvia Mayumi Obana. Conhecimento, envolvimento e sentimentos de concluintes dos cursos de medicina, enfermagem e psicologia sobre ortotanásia. Ciência & Saúde Coletiva, Rio de Janeiro, v. 18, n. 9, p. 2645-51, 2013. https://doi.org/10.1590/S1413-81232013000900019. Acesso em: 29 jan. 2024.

SANTOS, Scheila Barbosa dos. Direitos fundamentais e ortotanásia: entre a saúde e a autonomia do paciente terminal. 2015. 297 f. Dissertação (Mestrado em Direitos Fundamentais e Democracia) – Programa de Mestrado em Direitos Fundamentais e Democracia, Centro Universitário Autônomo do Brasil, Curitiba, 2015.

VILLAS-BÔAS, Maria Elisa. Da eutanásia ao prolongamento artificial: aspectos polêmicos na disciplina jurídico-penal do final de vida. Rio de Janeiro: Forense, 2005.