Compassion and *Leges Artis* in (Portuguese) Medical Law

Maria do Céu Rueff

CEJEA/FCT Universidade Lusíada
Centro de Direito Biomédico da Faculdade de Direito da Universidade de Coimbra

1. The legal-criminal setting of aid to death and dying

I will approach the legal-medical issue of "aid to dying" (Jorge Figueiredo Dias, 2008), or direct aid to death, a term that I will adopt during my presentation.

As aid to death in the legal criminal field, Figueiredo Dias (2008: 203) understands the aid provided in accordance with the patient's real or perceived request, when the patient is severely and hopelessly ill, often in unbearable suffering – a request in the sense that the patient may reach his/her death in a way that the patient believes, or may have reasons to believe, it will preserve his/her human dignity.

Nowadays we tend to highlight three forms of aid to death and dying:

- *Direct active aid to death*: when an active form of behaviour causes death or hastens its occurrence (e.g. by administration of lethal injection);

- *Indirect active aid to death*: when we cannot exclude or it is not safe to conclude that the medication given with the sole purpose of alleviating the pain or induce unconsciousness may result in the unintentional hastening the moment of death (e.g. administration of increased doses of morphine);
- *Passive aid to death*, for the cases in which the failure and interruption of treatment are likely the cause of a shorter life span. This is understood as objectively attributed to those situations (e. g. denial of surgical intervention or intensive care that is likely to prolong the patient's life span).

Several principles are here at stake: at first, the protection and defence of human life, according to art. 24 of the Constitution of the Portuguese Republic (CPR). Therefore, the aspect of the life protection is located in the Art. 134 of the Penal Code that incriminates the *homicide by request* consisting in the act of providing death to another person following the serious and clear request that he/she has made to the agent. Also the incitement or aid to suicide builds a type of illicit (art. 135 of the Penal Code). Even though we tolerate suicide, which is not punishable in our Penal Code. Note also that Art. 133 of the Penal Code, concerning the privileged homicide, foresees "compassion" as one of the reasons that may reduce significantly the guilt. It maintains, however, criminal accountability and the type of homicide for the agent.

In these normative predictions several factors are not taken into account, namely:

1. The situation of the disease.
2. The situation of the terminal illness.
3. The unbearable suffering.
4. The possible proximity for the ending of life.
5. The occurrence or necessity of medical care.
6. The doctor-patient relationship at the end of life and the possibility to alleviate suffering, according to the means available to the medical science today.
7. The exercise, let us say, of compassion due to the suffering that we can witness in the moment of transition – but yet belonging to life – which we call death.

I emphasize, on the other hand, that the Portuguese legislator took into consideration the medical activity in the special part of the Penal Code (art. 150), where the procedures carried out by the physicians according to the *Leges Artis* are just considered as atypical. Among other aims implicit in this norm, the expression "to suppress or minimise suffering" is also found.

This justifies the question already raised as self-assertion in the title of this paper: what (kind of) "*Leges Artis*" at the end(ing) of life? How to articulate "*Leges Artis*", end(ing) of life, compassion and criminal law?

2. "*LEGES ARTIS*" AND END(ING) OF LIFE

Given these norms of the Penal code, let specify some positions:

In cases of passive aid to death by patient's will, Figueiredo Dias (2008: 207) considers that primacy should be given to the patient's will,

according to art. 156 of the Penal Code, and concludes that "*the omission or interruption of treatment does not match a typical omission in the sense of the crime of homicide*" (underlined by the author).

In the case of indirect active aid to death, Figueiredo Dias (2008: 211-212) believes that the physician's conduct is atypical, given the difference of social content verified between the crime and the medical action with the intention of alleviating the patient's unbearable suffering. He remits here to categories such as social adequacy or the ambit of the normative protection, and understands that the resulting death cannot be objectively attributed to the agent, due to the fact that it does not exceed the permitted risk. Conversely, according to this author, the investigation of the presumed wish of the patient should be carried out in situations of passive aid, in which the patient is in no condition to express his/her wish, either because the death process has began, or when the patient is near death yet may still live for months and years, that is to say, in a "permanent vegetative state" (Figueiredo Dias, 2008: 209-210). This is the reason why in Portugal so much importance is given to the issue of the patient's living will or vital will.

The relevance of the principle of autonomy, resulting from the eminent dignity of the human being and the consequent right of self-determination of the individual, is not negotiable. It is interesting how Figueiredo Dias (2008: 206) stresses its validity in this matter. He says that the principle of autonomy is "a true *fundamental ethical rule* – if there is even a "*lex artis* – that should govern the medical activity". He further clarifies that the physician's respect for the patient's will corresponds to a healthy understanding of the physician's *function*, and

advances the following about the role of such function:

a) It may not consist in keeping alive at any price the patients who are entrusted to the physician, nor is it allowed keeping them alive contrary to their true will.
b) It shall consist in providing the patients "the best conditions to die naturally with peace and dignity", by giving up "the paraphernalia of technical instruments which are today available to artificially maintain the vital functions".
c) Having in view the progress of the medical technology, what determines the limits of the duty of medical care is not the efficiency of the machines, but the decision, case by case, addressed to human life and dignity. (Figueiredo Dias, 2008: 206).

These are some of the "*leges artis"* in end(ing) of life. The question still remains, how to deal with the cases of direct active aid to death. It is here that the author admits, in principle, the incrimination by the articles 133 to 135 of the Penal Code (Figueiredo Dias, 2008: 214-215). He puts, however, the question whether we shouldn't go further and produce a very strong reduction of the ambit of protection of the incriminating norm. This, by taking into account the motives ruling the act, and since there is a reasonable and objectively founded request towards death. Therefore, *de lege ferenda*, Figueiredo Dias (2008: 215) proposes that a new number is added to the types of homicide by request and aid to suicide, foreseeing that the courts may deliberate, in some cases, the exemption of punishment.

Faria Costa (2003) has a similar point of view but goes further. Using the term *euthanasia* and not aid to death, and by focusing only in its two main types (according to him) – passive and active euthanasia – he sets immediately aside the indirect euthanasia (or doctrine of the "double effect") claiming that it is not euthanasia.[1] Thereafter focusing on the active direct euthanasia, the author underlines the aspect of self-determination of whoever consents and requests, and he arrives at the medical act, in which the issue is in fact centred, then placing here the argumentative *locus.* In his words: "Throughout this reflection it has become clear that active euthanasia, sustained by serious, firm and expressed request, may not be carried out by anyone. It is common ground that such an act must have the dignity that it can be carried out by a physician only" (Faria Costa, 2003: 791).

On the other hand, taking into consideration the medical advances, above all medical support, Faria Costa (2003: 794-795) states that the end of life was thrown into "unthinkable chronological ages": in a way that the perception of the end(ing) of life for the person who goes through this experience is not so much a perception of death, but rather a perception of "ceasing to live". Therefore, the ethical-juridical sense of who claims for himself the power of "ceasing to live" is a value that the legal order cannot fail to consider. Though for now – he says – "maybe [a value] of low density".

Faria Costa states that the acceptance of impunity of an active euthanasia carried out by a physician presupposes a very rigorous procedural system which should be based on the following six requirements:

a) active euthanasia, based on a serious, firm and expressed request, cannot be but a clearly exceptional and justified practice;
b) it is justified only in the terminal phase of an incurable and severe illness;
c) the provision of palliative care is absolutely an indispensable procedure;
d) it cannot, in any case be practiced on minors of age, even if emancipated, nor on mentally ill patients, even though they have expressed their wish, when in a perfect state of mind;
e) only a physician can practice euthanasia;
f) the physician can always enforce the right of conscientious objection (Faria Costa, 2003: 796).

Concerning the legal frame, within Criminal Law, of the act of "ceasing to live", Faria Costa (2003: 801) comes to prefer, among alternatives such as "a personal cause for excluding criminal responsibility" or "a cause of exclusion of unlawfulness", a third one that he defines as "not even filling the legal type of crime". He justifies this position by taking into account the article 150 of the Penal Code:

> This norm expresses unambiguously a medical privilege. As long as medical procedures are carried out under the intentions previously mentioned, they do not even fill the type of legal crime of offences against physical integrity. So, within this normative architecture, it would not make sense or have little sense to split the unity of the medical act. What would imply that the active euthanasia, practiced by the physician, while executor of the medical act, should not even qualify the legal type of homicide. However, all that has just been considered (…) only makes sense and legal-criminal sense, if it is accepted (…) within the actual medical thinking, that such acts, those of 'ceasing to live', are still

> and will always be medical acts." Accordingly, this is a problem "that is not confined to the strictly legal field (Faria Costa, 2003: 802).

I completely agree with this position in three main assumptions:

> 1º. To consider the act of aid in "ceasing to live" as a medical act;
> 2º. To regard such act as extremely different from those foreseen under the protection of the homicide norms, even if in these norms some sort of privilege is at stake;
> 3º. To consider that this act of aid to death or aid in ceasing to live – whichever expression you may prefer – should be integrated in the acts likely to support the "contra-type" of article 150, no.16 of the Portuguese Penal Code.

I only do not agree with Faria Costa when he places – in my point of view excessively – all the emphasis in the patient's self-determination. Instead, the focus should be directed to the encounter of two autonomies – that of the physician and that of the patient – which the medical act should always presuppose. For it is at that moment of unbearable suffering that the patient mostly needs the help from another human being. It is also then that the physician as a human being is able to be self-determined in his/her performance by the experience of condoling, formed from the Latin con + (plus) dolere (to fill pain), which serves to introduce here another expression that describes identical reality: compassion, the latter formed by the words con + (plus) pathos, this is, passion with, meaning in this case to suffer together with another.

This is also evidenced by Jorge Soares (2010: 191) – physician and Director of the Portuguese Institute of Oncology – by stating that "the medically assisted suicide can only be understood (…) in the most nuclear of the relationship between doctor and patient, who makes him a rational, reflective, inflexible and insisting appeal to get aid to die, when medicine, family, friends and above all the physical and psychological suffering, exhausted any meaning of life or of what remains of it". Jorge Soares then continues: "it is not (– and can never be!) a professional duty of the physician performing any act that anticipates the death of his/her patient, even though his will is inflexible and sincere. But, one can understand it as a compassionate response to an insistent request, although under no circumstances being easy to decipher the language of suffering and evaluate the authenticity of the request that sometimes the physician thinks he hears."

3. Hippocratic Authors, compassion, lethal drug

The word "compassion" does not exist in the Hippocratic Oath, but its observation and the necessity to act in conformity with the Greek medical practice results from the so called "*Hippocratic Corpus*"[2]. The reading of nowadays called "clinical" cases, in one of those treaties, denominated *Epidemics*, clearly transmits the idea of the compassionate physician at the patient's bedside. Also in the treaty *The Art* or *Science of Medicine* is written that medical care may be given until the end, but that the death is something natural.[3]

As pointed out in other cases that I will briefly leave aside for now, the aid to death is not unfamiliar to the physicians of the Hippocratic

tradition. What is difficult to articulate is this reality with the passage of the Hippocratic Oath condemning the administration of any lethal substance to the patient. So it is necessary to clarify interpretations already made on this part of the oath, notably by João Lobo Antunes (210: 166) when he says – and I agree with him – that: "Making the Hippocratic oath normative and not understanding its symbolic meaning is one of the unfortunate and double-faced confusions of our [medical] profession."

Miles (4004: 67-68) means that the expression "I will not give a fatal drug to anyone if I am asked, nor will I suggest any such thing" has nothing to do with nowadays concepts of medically assisted suicide, voluntary/involuntary euthanasia or withdrawal of life support measures. Accordingly, he explains that the term suicide in the Greek language did not arise until long after the oath was written. Afterwards, because even when it arises, it appears associated with concepts such as acceptance of heroic death by another, or giving yourself the death for shame, which has nothing to do with an intentional termination of life as a way of ending the suffering caused by disease. Miles also puts in evidence that the Greek word euthanasia, which literally means good death, was not coined until 280 (b.C.), that is, about a century after the Oath was written and that this new term did not refer to aiding death (or assisting death), but to the natural death without agony, and therefore it does not coincide with the meaning it has today.

I must leave aside hereby the further discussion of this part of the Oat, taking into account the positions of Diego Garcia (2007: 69-93), Albert Jansen (2008: 5), Miles (2004: 73-74), Littré and Geoffrey Lloyd (both

apud Miles 2004). Any way, I have no doubt to conclude that none of the conceptions about this passage of the Oath has any similarity with aiding in situations of unbearable pain or compassion during all the care moments, even at the end of life. Rather, such part of the Oath is related to the maximum of prudence that should regulate the medical action and also to the preservation of the physician's exemption by providing medical care. Its aim is to guarantee that the confident relationship between doctor and patient is established always to help the patient and never to cause damage (harm or injury) to him. Any other limitation or moral value is not the most important at stake here.

4. Aid in death, as a medical act

Today some countries in the world allow either active direct euthanasia or assisted suicide.[4] I will not go into the analysis of the measures taken by those legal systems leading to the legalization of such practices. A study by Penny Lewis (2007) as well as another by Laura Ferreira dos Santos (2009)[5] follow this path. I retain from both the role they ascribe to the Dutch case, to accentuate how the normative change was processed.

The legal framework of the issue in Netherlands was based on the art. 293 of the Penal Code that provides for homicide by express and serious request. What took place before this legislation[6] was that some cases went to trial[7], having been judged by the Supreme Court, based on article 40 of the Penal Code that allows the justification by necessity. It was then declared that a physician before the conflict of duties – life preservation and pain relief of the patient – may defend

himself by justifying necessity, if he choose the latter for being most important under an objective point of view, even if this implies something which is in itself forbidden. The Supreme Court of the Netherlands recognized that the physician's duty to relieve a "hopeless and unbearable suffering"[8] could justify the application of defence by clause of necessity, which became the basis of the decriminalization of euthanasia and the opening for the assisted suicide. This means that the recognised defence basis resides in the patient's experience of unbearable suffering, but also means that this basis is sustained by the verification that only a physician may find himself faced with such conflict of duties: that is, concomitantly, preservation of life and relief of suffering (Lewis, 2007: 80, 125).

Amongst the invoked motives which led to such legal change is the prominent role of the physicians and the medical profession in Holland. What still explains the duty of the physicians in relieving suffering and the necessity for their role in the legal change (Lewis 2007:105). Laura Ferreira dos Santos (2009: 38) states: "In all this debate about the termination of life, apart from the action of the courts, the action of the Royal Medical Association of Holland (the first and apparently only one) association in the world to support from the beginning the voluntary termination of life, must be highlighted". Also João Lobo Antunes (2010: 165) places this reality into evidence by arguing "that the Dutch law is explicit in the absolute respect for autonomy, and demands the repeated expression of that will. Therefore, in Holland euthanasia is a medical act."

5. Medical compassion in dying: from an automatic homeostasis to a deliberate homeostasis

Antonio Damasio (2003: 31-39)[9] questions the origins of the ethical behaviour, notably whether it is moulded by the genome or through culture transmitted by learning and socialisation processes. The author states that emotions are the key to the mystery. To explain this, he summarises the neurobiology of emotions facing them in a complex picture that has do with life regulation, which he calls the homeostasis frame. At the top of the list he places the so-called social emotions and among them, the compassion, in which "the competent emotional stimulus is the suffering of the other individual. The feeling that follows it has as a consequence the comfort and re-balancing of the other or the group" (Damasio, 2003: 32-34).[10]

Damasio (2003: 36) emphasizes the difference between genetic behaviour and ethical principles – despite of the existence of a connection between both – and states that ethics consists in the construction and debate of the principles that took place through the human civilisations and not only by something brought by a genome. Whereby, as to the ethical behaviour, we have resulted with great probability from double influences: one that has to do with biological evolution, through the genome, and another that results from the construction of a social, cultural space, which can only occur in the humans, who are endowed with conscience and emotion.

Damasio puts the question why emotions have so much importance in the construction in Ethics and Law, and the answer comes from a fact that he says being curious: notably, that emotions, in their basic aspect,

have to do with the regulation of life. They are "*ipsis verbis* instruments of homeostasis. Without emotions and the mechanisms that are underlying them, it is not possible to survive in well-being (…)". But, according to Damasio, the ethical principles, the laws and socio-political organizations are also homeostasis mechanisms, even though they are not seen in this manner. In conclusion, Damasio (2003: 38) states: "I consider Ethics, in general, and everything else that belongs to it, as an extended homeostasis, a homeostasis that does not come directly from genome, a homeostasis that we have been building. And, it is curious to think that that it is a recent construction. We have a few thousand years behind us in the construction of these new homeostasis techniques, on the contrary to what happens with the emotions, which have millions of biological evolution. This is a gradual process (…), a process which is also a work in progress. (…) The beauty of this idea has to do with the transition of an automatic homeostasis to a deliberate homeostasis."

I do not hesitate in seeing in the discussion of the dilemma I am dealing with a "transition of an automatic homeostasis to a deliberate homeostasis". To the extent that we passed, successively, from the response of automatic compassion in medical care to its discussion in medical ethics, afterwards in the courts, and now as a normative instrument.

In fact, it is within the medical act that the question of aid to death is to be focused (I agree with Faria Costa as well as with the Supreme Court and the Physicians of the Netherlands): medical act determined by the will of the patient, but also, concomitantly, in a balanced way, by the other pole of the relationship: the physician. Thus, it is in the

encounter between both that an agreement will take place between the will to cease life and the duty to alleviate suffering, that is, the moment of compassion.

An integrated perspective of the medical law such a I have proposed (Rueff, 2009; Eser, 2004) – based on the interdisciplinary crossing of medical and legal methods –, will comprise certainly all situations of medical compassion at the end of life (a development that we are observing), in order to embrace the widest spectrum of situations. Until we arrive at the affirmation of João Lobo Antunes (210: 169): "It does not seem to me that the entire profession is threatened by the adoption of the tempered regulation of this practice: I am close to Battin, who speaks of 'the least bad of the deaths', supported by what he calls the *principle of mercy* or, if you will, compassion, which is not synonymous of beneficence".

In fact, not listening in a situation of incurable disease to the insistent request of the patient to the physician to alleviate suffering means not *humanely* responding to such request. If indeed it is difficult to see in this situation the accomplishment of the principle of beneficence – because beneficence without life and body is something that cannot be objectified – at least we may consider the case as an accomplishment of the principle of non-maleficence. In fact, the omission of the physician's intervention would mean, during the entire period of the inaction, an evil – that is, the unbearable suffering –, that precisely the patient implored to be ceased.

In criminal-legal language, the physician has here the domain of the fact, in the double sense of the term: the exclusivity of means, and the opportunity of putting an end to suffering, or rather, not causing

further harm. The Criminal Law cannot be indifferent to this reality, be it called compassion, or not.

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1 | Because "it is nothing more than the acceptance of a behaviour perceived by almost everyone as lawful". Also regarding passive euthanasia, the author says that he only considers it when it may be translated into an act of behaviour, even if omission, that leads to the termination of the life of the person who requests this in a firm, clear and constant manner, and since the act is carried out by a physician (Faria Costa, 2003: 781-782).

2 | Cfr further development in Rueff (2009).

3 | Thus: "Our practice is limited by the instruments made available by nature or art. When a man is attacked by a disease which is more powerful than the medical instruments, there should be no expectation that medicine is victorious. (…) When the physician fails it is the power of the disease which is responsible and not the deficiencies of the medical science."

4 | Is the case of Holland, Belgium, Switzerland, Luxemburg, or the state of Oregon in the USA.

5 | Suggestively titled "*Will you help me to die?*" traces the route of what she calls in the subtitle of the work "*The assisted death in the culture of the twenty-first century*".

6 | Carried out by the legal instrument titled *Termination of Life on Request and Assisted Suicide (Review Procedures)* act 2001 (Lewis, 2007: 77; Santos, 2009: 42).

7 | Namely the first in 1984 – Case Schoonheim (Lewis, 2007).

8 | Or *unbearable and hopeless suffering* (Lewis, 2007: 78).

9 | Titled *The Ethics of Neuroscience: under the sign of Espinosa.*

10 | João Lobo Antunes referred to "mirror neurons" in a recent interntional conference held in Lisbon.